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ABSTRACT

In this article, I begin by describing what I call this Black Lives Matter moment in the US. I then offer three reasons for considering racism as a bioethical issue, the least discussed of which is the way in which racism acts as a barrier to the creation of better healthcare systems. Next, I argue that the concept of race itself constitutes a bioethical issue in a way that is not fully reducible to racism. Finally, I discuss how we, both bioethicists and health care professionals, might meet this moment by identifying individual points of responsibility (beyond liability) for structural injustice.

KEYWORDS

Race and culture/ethnicity; public health; health care delivery

On April 8th, 2021, in the midst of an ongoing global pandemic, the US Centers for Disease Control and Prevention (CDC) released a statement naming racism as “a serious public health threat” (Walensky 2021). In so doing, the organization informed those who were listening of what the participants of the mass Black Lives Matter protests of the summer of 2020 already knew: that combatting the enduring racial injustice that has plagued the US since before its official founding cannot be put on hold until after the global pandemic has passed. Both widespread infectious disease and the widespread undervaluing of Black and other nonwhite people endanger lives. And the latter not only because of the increasingly publicized State and extrajudicial violence against Black, indigenous and people of color (BIPOC), but also through systemic health and healthcare disparities that we might describe as *slow violence*. That is, “a violence that occurs gradually and out of sight, a violence of delayed destruction that is dispersed across time and space, an attritional violence that is typically not viewed as violence at all” (Nixon 2011, 2).



In the words of Ruth Wilson Gilmore (2007, 28): “Racism, specifically, is the state-sanctioned or extralegal production and exploitation of group-differentiated vulnerability to premature death.” This vulnerability is produced, all too often, by depriving a group of the wide range of resources required to

ensure and maintain health, which means that a global pandemic and racism are not separable issues. Rather, the two operate in and through each other, exacerbating their dire consequences for BIPOC in the US and around the world.

In the limited space of this article, I will begin by describing what I call this Black Lives Matter moment in the US. I will then offer three reasons for considering racism as a bioethical issue, the least discussed of which is the way in which racism acts as a barrier to the creation of better healthcare systems. Next, I will argue that the concept of race itself constitutes a bioethical issue in a way that is not fully reducible to racism. Finally, I will discuss how we, both bioethicists and health care professionals, might meet this moment by identifying individual points of responsibility (beyond liability) for structural injustice.

THE BLACK LIVES MATTER MOMENT

I contend, following Eddie Glaude (2020, xix), that the US is at a crossroads in its history of racial injustice. We have been at such a crossroads at least twice before. The first time was during Reconstruction (1863–1877), following directly after the Civil War and the abolition of slavery. The task in that moment was to establish meaningful citizenship for formerly enslaved Black people. There were many strong

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visions, heroic community efforts, and incredible political accomplishments by Black and white people. Black men were elected to state congresses throughout the South, where they championed causes like public education for all children, and sixteen were sent to the Federal Congress (14 in the House and 2 in the Senate) (see Du Bois 1998, Chapter 14). Yet the period ended with the establishment of Black Codes (precursors of Jim Crow laws) throughout the South designed to return Black people to a state of virtual slavery, with the defense of these laws by the Supreme Court, and with the withdrawal of federal troops from the South. The Reconstruction period was much maligned by white historians of the early twentieth century sympathetic to Southern whites and remains a significantly underacknowledged moment in US history (see Lewis 2020).

The second time at the crossroads was the Civil Rights era of the 1950s and 1960s, when strategies of nonviolence were used by Black people and their supporters to expose the gross inequalities and horrors of the Jim Crow South. Again, there were many strong visions, heroic community efforts, and incredible political accomplishments by Black and white people. Sustained sit-ins, boycotts and marches across the South prompted violent Southern backlash, but also yielded groundbreaking federal anti-discrimination legislation in the form of the Civil Rights Act of 1964 and the Voting Rights Act of 1965. Yet this period of national action and attention also came to an end, albeit somewhat less dramatically, with Civil Rights legislation being rolled back in the subsequent decades through supposedly race-neutral policies and laws (see Anderson 2016, Chapter 4). The Civil Rights era is much acknowledged, but all too often understood as having successfully eradicated structural or legal racism.

