Holding space for nuance in irritable bowel syndrome: the ethical dimensions of medical ambiguity

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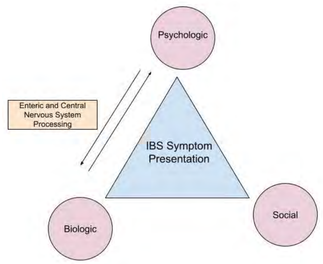

Introduction

Irritable bowel syndrome (IBS) is a disorder of gut-brain interaction. It is common, though symptoms can be ambiguous as they are thought to emerge from a rich biopsychosocial context. There is particular ethical potency in the care of IBS patients as the social dimensions of care factor so prominently in not only the experience of the illness but also its pathophysiology. A syndrome that rests among intricate and poorly delineated relationships between biologic, psychologic, and social domains, IBS may not always lend itself to traditional clinical discussions. Here, I hope to explore how:

1. Narrative ethics offers a tool to carry the nuance of this diagnosis
2. We can interrogate stories and how they operate in service of better patient care
3. How such thoughtfulness may help to eliminate IBS care disparities

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I.

Disease classifications are rarely as clean as they seem at the outset. This is particularly true for disorders like IBS. Clinical criteria may miss some patients or diagnoses.
Rita Charon, a pioneer in the field of narrative medicine, describes narrative ethics as a "ground-up" approaching singular patients and then move toward general principles, rather than the reverse. This may serve as a tool to encompass nuance in clinical practice.

II.

Stories play a particularly important role in IBS as the mind plays a role in both the perception and propagation of stories. Patient narratives about illness take on greater importance in this context.

"Bodies are realized – not just represented but created – in the stories they tell."
- Arthur Frank

Physician narratives and cognitive biases have a profound affect on clinical care, and often have an outsized role in medical spaces.

III.

One wonders what lay cultural narratives about IBS patients may vary by race.

- There is a paucity of data regarding disparities in IBS care
- Our data demonstrates that minority patients with IBS undergo more procedures than white patients with IBS
- More procedures counterintuitively do not reflect higher quality care
- Disparities in IBS is even more important to understand given that social experience is an important component of disease development and symptom severity

Illnesses at margin of understanding

Caring for IBS patients demands that one contend with larger questions

- What constitutes illness?
- How do the stories patients and physicians tell change symptom and treatment experience?
- In what ways are we biased? And how does that change outcomes for patients?

IBS is a disorder that requires more complex consideration than some other diseases. Grappling with this ambiguity will likely require more sophistication. Multidisciplinary approaches can help hold nuance in service of more comprehensive and sensitive patient care.

"That a field to some degree is always constituted by the questions we ask of it, that the status of the objective is problematical, does not cancel this obligation so much as make it a more difficult and subtle one to satisfy."
- Nina Baym

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Black Maternal Health Disparities and the Effects of Roe v Wade Being Overturned on Maternal Health Disparities

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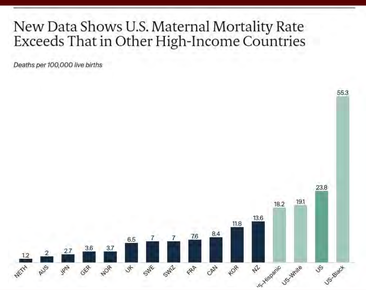

Introduction

"We need to reconsider the meaning of reproductive liberty to take in to account its relationship to racial oppression" – Dorothy Roberts. Black women are 3-4x more likely to die secondary to pregnancy related causes on top of that they are more likely to have a preventable death (44% vs 30% White women). The 5 main causes of pregnancy mortality are venous thromboembolism, hemorrhage, pre-eclampsia, infection, and cardiomyopathy. Pregnancy related mortality ratio has been increasing, going from 9.1 from 1987 to 1990 to 16 from 2006 to 2010; with Black women having the fastest rate increase in maternal deaths between 2007 -2014 with the death rates up to 12x higher in some cities.

Dr. Uche Blackstock has recently tweeted about an article that discussed new data from the last few years which showed the US maternal mortality rate continues to exceed that of other high-income countries. The high rate is driven by the deaths of Black birthing people.

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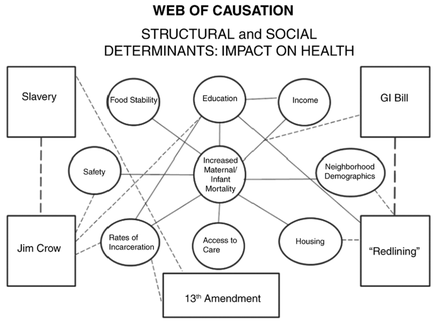

Frameworks in Place to Close the Gap

- Alliance for Innovation in Maternal Health
  - Published "reduction of peripartum racial/ethnic disparities patient safety bundles"
  - Started in 2014 and currently 48/50 states are enrolled
  - Bundles are sets of straightforward proven practices that are used in birthing facilities to improve patient outcomes and reduce severe illness and death
- Centering Pregnancy Group
  - Created prenatal care model in the early 1990s focusing on prenatal care for pregnant women
  - Group follows the recommended schedule of 10 prenatal visits (but longer visits 90mins to 2 hours)
  - Brings 8-10 women all with similar due dates together
- California Maternal Quality Care Collaborative (CMQCC)
  - Started in 2006
  - Used data driven approaches to understand the root causes of maternal mortality
  - In 13 years since started the reduction in maternal mortality rate went from 16.9 per 100,000 to 7.3
- Pregnancy Medical Home
  - In 2011, created by the North Carolina Division of Health for low-income pregnant Medicaid patients
  - Since the program launched it was reported that the state saw a decline in black maternal mortality rates but also a decline in C-section rate among Medicaid recipients and improvements in low-birthweight rates among babies

Roe V Wade Overturned

- On June 24, the U.S. Supreme Court overturned Roe v Wade Wade
  - As of Feb 2023, there are 13 states who have banned banned abortion, 5 states with a gestational limit ranging ranging from 5 weeks to 20 weeks, and 6 states that had had their abortion ban blocked
- Estimates on the impact of an abortion ban suggest that there there could be a 21% increase in mortality overall and a 33% 33% increase for Black women
- Doctors at Clements University Hospital and Parkland Hospital, Hospital, large safety net hospitals for Dallas County, looked at looked at outcomes among pregnant women and reported that after the Texas ban in September 2021 the maternal morbidity was almost doubled that among women in states states without similar laws
- Rates of abortion and unintended pregnancy have increased in increased in countries that restricted abortion access during during the past 30 years compared with those where abortion abortion is legal and accessible.
  - The World Health Organization (WHO) estimates that at at least 7.9% of maternal deaths are due to unsafe abortions, which is often due to complications including including uterine perforation, hemorrhage, and infection infection

