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Teaching and Learning Health Justice: Best Practices and Recommendations for Innovation

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We describe the development and implementation of an online graduate bioethics program that weaves a theme of health justice throughout the curriculum. Our account relies on a constructionist model of curriculum development and adult teaching and learning theory. Our curriculum draws upon core values of Jesuit higher education, including content with particular attention to justice for marginalized and vulnerable members of society and pedagogical strategies that cultivate students' capacities for critical thinking and engagement with ethics and justice issues in the context of healthcare. We propose four major contributions from the health justice literature as key content areas for inclusion in bioethics programs interested in focusing on health justice. We identify gaps in the literature and suggest how they might be addressed. Finally, we give examples of content, pedagogy, and preliminary findings from specific courses in our program, all in hopes of stimulating more conversation about how students learn about health justice.

Many, if not all, health science and related educational programs provide foundational content in bioethics. Professionals in these fields often wish to move beyond basic content in bioethics to courses at the graduate level, as indicated by increase in numbers and growth of new graduate bioethics programs over the past ten years. The student population in graduate bioethics programs differs from traditional undergraduate and entry-level health professions programs because it is composed of adult learners who are generally employed full time, experienced in life and in their respective disciplines, and engaged in many roles. The need for flexible graduate programs in bioethics that fit the schedules of working adults has motivated development of fully online and hybrid programs, which combine on-site and on-line methods of content delivery, to increase learning opportunities and options available to students.

In light of students' needs for flexibility, how might we assess pedagogical practice for teaching bioethics, and particularly justice, to adult learners? What should be the scope of the content? In fully online and hybrid programs, what are strategies for teaching adult learners about ethics with an emphasis on justice? Using our program as a case study, we attempt to answer these questions based on our review of best practice standards for adult learning and for teaching health justice. We describe gaps in these practices which relate to adult learning, justice content, and online curricular development in graduate bioethics education. Finally, we share three course descriptions, strategies for teaching about justice in bioethics, and preliminary findings on the effectiveness of these courses and strategies.

Designing a Bioethics Graduate Program for Adult Learners

All educational endeavors involve content and pedagogy, the "what" and the "how" of any learning activity. Shulman describes these basic components of teaching when he suggests, "The teacher has special responsibilities in relation to content knowledge, serving as the primary source of students' understanding on the subject matter. The manner in which that understanding is communicated conveys to students what is essential about a subject and what is peripheral" (Shulman, 1987, p. 9). One thing Shulman's idea suggests is that the curriculum of any degree program in higher education should be shaped by content knowledge, what is "essential about a subject," of a discipline. So, for example, formal accreditation standards guide health professions programs' curricular development. There are currently no comparable accreditation standards specific to graduate programs in bioethics. However, some professional bioethicists have offered guidance regarding what core content in graduate programs should include.

Dudzinski, Rhodes, and Fiester (2013), for example, recently summarized some of the most important curricular and pedagogical goals for bioethics programs:

> [A] central mission [of bioethics education] is to expand the vocabulary and analytical tools of its learners, expose them to new approaches and ideas, strengthen their skills in moral reasoning, and broaden their perspectives on bioethical issues and dilemmas. Its hallmarks are exposure to different disciplinary approaches and interactions with students and faculty from diverse disciplines (Dudzinski et al., 2013, p. 288).

Dudzinski and colleagues (2013) also suggest that bioethics students of all disciplines must "develop a clear understanding of their distinctive professional responsibilities" (p. 287). Lee, Viers, and Anderson (2013) reiterate the value of moral reasoning, in

particular, and suggest that whether and how well graduates of bioethics education in undergraduate, graduate, or health professions programs can "reason about situations" (p. 16) is one measure of curricular success. Furthermore, the cases and situations bioethics students are given to hone their reasoning skills should be ones they are "most likely to encounter" in their practices and lives (Lee et al., 2013, p. 16).

Another source to guide curricular development and design for bioethics education programs is the report of the American Society of Bioethics and Humanities Health Care Ethics Consultation Core Competencies (American Society for Bioethics and Humanities, 1998). Additionally, the experiences and expertise of diverse bioethics faculty inform and shape curricula in important ways, whether regarding a general bioethics focus or one particular area of bioethics such as human subject research or clinical ethics consultation.

Curriculum: What, Why, and How?

The Master of Science in Health Care Ethics (MSHCE) at Creighton University currently has about 50 students and was built to provide maximum flexibility for students in a fully online, asynchronous mode with thematic emphasis on health justice and vulnerable populations throughout the curriculum. Our curricular design followed best practice recommendations from the education literature by beginning with an identification of end-point educational goals and objectives. We then developed learning activities and assessment strategies to motivate those goals and objectives (Biggs & Tang, 2011; Diamond, 1998; Fink, 2013; Wiggins & McTighe, 2001). Determining what students should understand at the end of an educational experience, whether it is a program of study or a single course, can be a daunting task, partly because so much material could be included on any single topic. To address this challenge, we developed one strategic focus on content and one on pedagogy.