Our current moment at the crossroads is best represented by the Black Lives Matter movement. While Black Lives Matter names a specific social movement and organization whose origins and continued work are strongly tied to police and extrajudicial violence against Black people, the slogan or sentiment itself—*Black lives matter*—names and calls more generally for organized struggle against a core underlying principle of white supremacy: the idea that white lives are of inherently greater value and therefore more deserving of preservation and protection than Black ones, and, furthermore, that Black life poses an existential threat to white life and therefore needs to be controlled with the threat of elimination.

Why put all this in an article about bioethics? To underscore the existential urgency of this issue. What we owe to this country and to those who have dedicated themselves to the struggles at all these crossroads (and in between them) is to do everything that we can to make this third racial reckoning our last. (I grant this is almost surely impossible, but we are called upon to act as if it is not.)

Eddie Glaude (2016, 31) calls the foundational American idea that white people are more valuable than others the *value gap*, as a way of exposing how that value gap is the fundamental assumption driving various familiar forms of racial inequality and prejudice like the achievement gap, the wealth gap or the empathy gap. Given the many gaps in health outcomes between white and nonwhite people in the US, it makes sense to argue that US healthcare systems as a whole operate, at least implicitly, on the basis of this same value gap.

Similarly, Charles Mills (1997, 96), invoking the German word *Herrenvolk* (meaning “master race”), describes the political system of white supremacy as prescribing for societies like the US a sort of “*Herrenvolk* ethics” in which nonwhite people are not seen to merit the same level of moral concern that one expects to be directed toward white people. At the time of its mid-twentieth-century founding, the modern form of medical ethics could also be described as a *Herrenvolk* ethics. Its newly elaborated concerns about autonomy, consent, transparency and acceptable levels of risk in medicine and medical experimentation seemed not to apply to nonwhite patients and research subjects, who continued to suffer ethical violations, the likes of which are extensively detailed in Harriet Washington’s *Medical Apartheid* (2006).

What can the American healthcare system do to close the racial value gap? How can bioethicists help in this task and assure that today’s bioethics is no longer a *Herrenvolk* ethics? I can only begin to suggest answers in this piece, but, if nothing else, I wish to make clear that, given this country’s current health disparities and given the current national attention being paid to racial injustice, meeting this historical moment will require *all hands on deck*.

It is obvious that there are some people whose genuine commitments to racial justice might, in virtue of their positions in political and organizational power structures, have greater impacts than others. Nevertheless, history has also shown that mass social movements are crucial catalysts for and ongoing drivers of change. One does not need to be US president,

or a police chief, or a law maker, or a judge, or the head of the CDC, an insurance company or a hospital to do something in this fight. Nor will marching in the streets on its own be enough. To meet this moment requires every person of conscience to do *something*. And the deepest, most lasting change is likely to come from those people doing something from right where they are in their daily lives, both personal and—as I will argue here—*professional*. This, as I will elaborate below requires *individual* commitment against *structural* racism, meaning that one must see oneself inside the system, center one's own transformation rather than one's guilt or innocence, and commit to praxis.

RACISM AS A BIOETHICAL ISSUE

While my call for “all hands on deck” reflects a conviction that the fight against racial injustice must be engaged from outside and within *all* social and political systems across the country (and within their globalized networks), the US healthcare system is no minor site of struggle. It has played an important role in maintaining health disparities and has perhaps an even more important role to play in reducing them.

Racism as a Barrier to Health

Racism operates as a barrier to the health of BIPOC populations in both indirect and direct ways. Indirectly, it operates by reducing the access of BIPOC populations as a whole to positive social determinants of health while increasing their risk of exposure to negative ones. Moreover, an increasing body of research shows that experiences of discrimination result in heightened levels of chronic stress that are *directly* damaging to BIPOC health (Williams and Mohammed 2013, 1161).