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WITHDRAWAL OF LIFE SUSTAINING THERAPY IN NEUROSURGICAL PATIENTS: AN URBAN BIOETHICAL REVIEW

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Abstract

Physicians encounter significant difficulty when faced with decisions related to withdrawal of life-sustaining therapy (WLST) in patients with devastating brain injury (DBI). The complexity of this decision-making process is multifactorial, including practitioner- and patient-specific variables, as well as surrogate decision-maker bias, inaccuracies in scoring systems, and inconsistencies in guidelines endorsed by professional societies; these issues all contribute to the significant uncertainty of these situations and variability in treatment paradigm. Solutions are complex; however, analyzing WLST with an urban bioethical lens — which emphasizes the principles of solidarity, agency, and social justice — can enhance physicians' ability to navigate this uncertainty and ensure that potential solutions are patient-centered.

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Life-Sustaining Therapies

A machine to help with breathing (ventilator)	A tube or mask to supply oxygen
A machine to help your kidneys (dialysis)	A tube into your vein to provide fluids and medicines (intravenous, IV tube)
A tube into your stomach to provide food (nasogastric or gastrostomy tube)	Cardiopulmonary resuscitation (CPR)

Background

- Devastating brain injury (DBI) is defined by the Neurocritical Care Society as neurological injury where there is an immediate threat to life from a neurologic cause.[1]
- Withdrawal of life-sustaining therapy (WLST) is the leading proximate cause of death in patients with DBI.[2]
- Existing evidence supporting decisions to WLST is profoundly weak.
- Major dilemma – does premature WLST deprive patients of an opportunity to recover? Or does consistently sustaining life in patients with DBI subject patients to further adversity and discomfort.[3]
- There is significant variability in clinical decision making between hospitals and practitioners. Why?
  - Complex interaction between:
    - practitioner- and patient-specific variables
    - surrogate decision-maker bias
    - inaccuracies in scoring systems
    - inconsistencies in professional society guidelines

Recommendations

- In most cases, early, aggressive resuscitative efforts should be pursued for at least 72 hours, as prognosis is unreliable. Physicians should:
  - Challenge their biases
  - Remain wary of inaccuracies in clinical scoring systems
- The urban bioethical toolbox can be profoundly useful when navigating the decision-making process during times of uncertainty.
  - Solidarity: patient and provider as separate entities ➡ emphasis on healing bond between patient and provider
  - Agency: standardized list of solutions for all patients ➡ consideration of practicality of a solution within the patient's background
  - Social Justice: lack of consideration for patient background in distribution of resources ➡ emphasizes need for tailored advice to patient and family background.
- Formal training on difficult conversations and palliative care should be integrated into neurosurgical training and beyond.
- "News delivery teams" should be interdisciplinary and diverse. All members of the care team should be encouraged to provide input throughout the decision making process and during family discussions.
- Advanced directives should be drafted while young. They should be revisited regularly and modified to accommodate evolving personal values and beliefs.
- Professional societies and organizations making recommendations must collaborate and come to a mutual agreement that avoids ambiguity.

INCREASING DIVERSITY AND REPRESENTATION OF UNDERREPRESENTED IN MEDICINE STUDENTS USING PATHWAYS PROGRAM

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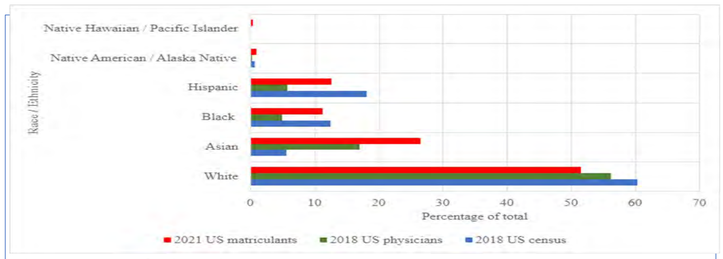

Figure 1. Total Diversity Comparison

Introduction

In 1978, 542 Black men attended medical school, yet in 2014, that number was only 515, meaning in 40 years, there has been a decline in Black men entering medicine (Ricks 2020). The sad reality of a declining Black male physician population is just one piece of a larger issue. There is a roughly 2.5x discrepancy for Black physicians, 3x for Hispanic physicians, and at least 2x discrepancy for American Indian or Alaska Native physicians.

These many challenges are the major leading causes of the dire emergency we are facing in medicine as URM and other minority groups are even declining in recent data. I next review the amazing solutions spanning the college level, medical school, and then residency as well as the role students can play. The goal is to show the progression of how change can be affected by the various roles in the physician's education timeline. I end with a case study of my Minorities to Medicine Pathways Program. When working in tandem with systematic changes at various levels, we can truly increase the diversity of our medical schools and overall medical field. Greater representation in medicine can improve the care of all types of patients and backgrounds, enhance our medical education system, and work to educate the next generation of physicians with a greater variety of clinical approaches, life experiences, and teaching styles which are not commonly found in our current physician workforce.

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Table 1: Itemized Costs to Apply to Medical School

Necessary Steps to Apply to Medical School	Costs
1. MCAT Preparation a. Question Bank b. Practice Tests c. Test Books d. Optional Classes	 $100+ $25 each (often 4+) normally $100-1,000+ $1,000-7,000+
2. MCAT Registration	$330
3. Primary Application a. Transcript submission	16 Average - $170 + 15(43) = $815 $5-25 total - school dependent
4. Secondary Application	16 Average - $50-125 = 50(16) or 125(16) Range from $800-2,000
5. Interviews a. Virtual - camera/webcam b. In-person - housing, travel, food	 $<100 typically $200-1,000+
TOTAL	$2,000-10,000+

Challenges That Lead to Disparities

Cost to Medical School – There are inherent barriers that prevent primarily URM students from entering medical school. Almost half of students entering medical school come from parents whose income is the top 2 quintiles. This goes hand in hand with the high costs to apply to medical school, based on recent data, would be at least $2,000 conservatively.

Lack of Mentorship and Representation – There are serious discrepancies between the physician population and the census population as explained earlier and this compounds for addressing mentorship. For URM students, finding mentorship Is difficult because of the lack of doctors who look like them, which makes matriculating into medical school even harder. In addition, non-white faculty are retained at lower rates compared to their white counterparts.