Focus on Content: What and Why. One way to follow Shulman's advice for identifying essential content in a discipline—bioethics, in our case—is to focus on the field's "big ideas" (Wiggins & McTighe, 2001, p. 23) that have enduring value beyond the classroom. Big ideas require a great deal of uncoverage; that is, they are complex, abstract, and often misunderstood by learners. *Health justice* and *vulnerability* in health care are two big ideas for the MSHCE program at Creighton.

These concepts are important for five reasons. First, we believe that preventable, remediable inequalities in health and in health services delivery adversely affect the most vulnerable among us, and that lack of opportunities for well-being among members of vulnerable populations are egregious moral failures that bioethics should address (Powers & Faden, 2006). Second, bioethics education (for health professions students and graduate students) insufficiently addresses such health injustices, what they are, how to understand them, and what should be done about them. Therefore, there is need in bioethics curricula to highlight health justice. Third, in the MSHCE program, the phrase "health care" refers to care of people's health generally rather than the narrower and more common assumption that "health care" and "health services delivery" are synonymous. Fourth, we emphasize social justice teachings of the Catholic tradition, including prioritization of needs of people who are poor. Fifth, the focus on health justice exemplifies Creighton University's Jesuit value of educating men and women with and for others in all of its programs, including the health sciences (Welie & Kissell, 2004). As former Superior General of the Society of Jesus, Kolvenbach (2001) stated, "Jesuit universities have stronger and different reasons than many other academic and research institutions for addressing the actual world as it unjustly exists and for helping to reshape it in the light of the Gospel" (p. 28).

Thus, the focus on health justice and people who are vulnerable is a central organizing principle for the learning goals of our program. In other words, the learning goals of our program reflect what we think is essential regarding health justice and vulnerability, such that students can better understand and value these elements throughout their personal and professional lives.

Focus on Pedagogy – How. The "how" of the MSHCE program, or pedagogy, supports students' achievement of our program's goals and specific courses' learning objectives. Through this "how," teachers of bioethics can transform content knowledge "into forms that are pedagogically powerful yet adaptive to the variations in ability and background presented by the students" (Shulman, 1987, p. 15). Because it is fully online, the MSHCE program follows best practice standards for online education (Quality Matters, 2014). For example, one important adaptation from onsite to online learning environments regards sequencing and pacing of content. To assist students in scaffolding their learning and managing their time efficiently, the program builds on content presented in prior courses. Additionally, we designed the program using principles derived from Knowles (1980) in order to cultivate the following:

- Safe, active, and collaborative learning forums with peers that include individual and social construction of knowledge.
- Learning experiences that invite and engage the insights of learners' prior life experiences.

- Essential and meaningful activities, in which students practice reasoning skills in situations they are "most likely to encounter" (Lee et al., 2013, p. 16).
- Learning activities about vulnerability and injustice that encourage exploration of alternative personal perspectives and critical reflection (Clapper, 2010; Grow, 1991; Mezirow, 1983; Milligan, 1995).

These structural and environmental features of our online learning sites meet students' needs for schedule flexibility and are grounded in the educational literature on best practices.

Four Major Contributions from the Literature on Bioethics Education about Health Justice

This section presents major concepts and questions from the best thought on justice teaching in the context of healthcare. Certainly justice issues that touch the realms of health and healthcare practices encompass clinics, hospitals, healthcare systems, states, regions, nations, and the globe. The predominant influences on health are pre-clinic or "upstream:" interactive social and cultural determinants such as income and wealth, education, and the social and physical environment (Geiger, 2006; Powers & Faden, 2006; U. S. Department of Health and Human Services, 2014; World Health Organization, 2012). These upstream social and cultural domains are central content areas in our program.

People experiencing health injustice can be poor, marginalized, oppressed, dislocated, language-disadvantaged, and ill or injured. Health injustices express in two major ways for members of these vulnerable populations: inferior access to healthcare services and lower quality of healthcare services. Members of these vulnerable populations also suffer diminished overall health status. Given the nature, extent, and outcomes of these injustices, we recommend specific content and pedagogy for health justice in bioethics education. Overall, the content should emphasize people who are vulnerable and disadvantaged. The pedagogy overall should stress affective learning, which focuses on students' attitudinal and emotional orientations to members of those groups. Our recommendations arise from our review of the literature on justice theory and are filtered through our experience teaching these concepts to our students. Each recommendation that follows includes a rationale and offers both a "what" (content) and "how" (pedagogy).