Among commonly understood social and economic factors that drive health outcomes, we find factors like economic stability, neighborhood and physical environment, how much and what sort of food one eats, educational attainment, and community and social contexts. Histories and contemporary practices of racism and discrimination can and often do act through each of these factors (Williams and Mohammed 2013, 1158–60). Employment discrimination, income and wealth disparities, and the frequent fluctuations of the employment sectors in which BIPOC populations are often concentrated all work against economic stability. Past (and lingering) practices such as redlining, urban “renewal,”

suburbanization, and gentrification have resulted in enduring and intractable residential segregation across the U.S., creating neighborhoods that are separate and definitely not equal. Access to public transportation, parks, playgrounds, and essential goods and services varies widely based on the wealth of the neighborhood, its desirability to businesses, and the trust placed in it by lending institutions. Economics and neighborhood come together to ensure or deny food stability and to determine whether one can easily access fresh and healthy foods at affordable prices. Economics and neighborhood also come together in determining the quality of public education available to children, their preparation for higher education, and the affordability or even conceivability of pursuing such an education.

Racism and discrimination can disrupt community and social contexts in a variety of ways as well, in the form of negative relationships with law enforcement and the separation of families through mass incarceration or biased removal of children from parents by child welfare systems, just to name a few. For example, Black men are six times as likely to be incarcerated as white men and, for Black men in their thirties, about one in every twelve is in prison or jail on any given day (Sentencing Project 2021). Black women are 1.7 times more likely to be incarcerated than white women and half of incarcerated women with children are confined in locations more than 100 miles from their families (Sentencing Project 2020; Maxwell and Solomon 2018). Meanwhile, an analysis of foster care placement rates between 2000 and 2011 found that 11.5% of African-American children were likely to enter the foster care system between ages zero and eighteen, as compared to only 4.9% of white children (Stephens 2021, 2).

Looking at these social and economic determinants of health, some observers will be tempted to reduce the issues to ones of socioeconomic status (SES) or to search for so-called “cultural” explanations that amount to blaming communities of color for failing to instill in their members an appropriate work ethic or sense of personal responsibility. Such moves, however, pay insufficient attention to the long history of legal and political discrimination that deliberately stripped BIPOC communities of material resources and capacities for self-determination, setting them on deeply unequal footing with respect to the dominant racial and economic classes and establishing social and political norms that would resist all efforts at repair or redress.

Moreover, racism has direct impacts on BIPOC health that have been shown to be irreducible to SES or individual behavior. According to Colen et al. (2018, 167–8), while the association between SES and health is typically positive, linear, and monotonic, such that “with each additional increase in socioeconomic standing, we expect an individual’s health to improve in a stepwise fashion,” when this correlation is broken down in terms of race: “Black/White disparities in health are often *more* pronounced among high as opposed to low SES subpopulations and upward mobility does not seem to bring similar improvements in health for African Americans compared to Whites” (*my emphasis*).

Similarly, higher educational attainment brings fewer returns to Black women in terms of reducing infant mortality. For example, Fishman et al. (2020) find that college-educated, US-born Black women exhibit similar socioeconomic, contextual, psychosocial, and health disadvantages as White women with a high school degree or less. They also note the finding by Elder et al. (2014) that SES, demographic factors, and prenatal health behaviors explain only 25% of the infant mortality disparity between African Americans and Whites (Fishman et al. 2020). Taking infant mortality rates as a reflection of how society cares for its most vulnerable individuals, they argue against the common myth that education is the great equalizer and call for attention to substantial individual-level and contextual disadvantages experienced by Black women across adolescence and young adulthood relative to White women, regardless of any eventual college or professional degrees (Fishman et al. 2020).

Growing evidence points in these cases to the effects of discrimination as a source of chronic and toxic stress for Black people in the US, which impact both their mental and physical health. Sources of stress that are being identified include perceived experiences of interpersonal discrimination, perceived *threats* of interpersonal discrimination, and major negative race-related events which, like natural disasters, act as macro-stressors. Broader cultural racism can also contribute to negative health effects when members of stereotyped groups, like Black people, begin to internalize societal racism and to self-stereotype (Williams and Mohammed 2013, 1161). Improvements in SES do not protect Black people against the stress caused by discrimination and, in fact, middle-class Black people may be more likely to find themselves in predominantly white environments where their concerns about interpersonal discrimination are heightened.