External Challenges – Addressing the Minority Tax – the extra responsibilities regarding diversity, equity, and inclusion work placed on minorities, discrepancies in mental health for URM students, and effects of historical racism/discrimination in present-day medicine

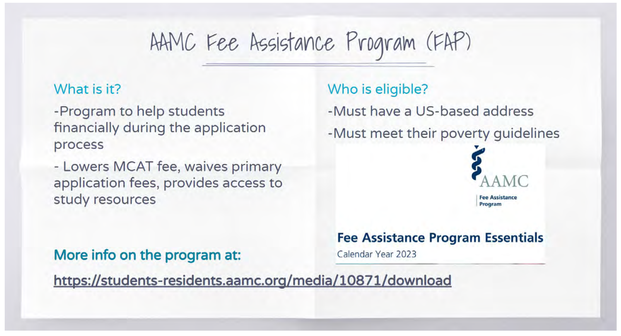

Figure 5. Federal Assistance Program (FAP) Overview slide for Pathways Program Session

Solutions and Pathways Program

College Level/University Level - Federal Assistance Program, FAP, for short which reduces the registration fee for the MCAT from $330 to $135 and a 1-year subscription to a free MCAT Prep bundle which includes 4 practice exams, question banks, formal study materials at a value of $269 for free. Addressing mental health issues minority students face with therapists from their backgrounds.

Medical School Level – Addressing issues of representation in both the student and faculty levels. To achieve diverse student representation – address the extreme costs to attend medical school, unforeseen challenges of medical students with emergency funds, and the importance of mentorship to ensure these students graduate and have adequate support.

Pathways programs – Using a program I created, educating pre-medical URM students on topics such as the MCAT, what "applying" to medical school costs, free resources, medical student life, and using panels of students and faculty regarding their experiences and tips for admission to medical school.

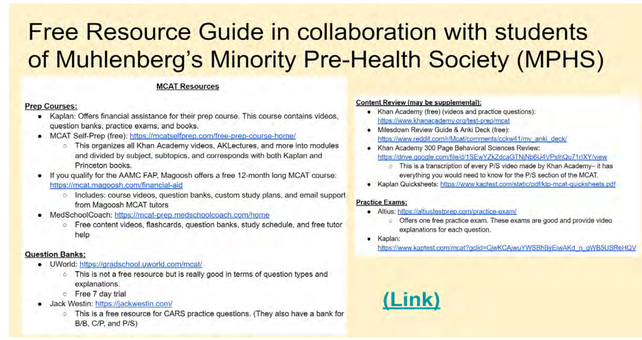

Figure 4. Free MCAT Resource Guide For Pathways Program Session

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AN ETHICAL EVALUATION OF FOOD INSECURITY (FI) AND ITS EFFECT ON CHILD HEALTH IN URBAN SETTINGS AND A DISCUSSION ABOUT AN ETHICAL OBLIGATION AS A HEALTH CARE PROVIDER TO ADDRESS THE ISSUE

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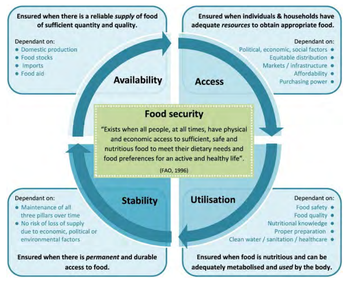

Introduction

- FI affects 1 in 7 households with children, disproportionately impacts marginalized populations, and has worsened as a result of COVID-19
- Amartya Sen was a pioneer in viewing FI as a violation of human rights and a consequence of poverty and inequality
- In order to address FI we must address root causes of FI, which include poverty, structural racism, and lack of social cohesion among more.
- Urban bioethics provides a lens to examine FI through agency, solidarity, social justice, community collaboration, and structural competency.
- My thesis explores the history of FI in the US, disparities in who is affected, the impact on children's health, and how we should address the issue within the healthcare system.

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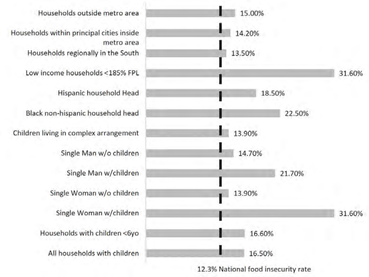

History of FI in the US

- 1995 FI incorporated into the Census Bureau's "Current Population Survey" through the "Food Security Supplement" (FSS) section.

Disparities and Racism

- FI disproportionately affects single parent households with children, families with low socioeconomic status (SES), and Black and Latinx families.
- Racial disparities persist after controlling for SES
- "Retail Redlining" results in fewer supermarkets in Black neighborhoods and more reliance on unhealthy food options
- FI is linked to intergenerational violence and trauma

Covid-19

- FI rates tripled to 38% as of April 2020 with 18 million children living in food insecure households.
- School meal programs disrupted due to school closures, adding to the burden on parents to feed their children

FI and Child Health

- Food insecurity has negative impacts on physical health, including increased risk of illness, slower recovery, micronutrient deficiencies like anemia, chronic diseases like asthma, and potential links to childhood obesity.
- Higher probability of aggressive behavior, inattention, irritability, hyperactivity, internalizing issues, depression, suicidal ideation, and high-risk behaviors.
- Longitudinal studies show negative effects on academic achievement, including lower test scores, repeating a grade, higher rates of absences, and suspension.

Addressing Food Insecurity Ethically

- Changes to SNAP during the pandemic include expanded benefit eligibility and waived paperwork requirements
- SNAP and WIC have become more punitive and localized, exacerbating racial inequalities and impacting access to public assistance for Black and Latina women.
- Food banks and pantries still have barriers such as limited hours of operation, transportation issues, and stigma hindering access for marginalized communities.
- Innovative programs such as prescription food boxes with integrated nutrition education and cooking demonstrations within healthcare settings show promise in improving access to healthy food and creating healthy habits.
- Social cohesion (solidarity within a community) can protect against FI, especially in minority populations.
- Important to screen for FI and have on-hand resources within clinics and in the community
- Opportunities for physicians to extend advocacy beyond clinic walls and partner with community organizations

