

Urban Bioethics: Adapting Bioethics to the Urban Context

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ABSTRACT

Urban bioethics is an area of inquiry within the discipline of bioethics that focuses on ethical issues, problems, and conflicts relating to medicine, science, health care, and the environment that typically arise in urban settings. Urban bioethics challenges traditional bioethics (1) to examine value concerns in a multicultural context, including issues related to equity and disparity, and public health concerns that may highlight conflict between individual rights and the public good, and (2) to broaden its primary focus on individual self-determination and respect for autonomy to include examination of the interests of family, community, and society.

Three features associated with urban life—density, diversity, and disparity—affect the health of urban populations and provide the substrate for identifying ethical concerns and value conflicts and creating interventions to affect population health outcomes. The field of urban

bioethics can be helpful in creating ethical foundations and principles for public health practice, developing strategies to respect diversity in health policy in a pluralistic society, and fostering collaborative work among educators, social scientists, and others to eliminate bias among health professionals and health care institutions to enhance patients' satisfaction with their care and ultimately affect health outcomes.

Educational programs at all levels and encompassing all health professions are needed as a first step to address the perplexing and important problem of eliminating health disparities. Urban bioethics is both contributing to the social science literature in this area and helping educators to craft interventions to affect professional attitudes and behaviors.

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Urban bioethics is an area of inquiry within the discipline of bioethics that focuses on ethical issues, problems, and conflicts relating to medicine, science, health care, and the environment that typically arise in urban settings. Urban bioethics challenges traditional bioethics to examine value concerns in a multicultural context, including issues related to equity and disparity, and public health concerns that may highlight conflict between individual rights and the public good, as well as other ethical problems. Urban bioethics also chal-

lenges bioethics to broaden its primary focus on individual self-determination and respect for autonomy to include examination of the interests of family, community, and society.¹ To understand the nature of urban bioethics, a brief introduction to the broader field of bioethics is in order.

BACKGROUND

Bioethics began in the 1960s as an intellectual movement among a small group of physicians and theologians who started to examine the ethical implications of the new medical technologies that were emerging at the time.^{2,3} Over the course of the past 40 years, bioethics has developed into a highly visible interdisciplinary field that draws on contributions from a variety of perspectives, including those of philosophy, theology, medicine, public health, law, and the social sciences. The field has matured considerably since its beginnings, and the scope of its concerns has constantly expanded in response to scientific and technological ad-

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vances and changes in the health care delivery system. From the early days, when the physician–patient relationship, end-of-life care, human subjects research, and theories of justice in health care dominated intellectual debate, the field has grown to encompass much more, including psychosurgery, transplantation, assisted reproduction, fetal tissue transplantation, stem cell research and cloning, genetic discrimination and enhancement, public health, and international health.

Health Care Ethics

Although bioethics may divide up the discipline in various ways, we will do so by distinguishing between two principal domains: health care ethics and environmental ethics. Health care ethics can be further divided into several subdomains.

- Clinical ethics concerns the rights and obligations of physicians and patients in the clinical encounter, and includes such topics as patient autonomy versus medical paternalism, truth-telling, and confidentiality.
- Research ethics considers the rights and responsibilities of researchers and subjects and the ethical design of clinical research studies.
- Organizational (or institutional) ethics, a rapidly growing newcomer to the field, examines ethical problems from the standpoint of the health care organization itself, which is regarded as a moral agent with ethical responsibilities and moral accountability.
- Public health ethics moves away from the individualistic orientation implicit in clinical ethics and brings an ethical lens to bear on public health measures aimed at protecting and promoting the health of populations.
- And finally, social ethics, for want of a better term, asks what principles of justice require, specifically with respect to access to health care, and whether health care is a moral right.

We can think of urban bioethics as including each of these subdomains of health care ethics, but being focused on issues and problems that arise in an urban context.

Environmental Ethics

The second major domain of bioethics is environmental ethics.⁴ Because the environment has a significant impact on human well-being and is often a major source of health-related problems, there is obviously some overlap between environmental and health care ethics. Discussions of genetically modified crops, food safety, air pollution, and water

shortages, for example, often link health with environmental issues. But what is distinctive about environmental ethics is that while it is addressed to the concerns of human beings, its areas of inquiry are not as anthropocentric as those of health care ethics. It also attends to nonhuman parts of nature, animate as well as inanimate, and the relationships among various life forms. One important problem for urban bioethics to examine, therefore, is the disruption of natural ecosystems as a result of urban development, counting human health consequences as just one consideration among others. These effects result from the encroachment of the built environment on the natural one. In addition, there are significant problems at the intersection of environmental and health care ethics having to do with the impact of environmental factors on the health of city dwellers.⁵ Environmental ethics encompasses concern about both the natural and the built environments, both of which have significant health-related impacts on physical and mental health. Urban bioethics focuses on the ethical implications of the links between health and the environment and the disparate effects of the environment on the health of various urban populations.