1. Teaching health justice should motivate understanding of our individual and collective responsibilities for responding to inequalities in health status and healthcare service delivery.

Most students in our program are nurses, physicians, chaplains, and other health or health-related professionals with little formal education about interactive social and cultural determinants of health. Also, generally they have had minimal to no exposure to the causes or scope of health justice problems.

Along with exposing students to structural inequities that impact health, we agree that professors and teachers need to present and model "cultural work" (Freire, 2005, p. 121). Friere defines one affective result of such work as *critical consciousness,* self-awareness of one's own identities, of one's stance or orientation to others' identities, and of broader systemic trends and patterns of oppression that cause and exacerbate health injustices. In the context of health professions education, one use of Friere's concept of *critical consciousness* has been to advance the medical education literature on cross-cultural communication (Kumagai & Lypson, 2009). This concept also has broader applicability in bioethics education about health justice. As we all learn about the scale and extent of both institutionalized and unconscious health injustices, we must acknowledge with our students our own roles both as oppressors and oppressed. Otherwise we further contribute to both categories as dehumanized and dehumanizing (Freire, 1970). One way to teach this content both conceptually and affectively is to model, in classroom-based as well as practice-based settings, strategies for coming to terms with our membership, at different times, in both of those categories.

2. Complementary critical perspectives are lenses for analyzing injustices in health status and healthcare service delivery.

Examples of complementary critical perspectives used in our program are feminist justice theory and postcolonial theory. Both promote critical thinking about and responsiveness to vulnerability, including oppression and multigenerational trauma (Rentmeester, 2012; Young, 1990). Feminist justice theory and critical race theory are complementary approaches for assessing systematic injustices because they address how gender, "race[,] and racial power are constructed and represented in American legal culture and, more generally, in American society as a whole" (Crenshaw, Gotanda, Peller, & Thomas, 1995).

We draw strongly on feminist and postcolonial conceptions of oppression and the continued influences of oppression on health status among members of traditionally underserved populations. We have found that doing so cultivates students' historical

perspectives, dynamism, and creativity in responding to present-day health justice problems.

> [P]ostcolonial bioethics generates a vocabulary useful for considering important conceptual and temporal connections (1) between historical trauma suffered by people of color and current racial and ethnic inequalities in healthcare access and health status and (2) between colonial domination of people of color, epistemic violence, and underservice to people of color with mental illnesses (Rentmeester, 2012, p. 366).

When students learn to use such critical analytical perspectives, they draw upon a vocabulary that enables specific identification of what's unjust about a structure or situation. For example, applying justice theory to healthcare contexts requires that students understand that health justice is structural, not just distributive, and that modifying oppressive structures requires collaboration and collective action.

3. Teaching health justice means helping students use theory to illuminate their practices of formulating and executing professional responsibilities.

Along with our students we want to consider what justice theories and principles may require of health professionals (Beauchamp & Childress, 2009; Braveman et al., 2011; Powers & Faden, 2006). A health justice focus should include health professionals' obligations to promote health justice in arenas varying from the clinic to upstream social influences. One of the most important expressions of injustice in the context of health care involves oppression and the question of complicity in that oppression. How does one untangle individual obligations from collective professional responsibilities here? One of us (Stone, 2010) has tried to develop a robust justification of physicians' general obligations regarding social influences on health that would extend their duties upstream from and long prior to clinical encounters.

In other words, Stone argues that physicians' obligations to patients are population-based and not focused only on clinical encounters with individual patients. In contrast to Stone's view, Gruen, Pearson, & Brennan (2004) argue that physicians' obligations to advocate for patients are closer to their specific spheres of practice, which are conceived as "downstream" and nearer to actual clinical encounters with individual patients. Health professionals' obligations are a major focus in our program for two reasons: (1) many or most bioethics graduate students are health professionals who will consider what they should do regarding health justice problems, and (2) many graduates will be positioned to educate and advise health professions students, post-doctoral trainees, and fellow practitioners about what health justice demands.

4. Specific moral values play a role in health justice education, skill development, and collective responses to health justice problems.

Stewardship is one key value (Lee et al., 2013, p. 17) in justice theory and ethics education that relates importantly to affective learning. That is, the United States (U.S.) healthcare system, its personnel, and its resources must be carefully and deliberately stewarded to respond consistently to inequalities in health status and healthcare access. Another key value in justice theory and ethics education is *solidarity* because it can motivate collective action (Reichlin, 2011). One strategy for helping students learn about *solidarity* as a value is to help them cultivate an appreciation of the historical contexts for the problems that situate some patients' poor health. "History," for example, "illustrates both how tenacious and variable systems of oppression are and how dynamic and creative we must continue to be to rise to the challenges they pose" (Bell, 2007, p. 1).