Name	Population served	Description
Supplemental Nutrition Assistance Program (SNAP)	Individuals and families that meet state income eligibility requirements (generally at or below 130% of the federal poverty level for gross monthly income)	Supplements food budgets of individuals and families through monthly benefits that can be redeemed for food at retailers
Supplemental Nutrition Program for Women, Infants and Children (WIC)	Pregnant, postpartum, and breastfeeding women, infants, and children up to age 5 years who meet state income eligibility requirements (between 100 and 185% of the federal poverty level) and are deemed to be nutritionally at-risk	Provides access to nutritionally important food items including infant and toddler formula, milk, and other food products through monthly cash value benefits, as well as nutrition education, breastfeeding support, and referrals to healthcare
Child and Adult Care Food Program (CACFP)	Children and adults served by child or adult care centers, family or group care homes, and emergency shelters that meet income eligibility requirements based on poverty status of the area or income of enrolled children	Reimburses child and adult care providers, family and group care homes, and emergency shelters for paid, reduced-price, and free meals and snacks that meet federal nutrition requirements
National School Lunch Program (NSLP)	Children in schools and residential child care institutions whose households meet income eligibility requirements (130% and 185% of the federal poverty line for free and reduced meals, respectively)	Reimburses schools and school districts for free and reduced-price lunches during the school year that meet federal meal pattern requirements
School Breakfast Program (SBP)	Children in schools and residential child care institutions whose households meet income eligibility requirements (130 and 185% of the federal poverty line for free and reduced meals, respectively)	Reimburses schools and school districts for free or reduced-price breakfasts during the school year that meet federal meal-pattern requirements
Summer Food Service Program (SFSP)	Children up to age 18 who either live in an area where at least 50% of residing children qualify for free and reduced-price meals, or are enrolled in an organized program in which at least 50% of enrolled children qualify for free and reduced-price meals	Reimburses sponsors (including schools, government agencies, and nonprofit organizations) for free, supervised meals that meet federal nutrition requirements served at approved sites during the summer when school is not in session

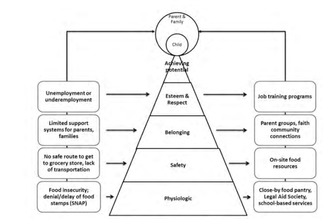

Fig. 4.4 Depiction of how Maslow's Hierarchy of Needs can be used to translate risks into connections to community resources. (Credit: Adrienne W. Henize, JD et al. [52])

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The Current State of Interpreters in Healthcare and Where We Go From Here

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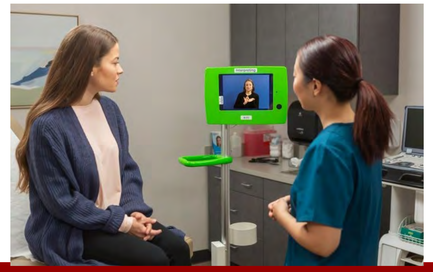

Introduction

- Over 25 million Americans reported limited English proficiency (LEP) with Spanish being the most common language in 2013.[1]
- Healthcare institutions started incorporating interpreter services to meet the increasing need, but the quality and implementation of these services differ depending on resources, accessibility, and execution.
- This perpetuates and potentiates the health disparities that this population already faces, and it can also negatively impact a patient's agency as they do not have the proper resources to fully advocate for their health.
- We need to address the systemic factors at play and what changes should be made to achieve equitable care, specifically:
  - why we should reconsider using ad hoc interpreters
  - how interpreters can affect agency of a patient
  - what it means to promote cultural competency at an institutional level
  - how we can improve the training that medical interpreters undergo
- We should strive to weave the core tenets behind these [illegible]

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Identifying the Problem

Table 1.
Five Most Frequently Spoken Languages Other Than English (LOTE) in U.S. Homes: 2019

Language	Estimate	Percent of LOTE population
Spanish or Spanish Creole	41,757,391	61.6
Chinese	3,494,544	5.2
Tagalog	1,763,585	2.6
Vietnamese	1,570,526	2.3
Arabic	1,260,437	1.9

Source: U.S. Census Bureau, 2019 American Community Survey, 1-year estimates.

Multiple studies demonstrate that using interpreter services leads to better patient outcomes, but the implementation remains suboptimal due to several different factors:

Ad Hoc Interpreters

- Some patients prefer trained interpreters due to medical accuracy and privacy concerns.[2]
- However, use of ad hoc interpreters (e.g., family member) remains prevalent despite availability of language services due to convenience, technical difficulties, and lack of interpreter in that language.
- Ad hoc interpreters are more likely to make errors of false fluency and omission, which can lead to serious clinical consequences.[3]

Agency

- Inadequate interpreter support can potentially affect a patient's agency if the interpreter (either trained or ad hoc) does not accurately interpret the patient's words, which can inadvertently shift the narrative.
- To better advocate for the patient without infringing on their agency, the interpreter can ask open-ended questions if they believe clarification would improve the patient encounter.

Cultural Competency

- Language barriers in isolation are associated with poorer health outcomes, but the effect is compounded by factors like health literacy, immigration status, and cultural differences.[4]
- One study found decreased odds of mortality in Latino children following an intervention that educated staff on culturally competent care, providing 24-hour language services, and employing more bilingual staff.[5]

Medical Interpreter Training

- There is a lack of regulation of medical interpreter training, and education programs do not possess a consistent set of criteria that shapes their training.[6]
- Education programs can range from a few hours to over 200 hours.[6]
- Much like how physicians undergo rigorous training to obtain their license, it should be expected that medical interpreters are held to a similar regard and undergo their own standardized form of training.

Evolving our Current System

What are potential solutions to improve upon the current infrastructure of interpreter services?

Competency-based Training

- There should be standardized training for medical interpreters which focuses on a set of competencies (e.g., medical terminology, intercultural communication) rather than number of hours.
- Rather than interpreting word-for-word like a "conduit," interpreters should be trained on how to facilitate patient-physician interactions by bridging cultural misunderstandings.

Physician Training

- Physicians should be trained on how to effectively collaborate with interpreters.
- For example, the physician should speak slowly and avoid addressing the patient in third-person.
- Some patients are more satisfied if the provider was bilingual. One study organized a 10-week medical Spanish course for ED physicians, and patients felt they were more listened to and overall reported greater satisfaction.[7]
- Learning even simple phrases can build better rapport with the patient.

Optimizing Accessibility

Time

- Physicians perceived spending longer times with patients with LEP. [8]
- To compensate, they may forgo interpreters entirely and "get by" with gestures and limited phrases.[9]
- To assist with time constraints, staff can set up interpreter services in advance for patients who require them.

Different Modalities

- The most common modalities of interpreters are in-person, telephone, and video (tablet/iPad).
- Video interpreters offer advantages from both in-person (e.g., visual communication) and telephonic (e.g., remote accessibility) modalities.

Cost

- Only 3% of hospitals receive reimbursement for language services.[10]
- This is concerning when a large proportion of patients with LEP have Medicare/Medicaid.
- The government should subsidize or reimburse these services because the burden of cost should not fall on medical institutions.