Racism as a Barrier to Health Care

Broader cultural racism also comes into play as it concerns the quality of health care African Americans receive. As Williams and Mohammed (2013, 1162) note, according to a 2003 report from the Institute of Medicine, Black people and other minorities receive fewer procedures and poorer-quality medical care than white people across nearly all therapeutic interventions, from high-technology procedures to basic diagnostics and treatments, and this disparity remains after statistical adjustment for variations in health insurance, SES, stage and severity of disease, co-occurring illness, and the type of health care facility (Smedley, Stith, and Nelson, 2003). They attribute this disparity to predominantly unconscious bias on the part of health care providers due to the prevalence in the US of *cultural* racism (that is, the ideas of Black inferiority and white superiority that have historically been and remain embedded in multiple aspects of American culture).

Indeed, as Lisa Ikemoto (2003, 80–2) has argued, health care systems are often structured in ways that both reflect and enable implicit racial bias. She points, for instance, to the role of discretion. That is, within a complex health care system, a patient’s experience depends largely on how those within the system decide to apply the multitude of rules and practices that are possible for the specific situation. Whether a test, referral or therapy is necessary for a patient isn’t a purely objective question. Medical professionals interpret which patients need what and racial bias can affect that perception of need. She also discusses the the high level of bureaucracy in most health care provision and the difficulty lay people have navigating it, including processes like intake, appointment scheduling (and resulting waiting times), referrals, lab testing, planning for follow-up care, and of course, insurance coverage or other patient assistance programs. While health care workers may become experts at navigating these bureaucratic systems over time, most patients would struggle to do so. Therefore, it matters *which* patients are seen as deserving resources and help navigating the system. It also matters whether a patient receives care from a public facility where everyone may be overworked or a private one where going the extra mile for patients is considered the norm.

Ikemoto also highlights the emphasis on efficiency in health care. With limited time for interactions with patients, clinicians may feel the need to focus in only on what they consider medically essential. They may also resort to mental shortcuts, which can open the door to racial profiling. As Ikemoto (2003, 92–3)

writes: “Evidence shows that the need to make quick judgments in time-pressured encounters, in which cognitive load and task complexity are high, increases a person’s use of stereotypes.” Compounding this concern about effective communication between patient and provider is the impact of the provider’s institutional authority. The provider’s expertise, the fact that the patient is relying on that expertise, and the fact that most encounters will take place in contexts and surroundings more familiar to the provider than the patient is likely to make it harder for socially marginalized patients to communicate their needs and participate in deciding their treatment (Ikemoto 2003, 82).

Meanwhile, structural and institutional racism often block access to (even biased) medical care in the first place. Black people are more likely than whites to be **uninsured**, even after the Affordable Care Act. They are also significantly more likely to fall into the coverage gap where one doesn’t earn enough to get tax credits but earns too much to qualify for Medicaid (Kaiser Family Foundation 2019). Lack of insurance also typically prevents people from seeing the same physician over time, making it hard to receive preventative care, early interventions into diseases, or effective long-term management of chronic health issues.

Racism as a Barrier to Better Health Care Systems

Taking the bioethical harms of racism a step further, I believe there is a strong case to be made for the role of racism in engendering resistance to the creation of better health care systems in the US. In simplified terms, we might say that health care systems are improved if (among many other possible things), they (1) provide a greater number of people with regular, reliable, high quality care regardless of SES or employment status, and (2) include broader public health measures that increase access to positive social determinants of health and reduce exposure to negative ones.