One affective feature of the values of *stewardship* and *solidarity* is how one orients oneself to the project of collective action. Although individual growth and action are important in health justice work, modifying oppressive and unjust system-level structures generally requires collaborative leadership and collective action. Students need facilitated formal learning opportunities to become familiar with this skill set (Earnest, Wong, & Federico, 2010; Gruen et al., 2004; Kanter, 2011; Rich, 2011; Stone, 2010). They also need support and direction when they struggle with the reality that such a small proportion—only about 10%—of a person's overall health is influenced by direct health services (Schneider, 2011, p. 490).

So, we've just canvassed the four domains that we have defined as important to a bioethics graduate program that emphasizes health justice. Next, we describe how further scholarly attention to these domains can generate innovations in health justice pedagogy.

Important Areas for Innovation in Health Justice Pedagogy

The kinds of health justice situations students study and prepare themselves to encounter need to be frequently updated because important variables—such as government policies, social and cultural trends, and best practice standards, for example—can change over time. For instance, broad and pervasive racial and ethnic inequalities in access to health services were not recognized in the health literature prior to the 1970s, except by those with rare foresight. As another

example, the routinization of costly biotechnological and pharmaceutical advances to screen for and treat cancers such as cervical and breast cancer (Partridge, 2013), and unequal access to those advances, suggest that these kinds of injustices in healthcare should now be considered foundational content in health justice teaching. Also, in keeping with recommendations from Lee and colleagues (2013), students need practice in moral reasoning about real-life situations (p. 17). Accordingly, in the next section, we map interesting and important avenues for further scholarship into the future of health justice pedagogy.

Critical Pedagogy Regarding Solidarity in Health Justice Studies

As we've suggested above, *solidarity* is one important educational value in health justice teaching and learning. But if we are to effectively motivate collective responses to health injustices, there is still a need for health justice scholars and teachers to help students clarify the nature and scope of healthcare professionals' responsibilities and public roles in modeling and exercising this value regarding health and healthcare.

Expressing solidarity through collective action is one theme to explore more deeply as one strategy for helping students productively integrate this value and to respond to their frustrations about patients who seem to "fall through the cracks" in our healthcare system. These cases happen at the intersection of the clinical encounter and systemic social injustices. For example, healthcare professionals can organize to draw upon their social power, authority, and solidarity (Reichlin, 2011) to try to improve the upstream social, cultural, and environmental conditions that influence health status and health outcomes over the long-term. The pedagogical literature on justice teaching can evolve to explore questions such as these: How can bioethics students—undergraduate, graduate, or health professions—become involved in such organizing? What does the value *solidarity* mean for them?

Energizing Collective Action

Currently, few pedagogical resources exist for teachers trying to help students navigate their way through the limitations of clinical encounters with patients who "fall through the cracks." That is, students often struggle with how to help people whose most critical vulnerabilities come from factors, such as poverty, which are beyond what can be dealt with in clinical encounters. If students feel too overwhelmed by that reality, they might become alienated or demoralized and dismiss health justice problems as intractable. Some of us have turned to literature on leadership to learn how best to help students with this feature of learning about and responding to health justice problems.

There are numerous useful resources for how to be leaders in motivating structural changes that could promote better health on a community level (Earnest et al., 2010; Gruen et al., 2004; Kanter, 2011; Rich, 2011; Stone, 2010). Often, however, learners can still wonder how to forge links between leadership, solidarity, and energizing collective action to address structural injustices that affect health. As mentioned, bioethics students need opportunities to cultivate historical perspectives regarding the origins of structural injustices to help manage their frustrations with the limits of clinical expertise in solving patients' problems. When cultivated, these historical perspectives can help foster affective learning and offer motivation for addressing injustices.

We have argued that teachers of bioethics are well-positioned to help learners develop critical consciousness and long-term investment in identifying and problematizing one's own and one's profession's biases in social encounters. A remaining question is, *which strategies help students establish awareness of their own patterns of perception and behavior that might undermine their effectiveness with patients and others?* This ethical and empirical question is an example of the kind of inquiry into affective learning that health justice scholars and teachers should investigate further.

Narrowing the Gap between Conceptual and Affective Learning

Curricular content in health justice typically focuses on theory. This is important conceptual content, but it should be complemented with efforts to challenge and support students' affective learning about their personal motivations to respond to injustice. We've suggested that one way to narrow the gap between conceptual and affective learning about health justice is by cultivating more historical perspective on oppression and its influences on health in order to generate students' greater sense of connection with historically entrenched sources of health injustices. Another strategy we've suggested is to critically examine one's ancestral or one's own membership in groups that are oppressed, oppressors, or both. Such self-reflection can promote realizations about one's roles in perpetuating health injustices. More strategies need to be developed about how to investigate and explore these kinds of group memberships.