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SOLIDARITY, NOT CHARITY: MUTUAL AID AND COMMUNITY RESILIENCE IN RESPONSE TO THE COVID-19 PANDEMIC

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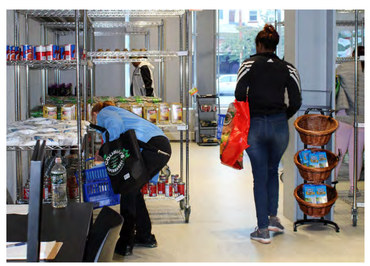
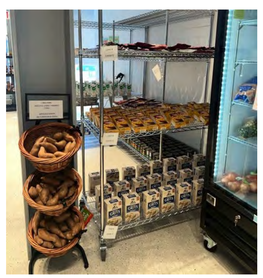
Introduction

The COVID-19 pandemic highlighted the well documented health disparities affecting racial and ethnic minorities, particularly those living in underserved urban settings. The lack of public health infrastructure to respond to emergencies, such as pandemics, can be rapidly met with collective action from communities to take care of their most vulnerable. This thesis describes the work of North10 Philadelphia, Fabric Masks for North Philly, and the Maternal Wellness Village—community-based organizations that rapidly pivoted their work to fill the unmet needs of people in North Philadelphia related to food insecurity, personal protective equipment, and childbirth preparation and social support, respectively.

Case 1: North10 Philadelphia

- Food hoarding, supply chain disruptions, and soaring food prices left grocery stores empty and further prevented individuals from purchasing the food they needed during the pandemic.[1]
- Taking on CUB's food distribution efforts, North10's Lenfest Center packaged bags of food for weekly delivery.
- In 2021, they delivered 3,374 boxes of food to homes in North Philadelphia across 32 zip codes, 80% being in the 19140-zip code.
- In the same year, North10 renovated their physical space to accommodate the creation of a full-choice food pantry known as the Choice Market to continue food distribution efforts.
- In August of 2022, 437 households were enrolled in the program providing for 1,846 individuals.





Case 2: Fabric Masks for North Philly

- One of the main challenges during the pandemic was figuring out how to mitigate the risk of viral transmission, especially for medically vulnerable individuals who could not always comply with stay at home and social distancing recommendations.
- Facial coverings were regarded as an appropriate means for decreasing aerosol transmission of viral particles but were not widely available.
- Fabric Masks for North Philly was an initiative that started at Temple's Lewis Katz School of Medicine in April 2020 to create volunteer-made face masks to be distributed to the community.
- In total, FMNP made and distributed almost 15,000 face masks to over 35 organizations in North Philadelphia free of charge.

Case 3: Maternal Wellness Village

- Black birth workers serve as racially concordant, culturally relevant providers for Black birthing people who disparately experience maternal morbidity and mortality. [2]
- With pandemic constraints on in-person support, Maternal Wellness Village, a Philadelphia-based group of Black doulas, psychotherapists, and lactation consultants, launched Village Connect in 2020.
- Black pregnant people in the third trimester were offered:
  - Four virtual group childbirth education sessions (live or recorded) covering topics such as nutrition and comfort measures in labor
  - Twelve individual virtual psychotherapy sessions through six months postpartum
  - Access to optional telehealth visits for infant feeding support
- Among the 19 Village Connect attendees, 89% reported they attended or viewed at least 50% of the childbirth education sessions, 85% attended at least 6 therapy sessions, and 28% utilized the optional lactation support.

Conclusion

- The COVID-19 pandemic brought the inequalities in disease and risk burden to the forefront of the national conversation and sparked historic grassroots efforts to address them.
- The increased visibility of public health infrastructure gaps disproportionately placing communities of color in urban settings at increased risk called for urgent action that was met by community led initiatives to bridge these gaps.
- Mutual aid efforts afford us the opportunity to circumvent formal systems to meet the immediate needs of those around us; however, more work needs to be done in order to ensure the continued success and longevity of these efforts.

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Direct Primary Care: A Bioethical Analysis And Discussion of Practice Characteristics

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Introduction

Primary care providers in the United States face many challenges that complicate care delivery and contribute to burnout, including heavy administrative burden, large patient panels, and relatively low compensation when compared to other medical specialties.[2] Direct primary care (DPC) is one alternative model of primary care delivery that some think could provide a solution to problems affecting primary care. While DPC may decrease physician burnout and provide a viable source of primary care for some patients, there is the potential for DPC to contribute to already existing health inequities.

Direct Primary Care Defined

Patients are charged a recurring fee for membership to a practice that provides a set of primary care services included within the fee[5]

Patients are not charged more than the monthly retainer fee for visits or for services included in the membership[5]

The DPC practice does not bill any third parties on a fee-for-service basis for the care provided to patients[5]

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DPC Practice Characteristics

DPC Practices in the Ten Most Populous US Cities[4]

City	State	Number of DPC Practices	Minimum Monthly Membership Fee	Maximum Monthly Membership Fee	Average Monthly Membership Fee
New York	New York	7	$59	$218	$141.87
Los Angeles	California	2	$94	$149	$128.13
Chicago	Illinois	5	$40	$240	$139.42
Houston	Texas	7	$45	$300	$123.51
Phoenix	Arizona	3	$28	$148	$113.75
Philadelphia	Penn.	3	$59	$120	$108.42
San Antonio	Texas	9	$79	$200	$125.39
San Diego	California	1	$129	$159	$152.25
Dallas	Texas	6	$49	$445	$119.36
San Jose	California	0	NA	NA	NA

- DPC practices are free to determine their membership fees, and each practice may decide which services are included within the membership fee.[5] The membership fee may cover:
  - In-person office visits (for both acute & chronic concerns)
  - Telehealth appointments
  - Some lab testing
  - Discounted medications and imaging
- DPC practices have smaller patient panels than typical primary care practices (600-800 patients per physician at DPC practice vs. 2,000-2,400 at traditional primary care practice)[2]
- Patients are encouraged to maintain insurance coverage to cover things not included in DPC membership fee, like hospitalizations, outside referrals, some imaging
  - Not all DPC practices accept patients with Medicare or Medicaid
- Benefits of DPC cited by proponents of the model include:
  - Increased time to form relationships with patients
  - Decreased administrative burden for physicians
  - Increased physician autonomy over scheduling[3,7]

Bioethical Concerns within DPC

Equitable Care Delivery

- Patients must pay fee to belong to practice – while membership fee varies between practices, even a small membership fee may make DPC unavailable to some patients based on socioeconomic status
  - Health benefits cited as a result of belonging to DPC practice, such as reduced hospitalizations and fewer surgical procedures, are not available to patients of lower socioeconomic status, potentially contributing to already existing health disparities[7]