URBANICITY AND URBAN BIOETHICS

To better understand why urban dwellers confront the particular health problems they do, we need to identify the salient characteristics of urban life. Although no two cities are exactly alike in terms of size, physical layout, population density, ethnocultural composition, and so forth, the succinct definition proposed over 60 years ago by Wirth,⁶ a member of the famed Chicago school of urban sociology, is still a good place to begin: “For sociological purposes a city may be defined as a relatively large, dense, and permanent settlement of socially heterogeneous individuals.” This heterogeneity is due largely to the variety of different ethnic and cultural groups that reside in cities. From the central, southern, and eastern European immigrants of the 19th century (augmented by freed African slaves and their descendants after the Civil War) to the more recent Asian, Caribbean, and Latin American immigrants, U.S. cities—like cities everywhere—have long been magnets for populations seeking greater individual freedom and economic opportunity, sometimes because of extreme hardships in their native countries.

Wirth’s characterization draws attention to two dimensions of the urban context that have an impact on the health of urban populations and, as a result, create urban bioethical problems. These two features, density and diversity, are hallmarks of urban life and do not exist to the same degree outside urban settings. However, there is a third feature that, while perhaps not a defining feature of urban life, is certainly

a crucial ingredient in the urban experience: disparity. Social and economic inequalities based on race and class, so evident in contemporary cities, lead to racial and ethnic disparities in health status and outcome, and these raise serious questions about society's commitment to equity and the fair allocation of health care resources.

Density

It is a truism of urban sociology that disease thrives in crowded, congested places. As Palen and Johnson⁷ note, one of the basic assumptions of medical epidemiological research is the sociological dictum that a relationship exists between health status and spatial location. Until this century, the most obvious example of this postulate was the differential in health status between city residents and their rural counterparts.

Starting in the latter part of the 19th century, the United States embarked on a series of measures that included the building of municipal water systems and the initiation of public sewage and garbage removal. These public health initiatives dramatically improved the health of city dwellers. Although disease typically was hatched and incubated in poor sections of the city, the density and interrelatedness of city life ensured that more affluent citizens were not immune to contagion. As a result, it became clear that effective public health measures protected the health and well-being of the entire community, and the backing of these measures by the socially and economically advantaged members of society was and remains critical to their success. It remains true today that density of urban living makes the health-related problems of any group within the city a serious concern of all urban dwellers.

Most public health measures, including those not directed to the containment of epidemics, have in common an emphasis on populations rather than individuals. To a large extent, urban bioethics shares this emphasis: urban bioethicists' tasks include the development of theories that provide ethical foundations for public health practice, and they formulate and deploy principles appropriate to the population-oriented practices of public health rather than to problems encountered in the clinical context. This is one example of the way in which attention to the urban context of health problems leads urban bioethicists to think beyond traditional ethical principles and to construct an ethical conception that fits the realities of urban life.

Diversity

Although cultural and racial diversity have now spread beyond the central city into suburbs, small towns, and rural areas, the percentage of foreign-born residents living in U.S.

cities has continued to grow significantly, and cities have become far more diverse since the 1980s.⁸ These groups bring with them different cultural identities with distinctive sets of traditions, practices, and community values. The phenomenon of diversity, therefore, is largely the phenomenon of multiculturalism, and since multiculturalism is an inescapable fact of the contemporary urban experience, the ethical problems it generates necessarily occupy a great deal of urban bioethicists' attention.

Liberal-democratic societies, and the liberal American bioethics community, espouse the principle of respect for cultural diversity, but what this means in the clinical setting and for the design of social and institutional policy with regard to health care requires further investigation.

Is there an obligation to respect the cultural values of individuals even if the traditions and practices that give those values their content are in conflict with the dominant ethical norms of the adopted country? How should health professionals deal with persons from other cultural backgrounds who may have very different understandings of the nature of disease and the importance of health care? Indeed, the very valuing of life itself may be quite different among various cultures. As to the first question, different cultures may confer decision-making authority on parties other than the individual adult patient (e.g., on the patient's adult relatives, the patient's family, or the patient's community) and in these cases it seems that the cost of deference to one of these modes of decision making is a diminished regard for the autonomy of the patient. How to navigate this morally complex terrain is a problem confronting health providers who treat patients from other cultures, and it poses a serious challenge for urban bioethics in the clinical context.

Diversity raises questions of a different sort as well, namely, how to develop and implement health policy for a culturally (as well as ethnically and religiously) diverse society. Bioethicists have traditionally taken their primary task to be that of working out the implications of allegedly universal or at least widely shared ethical principles, without regard for whether or how they are connected to the categories of discourse of particular communities. Bioethicists have not been completely indifferent to the problem of cross-cultural communication, of course, but they have typically viewed this as a complication in the application of these principles. When it comes to health policy, however, an extremely pertinent question is what role different cultural and religious communities should play in its formulation and execution, if for no other reason than that the policy is likely to apply to all and to constrain individual options.

Urban bioethicists take cultural diversity seriously and work to create principles to be applied to health policy development in a pluralistic environment. For urban settings,

where diversity often manifests itself in value disagreements that have significant implications for the health-related beliefs and outcomes of individuals and groups, urban bioethicists advocate that all views are to be given legitimate recognition and that policymakers should include all affected communities in their deliberations.