With respect to the first of these, unless private entities in the health care system become a lot less interested in profit and evolve a high level of collaboration with each other aimed at creating a wide network that includes low-cost or free care, the role of government in providing low-cost or free care will have to be expanded. It has clearly been the case that conservatives in US politics have historically (1) resisted expanded government (particularly at the federal level), (2) encouraged economic growth through increased privatization and market competition

(justified by a presumed correlation with societal well being), and (3) understood freedom as the absence of government interference rather than as the enablement of autonomy through the stable provision of basic necessities. Thus, it risks appearing obvious that political conservatives would oppose the creation of a more accessible health care system based simply on their political principles without any particular malice toward any particular US subpopulation.

Yet work on the history and present reality of US race relations suggests that, in US politics, conservative political principles and deeply held feelings of racial resentment have often evolved in tandem. For example, resistance to expanded federal government is historically connected to the Civil War and the idea that the federal government violated states’ rights by preventing succession, abolishing slavery, and granting citizenship (and voting) rights to Black people. Similarly, a belief in free market competition as the individual and collective path to prosperity has been a cornerstone of American ideals of equal opportunity and meritocracy. The myth that those ideals have been broadly *actualized* in American society has been essential to the belief in white superiority, which is taken, often unconsciously, to be evidenced in the greater success of white people in American society (where the alternative explanation for relative white success would be racism and discrimination against and exploitation of nonwhites).

Meanwhile, the idea of freedom as freedom from interference has been linked to racial myths that depict white people (and successful white immigrants) as hard working and self-motivated, while Black people and other nonwhites are portrayed as lazy, child-like, prone to criminality, and in need of white supervision to offer any valuable contribution to American society. Such myths justified the decision not to implement and sustain remedial measures after the end of slavery in an effort to provide *meaningful* citizenship to Black people in the US. They also serve to stigmatize dependency and moralize poverty, suggesting that even those who have never had access to bootstraps with which to pull themselves up (or have been repeatedly knocked back down for even trying) are still to blame for their own suffering. Dependency itself is often racialized, as in the politically powerful image of the Black welfare mother who prefers to have babies and collect welfare checks rather than work to support herself and her children, or the image of the criminal Black man who prefers illegal activity to honest work.

It is easy enough to understand why well-off conservatives with good private insurance and access to positive social determinants of health would not want to change a system that is working well for them (especially those who feel the value of a good thing *increases* when one knows that not all people possess it). It is harder to understand why poor conservatives without good insurance or with higher exposure to negative social determinants of health would oppose changes to the health care system that would be to their own benefit and that of their communities. Or, at least, it is harder to understand without awareness of the role of racial resentment.

In his 2019 book, *Dying of Whiteness: How the Politics of Racial Resentment is Killing America's Heartland*, Jonathan Metzl summarizes the results of having conducted health-related focus groups with self-identified white and African American men in Tennessee between 2012 and 2016. As exemplary of his findings, he offers the words of a white 41-year-old uninsured Tennessee cab driver dying of liver damage caused by hepatitis C: “Ain’t no way I would ever support Obamacare or sign up for it. I would rather die ... We don’t need any more government in our lives. And in any case, no way I want my tax dollars paying for Mexicans or welfare queens” (Metzl 2019, 3). Such an opinion, Metzl goes on to show, was not an outlier in his focus groups. In fact, he reports, “many white men ... voiced a willingness to die, literally, rather than embrace a law that gave minority or immigrant persons more access to health care, even if it helped them as well” (Metzl 2019, 124).

Metzl continues: “We often found that no ivory-tower health-policy explanation of the ACA’s potential benefits came close to challenging concerns about ways that health insurance came from the administration of an African American president or placed white Americans into ‘networks’ with immigrant and minority populations” (2019, 124–5). Indeed, one political science investigation found that President Obama’s strong association with health care as an issue increased the polarization of public opinion on the issue, such that during his presidency (specifically for the year 2009–2010), the racial divide in health care opinions grew 20% from President Clinton’s plan back in 1993–1994 (Tesler 2012, 690). That is to say, health care reform has been a racialized issue and only became more racialized during and after Obama’s presidency.