Fair Allocation of Resources

- Predicted relative physician shortage in the United States, meaning that physicians and their time to see patients can be considered a limited resource[8]
  - Principle of distributive justice states that scarce resources should be allocated fairly[1]
    - Patients should receive care in proportion to need
    - Burden of patient care should be divided equally amongst practicing primary care providers
  - DPC practices have smaller patient panels, meaning burden to care for patients falls more heavily on physicians at traditional primary care practices
  - In areas more heavily impacted by physician shortage, patients may be unable to receive primary care services as a result of downsized patient panels
  - Some DPC practices offer unlimited appointments, longer appointment slots, additional lab work and imaging
    - No evidence that longer appointments or more frequent appointments result in better health outcomes[3,6]
    - Potential for resource overutilization amongst patients of DPC practices – resources allocated in excess of true need

Local Context as a Social Determinant of Health for Immigrant Communities

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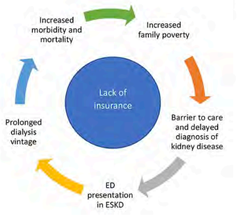

FIGURE 1. The circle of burden of the uninsured with chronic kidney disease. ED, emergency department; ESKD, end stage kidney disease.

Introduction

Local context should be considered a social determinant of health for immigrant communities, particularly those with precarious legal status.

In the absence of comprehensive federal immigration reform, undocumented immigrants are left to rely on the emergency department for access to healthcare via EMTALA.

- 1986 – the last time comprehensive immigration reform was passed
- 1986 – The Emergency Medical Treatment and Active Labor Act was enacted by Congress (EMTALA)
- Undocumented immigrants are explicitly excluded from almost all federal health insurance programs. These include Medicare, Medicaid, 1972 ESRD program under Medicare, CHIP, and the ACA subsidized marketplace

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10.7 million undocumented immigrants live and work in the US

Undocumented immigrants make up 3.3% of the US populations

But 27% of the US uninsured population

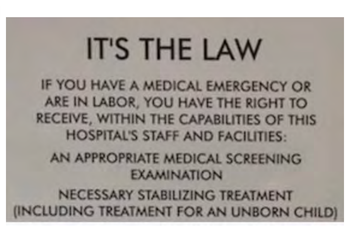
The Emergency Medical Treatment and Active Labor Act (EMTALA)

- Federal mandate for all hospitals that receive Medicare funding to provide emergency care to all patients regardless of ability to pay or documentation status
- 97% of US hospitals receive Medicare funding
- Created in response to 'patient dumping'

- Three obligations of EMTALA

1. Medical screening exam to determine if an emergency medical condition exists
2. Stabilization
3. Transfer, only when stable, if necessary

But each state is left to interpret what "emergency medical condition" means and what "stabilization" entails



Local Context Matters….

For immigrant communities, especially those who are undocumented, state and local laws significantly impact….

- *Clinical decision making and medical outcomes*

In Texas, undocumented immigrants with end-stage renal disease (ESRD) are only able to access emergency-only hemodialysis (HD). Whereas in California they are able to receive standard thrice-weekly HD.

Undocumented immigrants with ESRD in Texas have a 14-fold greater mortality rate after 5 years than those living in California. Because in California, the *diagnosis* of ESRD is considered an emergency medical condition.

- *Healthcare utilization and economic costs*

Undocumented immigrants with ESRD living in Texas required 10 times more acute-care hospital days than those living in California.

- *The psychological burden of patients and families, and the moral distress of providers*

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The Role of Midwifery Care in Urban Settings: Mitigating Disparities and Expanding Access

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Introduction

Midwifery has existed for thousands of years, and midwives have been providing care to women and birthing people in both medical and non-medical settings. Physicians specializing in obstetrics and gynecology and midwives are both able to care for pregnant women and birthing people, but do so in differing ways.

When examining the distribution of women's health providers across different areas of the United States, there seems to be a disparate number of midwives in urban areas. Given rising maternal mortality rates in the United States and focus on equitable care and expanding access to care, I sought to explore the role of midwifery in urban settings, and midwives' role in mitigating adverse outcomes in vulnerable populations. Using personal experience and existing data, this thesis highlights the aforementioned themes and provides recommendations to improve integration of midwives, thereby improving maternal health outcomes.

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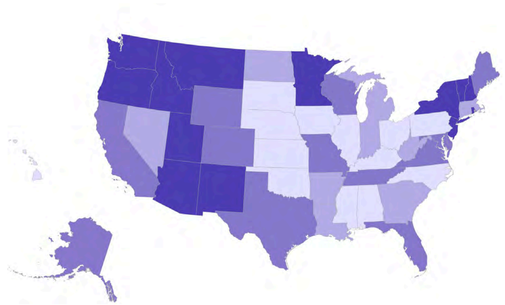

Figure 1: Map of the United States' Midwifery Integration

Deeper shades of purple represent higher integration and lighter shades represent lower integration of midwives

Midwifery 101

- There are several types of midwives: certified nurse midwives (CNMs), certified professional midwives (CPMs), certified midwives (CMs), licensed midwives, and traditional midwives
- Midwives can work collaboratively with physicians in hospitals, independently in birth centers, in health centers, or in the community
- States with the highest employment of midwives are California, New York, Texas, Pennsylvania, and Massachusetts
- Over 80% of midwives identify as white and over 90% as non-Hispanic or Latino, whereas only 7% identify as Black
- Integration of midwives is known to be associated with **improved maternal health outcomes** and lower rates of medical intervention in birth (C-section, preterm birth, neonatal death)
- Midwifery care improves clinical perinatal health outcomes for **Black birthing people** specifically

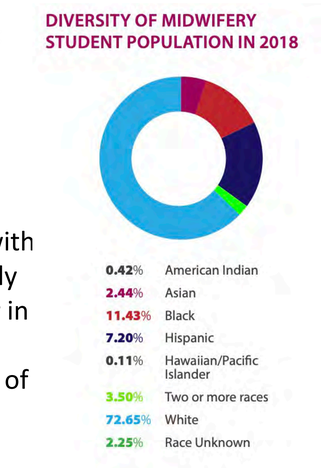

Figure 2: Chart showing the breakdown of race of the midwifery student population in ACME Accredited Midwifery Programs

Barriers to Midwifery Care and Proposed Solutions

Lack of Midwives in Academic Medicine

-Many urban medical centers are academic and have Ob/Gyn resident physicians

-It is more cost effective for hospitals to hire additional residents than midwives when case volume increases

-But given that midwives have better outcomes and educational benefit, perhaps prioritizing money should be inferior to reducing maternal mortality