Toward this end of narrowing the gap between conceptual and affective learning, one of us (Rentmeester) invites students in her course to articulate multiple ways in which our identities are constituted. For example, a person might be a

member of an oppressed group (or several) and a member of a privileged group (a poor white man, a wealthy white woman, a wealthy woman of color, a child with a disability). This exercise sounds straightforward. But explaining how multiple layers of oppressed and empowered identities can constitute a person's moral, social, and cultural identities and group membership is challenging.

One source of this challenge is that our identities are created not only through the subject's viewpoint, a first-person perspective, but also through third-person perspectives that can misrepresent others' identities. Misrepresentation needs to be problematized when it happens, and it needs to be done in ways that take a long view of affective learning. That is, constructively approaching misrepresentation of minoritarian identities, in particular, should avoid threatening or alienating students because some perspectives (particularly those with a tendency to misrepresent minoritarian identities) might have been identity-constituting over long durations. Identity-constituting views (even those that are misrepresentational and problematic) will often not change quickly or within the span of one course, even a good one.

Students (and teachers) need support and time to explore the pluralistic features of identities, their sources of fallibility, and their sources of misrepresentation. Students (and teachers) can have intense emotional responses to learning about (and teaching about) the complex and multi-layered nature of biases, attitudes, and habits of perception that percolate and bubble up during identity-explorations related to health justice. Continued theoretical and practical work on these questions about identities can help us cultivate self-understanding and help us to determine whether and how our actions ameliorate or exacerbate health injustice.

One Program's Curricular Design to Teach Health Justice

As we've suggested, our program can be used as a case study for considering content and methodological innovation in health justice pedagogy. The health justice and vulnerability themes begin in the first required course, as seen in Table 1, and continue throughout the program.

As seen Table 1, our Practicum is a later course, which moves students from theoretical levels of inquiry to practical experience in care settings for vulnerable patients. This course is one part of the curriculum in which students consider ways in which theory influences practice and ways in which practices illuminate important merits and drawbacks of justice theory. The focus, in the next section, however, is three key non-experiential courses in our program and how they respond to the imperatives of health justice pedagogy we've just described.

Setting the Foundation: *Health Policy and Ethics*

In the Health Policy and Ethics course, students are assigned readings and videos that emphasize the health care challenges for people who are vulnerable. We consider how health policy is formed, how resource allocations are made, and many attempts at health care reform in the U.S. and in other countries. We notice intersections among ethics, health justice, cumulative disadvantage, public health, and social and cultural determinants of health. Students view the documentary, *Sick Around the World,* which describes health care systems and policies in several countries including the U.S. (Palfreman, Neuburger, & Reid, 2008). One student's comment in end-of-term evaluations of the course suggests an appreciation of an opportunity to consider justice in healthcare contexts: "The class . . . helped me see how justice applies to healthcare." Specifically, students are led to see, learn, and reflect upon value differences among populations in the world, particularly those concerning solidarity and health justice. They further reflect on one another's reactions to course content as they engage in weekly discussions with their colleagues about how solidarity and health justice are expressed in health care systems in the U.S. and other countries. This approach lays the foundation for the concept *solidarity* as a core moral value in health justice studies. Course evaluations report that 90% of students strongly agreed or agreed that the course readings and assignments contributed to their meeting the course objectives.

Preparing Students for Critical Analysis: *Social and Cultural Contexts of Bioethics*

In the Social and Cultural Contexts of Bioethics course, we consider how meaning is made and who is in charge of controlling how that is done. The course introduces students to anthropological approaches to globalization, U.S. health care, power issues, and autonomy. Students learn to look for what is not overt in many bioethics discussions, to focus on the margins, and to understand why the unobvious is crucial to making meaning. They discover that autonomy is neither the exclusive property of the individual nor under her control, but rather a dynamic negotiation among factors such as the present circumstance, emotions, relationships, past experiences, interdependency, and various kinds of power. This course disrupts the dominant cultural tendency to focus on individual patients in health decision-making. It reveals new and complex interactions that influence

Table 1
Master of Science in Health Care Ethics Curriculum with Abbreviated Course Goals and Descriptions

