

DEI Is Not Enough

by Nancy M. P. King

The ongoing wave of institutional attention to diversity, equity, and inclusion (DEI) is long overdue and profoundly necessary, but it is radically insufficient, especially in health care, health-related research, and bioethics. Understanding why DEI in hiring and funding more people of color can leave significant inequities untouched helps move this essential effort beyond virtue signaling. Consider: Some institutions may decide that a few new non-White hires can do all that is needed to improve workplace conditions, serve on all committees, and be spokespeople for their employer—a familiar “Black tax” often imposed on employees of color. And if research funding is made available to a few more investigators of color without requiring more broadly inclusive efforts from all, those new investigators could also be taxed to level the playing field while still competing on a tilt.

This would let White people off the hook; traditionally privileged groups, and the scholarship and practice dominated by them, wouldn’t have to change at all—a “solution” both fundamentally unacceptable and inadequate. When DEI requires changes to hiring policies and practices, a thoughtful approach immediately highlights everything else that needs changing: assessment of job qualifications, promotion and retention standards and practices, employee voice in the workplace, amelioration of inequities in research infrastructure and mentoring, and more.

Many academic medical centers are trying in good faith to get DEI right. The extensive guidance offered by the MRCT Center of Brigham and Women’s Hospital and Harvard in *Achieving Diversity, Inclusion, and Equity in Clinical Research* helps show how much DEI work medical academia must do, from hiring faculty and staff and funding investigators to addressing the demographics of clinical trial participation. Yet even more “upstream” effort is required to make meaningful change.

For example, Ruquaijah Yearby’s Vulnerability and Equity Impact Assessment tool asks investigators to examine the potential effects of research participation on underrepresented and underserved groups they seek to recruit, engage with those communities about the research, and develop and carry out plans to mitigate potentially adverse effects. Engagement with potential participants is key; investigators who really listen may learn unexpected truths about group needs, interests, and priorities that help uncover connections between structural injustices and health disparities. Assessing, addressing, and ameliorating the effects of structural injustices may be best accomplished at the community level, and many truly effective remedies will have to come from outside hospitals.

Targeting discriminatory structures can both profoundly improve health and reach far beyond it. Madison Powers and Ruth Faden’s discussion of dimensions of well-being, of which

health is only one, demonstrates that ameliorating existing disparities in education, housing, employment opportunities, community and personal safety, and more helps strengthen the effects of “downstream” considerations, like DEI in hiring, by equipping more members of minoritized groups to do more with their lives than the structures of injustice have thus far allowed.

How does this matter for bioethics? An increasingly vigorous discussion of health justice is under way in the field, exemplified by much recent literature, particularly in this journal, including the recent special report *A Critical Moment in Bioethics: Reckoning with Anti-Black Racism through Intergenerational Dialogue*. The principle of justice has been neglected by many in bioethics but must be recentered by all of us. Doing justice to justice requires more than treating it as a specialty area for a subset of bioethics scholars, social epidemiologists, and public health practitioners. No one in bioethics would argue, “I don’t do autonomy; my specialty is X,” or “I don’t know much about beneficence because my scholarly interests are Y and Z.” Treating justice this way is wrong and has to change.

Yet justice work is both difficult and fundamentally social. Injustice is often deeply ingrained and resistant to change. Justice reaches beyond individuals and turns our gaze “upstream” from hospitals and clinics toward structures, histories, and life experiences, showing that justice and health are intertwined throughout society. If bioethics scholars are honest about our privileges (such as they are), we ought to see how thoroughly the deck has long been stacked against so many. DEI is only the beginning. If health really matters in bioethics, comprehensive professional and personal attention to social justice is an essential effort for us all.

DOI: 10.1002/hast.1388