Cost of Midwifery Care

-Majority of midwives practice in birth centers, which tend to be expensive or not accept insurance

- Black Americans are 2X more likely to be poor, and white birthing people are 3X more likely to birth in birth centers

- Collaborations in major urban areas (DC, Philadelphia) between health centers and birth centers have made this care affordable and accessible

- This model should continue to expand

Bias Towards Midwifery Care

-Midwives have historically been phased out due to the medicalization of birth and our country has adopted a narrative that refers to midwives as "medieval" or "strictly natural"

-In order to integrate midwives further into common practice, it is important to diminish bias, and expand patient information about midwives

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The Chronicles Of Psychiatry: Landmark Cases That Shaped The Civil Rights Of Psychiatric Patients

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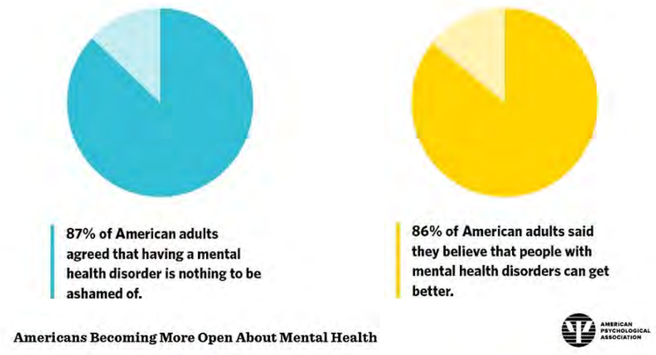
Introduction

The history, perceptions, and experience of mental illness can be traced back from ancient Egypt to modern-day America. This thesis begins with a survey of the complete history of psychiatry, highlighting the injustices suffered by patients with mental illness throughout all times. Through an analysis of landmark American cases, it examines the establishment of civil rights for psychiatric patients in the areas of the right to treatment, right to refuse treatment, and civil commitment. Drawing upon these precedents and historical contexts, this thesis explores how the principles of bioethics can be applied to the future of psychiatry with respect to emerging trends including the use of social media, telehealth, gene editing, and AI/VR in medicine.

Mental Health Through Time

- 16th century BCE: Ancient Egyptians believe depression and dementia are a result of malevolent spirits.
- 4th century BCE: In Ancient Greece, Hippocrates believes mental illness is due to phrenitis - an inflammation of the humors (black bile, yellow bile, phlegm, and blood).
- 11th century AD: Persian physician Avicenna emphasizes the importance of therapeutic alliance and therapy.
- 13th-17th centuries: Asylums house the sick, poor, and *insane*, where conditions are largely inhumane and unsanitary.
- 18th century: the Enlightenment is a turning point.
  - Johann Reil coins "psychiatry" in 1808, Germany.
  - "Moral treatment" led by Drs. Philippe Pinel and William Tuke of England, endorses humane and holistic treatment of asylum patients. Pinel highlights the link between socioeconomic difficulties and lack of mental well-being.
- 19th century: Benjamin Rush (the father of American Psychiatry), advocates for mental health hospitals, compassionate care, and classifies psychiatric diagnoses as treatable illnesses. He is also a proponent of bloodletting, purging, restraints, and other ill-informed, inhumane practices.
- 20th century:
  - Sigmund Freud uses psychoanalysis, the ego, dreams, and sexuality to explain mental illness.
  - Non-science backed treatments gain popularity: insulin shock therapy, lobotomy, severe ECT, among others.
  - DSM I is published (1952).
  - Lithium becomes available for bipolar disorder (1948); SSRIs become available for depression/anxiety (1988).
  - Nixon establishes the drug schedule and war on drugs, which disparately impacts POCs and the poor.
- 21st century: the rise of big tech, social media, AI/VR, and a global pandemic shift the conversation around mental health.



Civil Rights of Psychiatric Patients

Right to Treatment: Staff cuts at a state hospital in Alabama caused undue harm to patients, leading to the case *Wyatt v. Stickney, 1972*. The case established the Wyatt standards, requiring individualized treatment plans, qualified staffing at objectively adequate ratios, and the "least restrictive conditions necessary to achieve the purposes of habilitation" for each individual patient.

Right to Refuse Treatment: In the case *Rennie v. Klein, (1983)*, a New Jersey court found that an involuntarily committed patient who is competent (barring emergencies) has a constitutional right to refuse psychiatric medication. Forced medication may violate patients' First Amendment right to freedom of speech and religion, and Eighth Amendment right to be free of cruel and unusual punishment.

Civil Commitment: In 1966, a judge in the case *Lake v. Cameron* ruled that a person who meets clinical standards for involuntary civil commitment cannot be confined in a state institution if an alternative treatment that is less restricting of their liberty exists. In 1972, *Lessard v. Schmidt* established the standards for civil commitment, including notice, probable cause hearing, right to counsel, and privilege against self-incrimination, among others.

Future Directions

AI represents one of the most interesting advances for medicine but brings with it significant ethical concerns.

- Potential to perpetuate human biases through manmade algorithms, furthering disparities and harmful stereotypes
- Data privacy, security, and surveillance concerns due to lack of effective policies regarding machine learning
- Prohibitive costs of technology furthering inequitable access
- Need to balance clinical experience with algo predictions

By thoughtfully reflecting on the past and applying the lessons we have gleaned to the future, this thesis aims to promote a more ethical and equitable approach to mental healthcare, one that protects and actively fosters the empowerment of all patients, regardless of background, mental status, or socioeconomic status.

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Joining Forces for Better Joints: A Critical Analysis of the Current Literature on Race and Ethnicity in Orthopaedic Surgery

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Introduction

•Osteoarthritis affects over 100 million people worldwide and disproportionately affects people of color compared to that of white patients

•It has been very well-studied across different disciplines the effects of race and ethnicity on modern day medicine. These disparities have also been known to be exacerbated within urbanized communities.

•The focus of my paper will pertain to the knee and hip procedures, I will be critically analyzing the preoperative and postoperative management where most disparities can take effect.