Core Courses	#	Abbreviated Descriptions (Course prerequisites are noted with 'P'.)
Scholarly Reading and Writing	600	Generate clear, precise writing that accurately credits and incorporates others' work.
Health Policy	601	Explore health policy in light of social justice and human rights.
Research Ethics	602	Consider historical abuses to present global research with special attention to research subjects from populations that are vulnerable.
Law and Health Care Ethics	603	Explore ethical and legal themes in landmark cases in bioethics and distinctions between ethical and legal approaches to reasoning.
Social & Cultural Contexts of Healthcare	604	Consider social and cultural constructions and interpretations of major themes in bioethics, such as identity, autonomy, and power.
Philosophical Bioethics	605	Explore critical approaches to ethical reasoning and epistemological challenges in moral judgment in healthcare contexts. P: 601 or 602.
Theories of Justice	606	Explore macro-level critical approaches to ethical reasoning in healthcare and health policy with a focus on oppression and marginalized groups and identities. P: 601, 605.
Practical Ethics	607	Apply basic concepts and deliberative methods of institutional ethics committees.
Practicum	608	Analyze and develop responses to ethical issues shaped by organizational, community-based, or policy-based structures, focus on populations with vulnerability. P: 601-607.
Capstone	609	Apply insights and skills acquired in prior courses to a compelling ethical or justice problem identified in the Practicum, generate a scholarly paper. P: 601-608.
Sample Elective Courses		
Ethical Aspects of End-of-Life Care	614	Critical analysis of end-of-life care practices, such as life-sustaining interventions, physician-assisted suicide, euthanasia, palliative care, and terminal sedation.
Rescue and Transplantation: Manifestations of Scarcity and Power in US Health Care	619	Considers an anthropological point of view of the impact on society of a rescue-based health care system and the promotion of transplantation as a popular expression of acute-care-oriented ritual in health care.
Public Health Ethics	622	Explores the discipline of public health from an ethics perspective, including human rights, social justice, and health policy in global, national, and community contexts.
Catholic Bioethics	623	Introduces theological and philosophical foundations key to Catholic Church teachings on Magisterium, human dignity, and justice related to current controversial issues.
Oral Health Care: Intersection of Professional and Business Ethics	624	Considers dentistry's historical development as a health profession, oral healthcare and underserved populations, aesthetic treatments, advertising, and error management.
Health, Ecology, and Ethics	625	Considers intersections of justice, environmental ethics, and healthcare ethics related to the material conditions of human health, such as clean water, clean air, and habitable climate.

Note. All courses are 3 credits except 600, which is 1 credit.

students' understandings of the role of bioethics and health justice.

Averaging course evaluations from three different offerings of the course over three years indicates that 89% of students believed that the readings and assignments in the course were useful in achieving the course objectives. One student's comment in end-of-term evaluations suggests her integration of the course's theoretical content into her professional life: "Engaging content was very relevant to my professional role." Specifically, students explore the meaning of "us" and "other" from several different viewpoints such as eugenics, ill health, conformity, and projections of personal failings. They write about the concept *autonomy* using Anne Fadiman's *The Spirit Catches You and You Fall Down* as background (Fadiman, 1997). These approaches address context as a critical feature of health and identity.

Preparing Students to Think about How Policies Create Structures: *Theories of Justice*

This course manifests the content recommended in the literature for teaching about justice, and it addresses shortcomings in this literature that we've identified in an earlier section of this article. It focuses on two major points: (1) responsiveness to injustice requires being able to operationalize a vocabulary that can be used to specifically identify and name what's unjust about a structure or situation, and (2) such response often requires actions of collectives, not just individuals. The course evolved to address the conditions of health injustice that can directly undermine the therapeutic nature of clinical encounters. This course applies justice theory to healthcare contexts in ways that motivate students' understanding that health is structural, not just about the distribution of goods and services. This course also facilitates students' understanding that modifying oppressive structures requires collaborative stewardship, solidarity among healthcare professionals, and collective action.

Discerning intersections of an individual's obligations with collective responsibilities regarding oppression is one strategy for illuminating some of the most interesting, important, and complex expressions of injustice in the context of healthcare. As noted previously, the course draws upon feminist justice theory and postcolonial theory to focus on affective dimensions of struggling with one's own roles in perpetuating injustices that influence both health status and access to healthcare which may exacerbate the vulnerabilities of marginalized group members. According to overall course evaluation data among the last three iterations of this course during the last year, about 90% of students agreed or strongly agreed that the course's readings and written assignments effectively motivated their achievement of the course objectives. One student's comment in an end-of-term evaluation expressed her appreciation of the complexity of this material: "[This course] [m]aterial was important for students to be exposed to. Concepts presented were difficult subjects to reconcile in 8 weeks." Such a project of "reconciling" important major concepts illuminates another important affective dimension of learning: the cultivation of critical consciousness—*a la* Friere—and rigorous, but student-centered and supported interrogation of the multiplicity and simultaneity of our identities as oppressed and oppressors. Another student's reflection expressed her view that the course offered an opportunity to integrate her own personal and professional orientations to her life: "The information concerning justice, equality, actually the entire course[,] is applicable to everyday life in [s]ociety."