Disparity

Significant differences in health status and outcome among minority populations are a well-documented phenomenon and reflect a long-existent trend in the history of the United States.^{9–11} In cities, the health status of the populations of racial and ethnic minorities, and their mortality and morbidity rates, are significantly worse than in the population of whites.¹⁰ Differences in quality of care have been documented in various areas, including diagnosis and treatment of cardiovascular disease^{12,13} and cancer,¹⁴ pain management,¹⁵ and antiretroviral therapy for AIDS patients.¹⁶ Explanations for these disparities have focused on issues of access, socioeconomic status, education, geography, social structural forces, and cultural factors. While many health disparities are related to poverty and consequent lack of access to health insurance and care, racial and ethnic variations are also independent factors in determining disparate outcomes.¹¹ The urban setting creates a complex relationship between poverty and health outcome. Urban poor often live quite near or even in the shadow of academic medical centers that provide the very best medical care, yet they do not receive it. Many poor families are eligible for publicly provided health insurance but may not enroll or may seek care in lower-quality, perhaps more culturally comfortable environments. There are multiple factors responsible for such decisions on the part of patients and families; among them is the respect patients receive in health care institutions and from providers.

There is increasing evidence that institution bias and provider bias affect the quality of care and health outcome for minority patients.^{17,18} Physicians and other health care providers may have stereotypical beliefs about individuals from a given ethnic or cultural group. Language differences and the lack of availability of professional translation services can play a large role in increasing confusion and decreasing adherence to treatment plans. These cross-cultural encounters frequently result in misconceptions about attitudes and beliefs on the part of both the provider and the patient and can cause inappropriate decisions about diagnostic testing and treatment. Creating an environment of cultural awareness and sensitivity with respect for difference and individual values and beliefs is a first step in ameliorating this problem.

Urban bioethicists seek to understand the factors that result in disparate health outcomes. They work collabora-

tively with educators, social scientists, and others to develop strategies to eliminate bias among professionals and assist institutions to implement culturally respectful policies and practices to enhance patient satisfaction with care and, ultimately, to affect health outcomes.

EXAMPLES OF WORK IN URBAN BIOETHICS

In each of the three paradigmatic characteristics of cities—density, diversity, and disparity—urban bioethics is involved when identifying ethical concerns and value conflicts and creating interventions to affect population health outcomes. In the area of density, recent work in the field of infectious consequences of intravenous drug use is one focus of urban bioethics. Diseases such as HIV and hepatitis C are endemic in the inner city among intravenous drug users as a result of needle sharing and common sexual behaviors associated with the drug culture.¹⁹ There is substantial controversy over the appropriateness of “harm reduction” programs that attempt to lessen the health consequences of drug use, including the provision of clean needles to drug users to decrease disease transmission in this population.²⁰ Fundamental value differences exist between those who believe that harm reduction programs encourage and condone illegal and immoral behaviors, and those who see these programs as humane interventions to decrease a foreseeable consequence of behaviors that will inevitably occur in our society.

Research in this area has resulted in evidence that the feared consequences of harm-reduction programs—increased drug use and the initiation of younger users into the practice—do not occur in controlled settings.²¹ This enables public health leaders and policymakers to focus on the fundamental value conflicts at stake and attempt to create health policy to deal with this problem in the face of strong disagreement. Urban bioethics can be helpful to such leaders and policymakers in clarifying and analyzing the value conflicts and creating the framework for resolving these public health issues.²²

In the areas of diversity and disparity, in response to disparate health outcomes among racial and ethnic minority populations, urban bioethics assists in the examination of the role of bias and discrimination in professional decision making and patient outcomes. There is clear evidence that during the clinical transaction, a provider’s assumptions and beliefs based on preconceived notions about age, gender, socioeconomic status, race, ethnicity, or other cultural factors affect objectivity in responding to health complaints and needs. Despite a generally widespread desire to train health professionals to give sensitive, empathetic, and respectful care, there are few empirical data to support the relationship

between cultural competency education and improved health care.²³

Nevertheless, a recent Institute of Medicine report calls for integrating cultural competency education into the education of health professionals as a means of addressing racial and ethnic disparities.¹¹ There is a significant amount of work in this area to create curricula to educate more culturally sensitive health professionals and to provide institutional environments that are conducive to empathetic communication to increase the likelihood of improving health outcomes.²⁴ Educational programs at all levels and encompassing all health professions are needed as a first step to address the perplexing and important problem of eliminating health disparities. Urban bioethics is both contributing to the social science literature in this area and helping educators to craft interventions to affect professional attitudes and behaviors.

SUMMING UP

Urban bioethics situates bioethical concerns in the urban context, adding a new dimension to the discipline of bioethics as traditionally conceived and practiced. Concerned with the multicultural nature of the urban environment and with the particular ways in which cities foster health disparities, this field helps us examine many issues heretofore not adequately addressed by bioethics. Overlapping with other areas in bioethics such as public health ethics, clinical ethics, and institutional ethics, urban bioethics fosters a unique focus on the ethical dilemmas in the pluralistic environment of cities. It also informs the thinking of health professionals, policy-makers, social scientists, and others to promote ethically responsible measures aimed at improving the health of urban populations.

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