•We will discuss the utility of agency, solidarity, and social justice when implementing our urban bioethical toolbox

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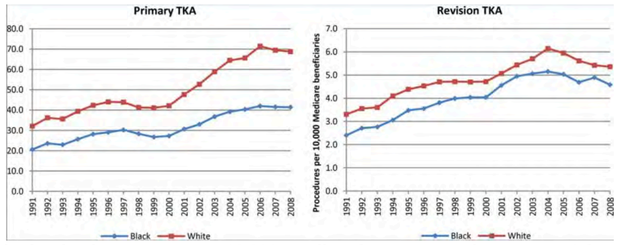

Standardized utilization rates per 10,000 enrollees for primary and revision TKA for Blacks and Whites

Preoperative Care

Nonoperative vs Operative Management

- According to the U.S. Department of Health and Human Services, non-Hispanic blacks were 1.3 times more likely to be obese as compared to non-Hispanic whites noted back in 2018. With obesity being the #1 modifiable risk factor for osteoarthritis.
- Obesity within certain ethnic communities can be heavily attributed to by structural racism such as "redlining" and "food deserts"
- Obesity can be a barrier to care which limits options in how to proceed with further treatment

Access to Care

- Compared with white patients (4.65 per 1,000 population per yr), black (3.90), Hispanic (3.71), Asian (3.89), Native American (4.40), and mixed-race (3.69) patients had lower rates of TKA utilization. Zhang et al
- Race preference and utilization of TJA: TJA was less likely for African American patients than white patients of similar age and disease severity (OR = 0.41), but the difference was reduced after adjusting for recommendation for the procedure at the index visit. Hausmann et al

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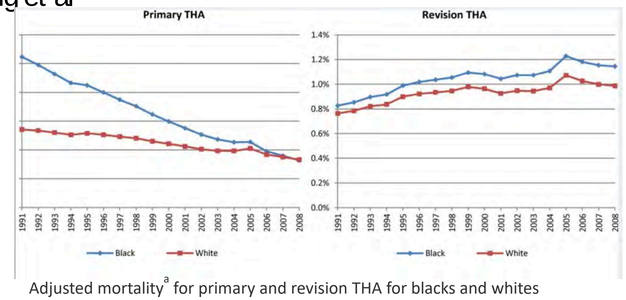
Postoperative Care

Outcomes and Sequela

- 30-d readmission rate after TKA: Readmission rates for African American patients after TKA were 24% higher than white patients. Singh et al
- Adverse health outcomes after TKA: The rates of mortality were markedly higher for black (OR = 1.52), Native Americans (OR = 6.52), and mixed-race patients (OR = 4.35) compared with white patients. Black (OR = 1.08) and mixed-race patients (OR = 1.17) had higher rates of complications than white patients. Zhang et al



Adjusted mortality[a] for primary and revision THA for blacks and whites

Where Do We Go from Here?

This thesis discusses the issue of racial disparities in joint surgery and explores the multifactorial systems that contribute to these inequities. I aim to emphasize the importance of recognizing and acknowledging these disparities and identifying several recommendations to address them, including an interdisciplinary approach to care, providing appropriate resources and care to underprivileged communities, prioritizing diet and exercise as primary preventive measures, increasing diversity in the field of orthopedics, and incorporating social workers into routine surgeries. I also aim to stress the significance of cultural competence and community engagement in improving patient outcomes and reducing disparities in healthcare.

"In Training"

Systems of Power & Exploitation in the Making of the American Physician

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Introduction

Residency training marks a period of rapid learning in the development of physicians. As new physicians acquire medical knowledge and practice clinical skills, they also undergo intense professionalization and socialization, which influences their understanding of the healthcare system and their role within it. The history of graduate medical education (GME), environment of residency training, and culture of medicine interact to create exploitation of trainees. By interrogating these forces and exploring an alternate approach to GME grounded in trauma informed care and critical pedagogy, we can begin to imagine a different kind of residency training that might better serve the needs of both learners and the patients they care for. This discussion is not meant to minimize the harms experienced by marginalized patients and communities in the medical system, rather to further explore the modern process of "training" physicians to elucidate some of the ways the current system is sustained and reinforced.

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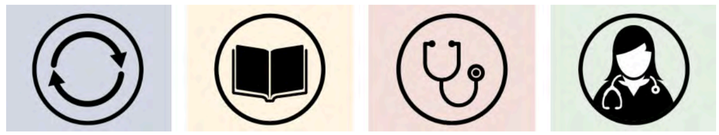

Part 1: History of US Graduate Medical Education

1. William Halstead and the creation of the modern residency program
2. "The Match" and consolidation of institutional power via *Jung v. AAMC*
3. Mid 1970s protests and burgeoning house staff activism
4. Early resident unionization and the fallout
5. *House of God* and the physician burnout discourse

Part 2: Creating an Environment of Exploitation in Residency Training

Graduate medical education is experienced as an "apprenticeship," as described by Reinhart: "Part of what draws us into this norm is that doctors learn by doing — that is, via apprenticeship — in which we repeat what's modeled for us. This is, to a degree, a necessary aspect of training in an applied technical field. It is also a fundamentally conservative model for learning that teaches us to suppress critical thinking and trust the system, even with its perverse incentives."

1. Hierarchy and Elevation of Experts
2. Capitalism and Corporatization Shaping Healthcare
3. Conditions of Residency Training
   - Work hours
   - Contracts and Benefits
4. Culture of Medicine
   - The arrival fallacy
   - Heroic individualism
   - Assimilation trauma
   - Paternalism
5. Primacy of the Behavioral Framework
   - Focus on acute, episodic care → less attention to social and structural drivers of disadvantage
   - Clinical tools reify social identifiers like race as biology
   - Interventions that promote individual responsibility

Part 3: Envisioning a New Approach to GME

The history of GME, working conditions of residency training and the culture of medicine interact to produce environments that exploit trainees. These forces also influence junior physicians' understanding of the system they are a part of and their future decisions about how to act within that system. Trainees experience oppression but also learn to produce it as they advance within the system. Their experiences in training mold their ideas about their own power and agency. Through residency training, they have internalized the primacy of institutions, and the processes and cultures that sustain them. By rethinking this crucial phase in physician development, we might influence the types of physicians we produce, the ways they act within and shape the healthcare system, and ultimately how they care for themselves, their communities, and their patients.

Tools for Remaking GME: Trauma Informed Education

- Potential to improve the residency training experience by grounding all work in the values of safety, trustworthiness, choice, collaboration, and empowerment
- Teaches the practice of medicine and the experience of patients and providers with an anti-oppressive lens that is sensitive to the history of relationships between institutions and communities
- Trauma informed education is asset based, a very different approach to the prime biomedical model which is risk and deficiency centered
- Seeks to identify structural issues and intervene on the systems level to address problems

Tools for Remaking GME: Critical Pedagogy

- Critical pedagogy necessitates that educators contextualize their teaching and encourages learners to interrogate the systems and power structures that create inequality
- Focused on ways to provide safety and security for all via more equitable working conditions and benefits
- Necessitates power-sharing with patients and recognition of the value of their own embodied knowledge about their health and their lives
- Education that develops critical consciousness and humility

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