Preliminary Program Assessment and Outcomes

In addition to data gathered after each course, we also invite student's free narrative responses to questions in surveys when they graduate from the program. Graduates' comments from these exit-surveys over the past three years consistently demonstrate how they value the health justice content and pedagogy in the curriculum. We've culled graduate's comments from these surveys that specifically demonstrate their content-based and affective learning about justice. One graduate's comment is worth quoting here:

> I knew that there were ethical concerns in my work in the hospital setting, but I did not know how to categorize or approach the issues. I now understand the influence of whiteness in health care delivery and policy-making, how systematic disadvantage and oppression influence health care outcomes, and the effect policies, law, and money can have on available medical treatment.

Other graduates commented that the program had made them more aware of health justice issues. One in particular noted, "It has awakened me to justice issues I had never before considered." Another important theme from program exit surveys were students' self-reports of affective learning, as expressed in terms of their attitudes toward those whom they serve. For example, one graduate noted the curriculum's positive impact on her attitude in working with and for persons who are vulnerable; she remarked that the program "enhanced and validated the social justice concerns for [vulnerable] populations that I had already begun to develop."

Conclusion

In this article, we have explored best practices in teaching with an emphasis on teaching about health justice. We offered rationale for the focus on health justice in graduate ethics education and advanced four recommendations for educators interested in designing graduate course work with a health justice focus: 1) teaching should motivate understanding of the causes of health inequalities; 2) complementary critical perspectives are helpful tools for analyzing injustices; 3) theory is used to frame conceptions of professional responsibility; and 4) moral values of *stewardship* and *solidarity* should play a role in health justice education. We have also identified three critical gaps in the literature regarding teaching health justice that include: 1) critical pedagogy regarding solidarity and stewardship, 2) energizing collective action, and 3) narrowing the gap between theoretical and affective learning.

Through sharing this description and analysis of the state of health justice teaching, we are committed to what Shulman describes as "putting an end to pedagogical solitude" (Shulman, 1993, p. 6). We've tried to show ways in which our curricular priorities express important points for which Shulman advocates: (1) sharing one's teaching, (2) documenting one's pedagogical work with one's colleagues, and, (3) contributing to on-going peer review by colleagues outside of one's university (Shulman, 1993). We agree with his articulation of the need for changing one's pedagogy from private to communal in orientation (Shulman, 1993). Thus, we share our approach to the "what," "why," and "how" of health justice teaching and learning.

References

American Society for Bioethics and Humanities: Task Force on Standards for Bioethics Consultation. (1998). *Core competencies for health care ethics consultation*. Chicago, IL: American Society for Bioethics and Humanities.

Beauchamp, T. L., & Childress, J. F. (2009). *Principles of biomedical ethics* (6th ed.). Oxford, UK: Oxford Press.

Bell, L. A. (2007). Theoretical foundations for social justice education. In L. A. Bell, & P. Griffin (Eds.), *Teaching for Diversity and social justice* (pp. 1-14). New York, NY: Routledge/Taylor & Francis Group.

Biggs, J. B., & Tang, C. (2011). *Teaching for quality learning at university: What the student does*. New York, NY: McGraw-Hill International.

Braveman, P. A., Kumanyika, S., Fielding, J., Laveist, T., Borrell, L. N., Manderscheid, R., & Troutman, A. (2011). Health disparities and health equity: The issue is justice. *American Journal of Public Health, Supplement 1*(S1), S149-S155. doi:10.2105/AJPH.2010.300062

Clapper, T. C. (2010). Beyond Knowles: What those conducting simulation need to know about adult learning theory. *Clinical Simulation in Nursing, 6*(1), 7-14.

Crenshaw, K., Gotanda, N., Peller, G., & Thomas, G. (1995). *Critical Race Theory: The key writings that formed the movement*. New York, NY: The News Press.

Diamond, R. M. (1998). *Designing and assessing courses and curricula: A practical guide*. San Francisco, CA: Jossey-Bass.

Dudzinski, D. M., Rhodes, R., & Fiester, A. (2013). Pedagogical goals for academic bioethics programs. *Cambridge Quarterly of Healthcare Ethics, 22*(3), 284-296. doi:http://dx.doi.org/10.1017/S0963180113000108

Earnest, M. A., Wong, S. L., & Federico, S. G. (2010). Perspective: Physician advocacy: What is it and how do we do it? *Academic Medicine, 85*(1), 63-67.

Fadiman, A. (1997). *The Spirit catches you and you fall down: A Hmong Child, her American doctors, and the collision of two cultures*. New York, NY: Farrar, Straus, and Giroux.

Fink, L. D. (2013). *Creating significant learning experiences: An integrated approach to designing college courses*. New York, NY: Wiley.

Freire, P. (1970). *Pedagogy of the oppressed*. New York, NY: Continuum.

Freire, P. (2005). *Teachers as cultural workers: Letters to those who dare teach*. Boulder, CO: Westview Press.

Geiger, H. J. (2006). What do we know? What do we need to know? What should we do? In A. J. Schulz, & L. Mullings (Eds.), *Gender, race, class, & health: Intersectional approaches* (pp. 261-288). San Francisco, CA: Jossey-Bass.

Grow, G. O. (1991). Teaching learners to be self-directed. *Adult Education Quarterly, 41*(3), 125-149.

Gruen, R. L., Pearson, S. D., & Brennan, T. A. (2004). Physician-citizens--public roles and professional obligations. *JAMA, 291*(1), 94-98.

Kanter, S. L. (2011). On physician advocacy. *Academic Medicine, 86*(9), 1059-1060.

Knowles, M. S. (1980). *The modern practice of adult education: From pedagogy to andragogy*. New York, NY: Cambridge Books.

Kolvenbach, P. (2001). An address on the commitment to justice in Jesuit higher education. *Studies in the Spirituality of Jesuits, 33*(1), 1-29.

Kumagai, A. K., & Lypson, M. L. (2009). Beyond cultural competence: Critical consciousness, social justice, and multicultural education. *Academic Medicine, 84*(6), 782-787.

Lee, L. M., Viers, H. W., & Anderson, M. A. (2013). The presidential bioethics commission:

Pedagogical materials and bioethics education. *Hastings Center Report, 43*(5), 16-19.

Mezirow, J. (1983). A critical theory of adult learning and education. In M. Tight (Ed.), *Education for adults: Adult learning and education* (pp. 127-138). London, UK: Croom Helm.

Milligan, F. (1995). In defence of andragogy. *Nursing Education Today, 15*(1), 22-27.

Palfreman, J., Neuburger, J., & Reid T. R. (Directors). (2008). *Sick around the world.* [Video/DVD]. United States: PBS Video.

Partridge, E. (2013). Our failure to deliver and what we can do about it. *Distinguished Lecture Series,* Creighton University, Omaha.

Powers, M., & Faden, R. R. (2006). *Social justice: The moral foundations of public health and health policy*. New York, NY: Oxford University Press.

Quality Matters. (2014). Quality matters inter-institutional quality assurance in online learning. Retrieved from http://www.educause.edu/eli/events/eli-annual-meeting/2013/quality-matters-interinstitutional-quality-assurance-online-courses

Reichlin, M. (2011). The role of solidarity in social responsibility for health. *Medicine, Health Care and Philosophy, 14*(4), 365-370.

Rentmeester, C. A. (2012). Postcolonial bioethics: A lens for considering the historical roots of racial and ethnic inequalities in mental health. *Cambridge Quarterly of Healthcare Ethics: The International Journal of Healthcare Ethics Committees, 21*(3), 366-374.

Rich, E. C. (2011). Clinicians and health care advocacy: The reasons why. *Health care advocacy: A guide for busy clinicians* (pp. 1-12). New York, NY: Springer.

Schneider, M. (2011). *Introduction to public health*. Burlington, MA: Jones and Bartlett Publisher.

Shulman, L. S. (1987). Knowledge and teaching: Foundations of the new reform. *Harvard Educational Review, 57*(1), 1-23.

Shulman, L. S. (1993). Teaching as community property: Putting an end to pedagogical solitude. *Change, 25*(6), 6-7.

Stone, J. R. (2010). Saving and ignoring lives: Physicians' obligations to address root social influences on Health—Moral justifications and educational implications. *Cambridge Quarterly of Healthcare Ethics, 19*(4), 497-509.

U. S. Department of Health and Human Services. (2014). *Healthy people 2020: Topics and objectives: Social determinants of health.* Retrieved from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=3

Welie, J. V. M., & Kissell, J. L. (2004). *Jesuit health sciences and the promotion of justice: An invitation to a discussion*. Milwaukee, WI: Marquette University Press.

Wiggins, G. P., & McTighe, J. (2001). *Understanding by design*. Upper Saddle River, NY: Education/Prentice Hall: Association for Supervision and Curriculum Development.

World Health Organization. (2012). *Social determinants of health: Report by the Secretariat.* Retrieved from http://www.who.int/social_determinants/B_132_14-en.pdf

Young, I. M. (1990). Five faces of oppression. *Justice and the Politics of difference* (p. 39-65). Princeton, NJ: Princeton University Press

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