Another sign of the role of race in creating opposition to health care reform is found in research published by the Kaiser Family Foundation that aims to

show and explain the disparities in insurance coverage between Black and white Americans. The finding is labeled, “Blacks make up a greater share of the population in the South, where most states have not expanded Medicaid,” suggesting that the decisions by those Southern states result in a disproportionate impact on Black people (KFF 2019). It is possible, and I would argue likely, that the causal relationship also runs the other way. That is, that the presence of more Black people in Southern states fuels higher levels of racial resentment which, in turn, produce opposition to the expansion of Medicaid (regardless of the fact that a significant number of uninsured white people in those states would benefit from such expansions).

Writing about the end of Reconstruction, WEB DuBois clearly articulated in 1935 the power of what we now term racial resentment. “So long as the Southern white laborers could be induced to prefer poverty to equality with the Negro,” he wrote, “just so long was a labor movement in the South made impossible” (Du Bois 1998, 680). Metzl’s (2019) findings could be similarly paraphrased: So long as the Southern white working class can be induced to prefer death to being put in health “networks” with Black people or immigrants, just so long is major health care reform in the US made impossible (see also Yearby 2021).

The conservative political principles referenced above, in their moralization of poverty, tend to engender in people’s thinking distinctions between the deserving poor and the undeserving poor. Those not considered responsible for their plight are thought to be deserving of assistance, if not always in the form of government, at least in the form of community support or charity. Those stereotyped as being poor as a result of laziness, irresponsibility, or a preference for dependency are not thought to be deserving of assistance. Indeed, resources spent on the latter group are thought to be wasted, since that group is believed unlikely to use those resources to achieve self-sufficiency, the only purpose for which welfare payments in the US are thought to be (temporarily) justified.

Racial stereotypes work to place Black and other nonwhite people in the category of the undeserving poor and to create an empathy gap whereby white people are less likely to extend to Black people the same level of empathy they extend to other white people, even white strangers (Tettegah 2016). In the absence of broad-based empathy, it becomes much harder to gain sufficient public support for health care and public health reforms that try to prevent marginalized people from slipping through the cracks.

RACE AS A BIOETHICAL ISSUE

Thus far I have argued that *racism* is a bioethical issue because it operates as a barrier to health, to health care, and to health care reform. Now, I wish to go further and argue that *race itself*, that is the very concept of race, is a bioethical issue. This argument revolves around Eric Voegelin's insight that attempts to offer scientific theories of race persist (despite being discredited) because the sense of race as central and meaningful in our social relations endures the rise and fall of various racial theories in the natural sciences.

Race is conceptually distinct from racism and, even if racism cannot exist without a theory of race, it is possible, in principle, to have a theory of race without that theory being hierarchical or justifying discrimination (that is, endorsing racism). While several bioethicists have recently emphasized the importance of attributing health disparities to *racism*, my contention here is that, beyond the bioethical harms of racism, exactly how we think about the concept of race and the effects of that concept of race on our thinking merit bioethical study and reflection (Yearby 2021; Tsai 2021; James and Iacopetti 2021).

Concepts of race often cluster around two poles: race as biological and race as social construction. Taken as a biological concept, race involves more than the obvious fact that physical traits are hereditary. It also relies on the belief that people can be meaningfully and discretely grouped biologically or genetically. Further, it assumes that racialized physical traits are outward *markers* of membership in these discrete groups. In other words, the idea of race as biological is the idea that racial categories are a feature of the natural world that humans discover and that science allows humans to understand (Taylor 2004, 47–8). Moreover, I would argue that to hold a biological concept of race commits a person to the idea that *the racial categories we currently use* are biologically or genetically meaningful. That is, a brand new genetic or biological system for categorizing human beings that was considered scientifically accurate would not be “race”—it would be a new category. Or, if that does not seem accurate, I can make a normative claim: It would not be clear, productive or useful to attempt to correct “race” under new genetic or biological markers; the existing connotations of the word are too strong.

If we think of race as a biological concept (whether a true or false one), then race becomes a *scientific* issue. In this case, it falls to scientists to investigate questions like, “What, if any, biological, physiological, or genetic features demarcate different racial

categories?” or “What, if any, is the most scientifically accurate way to divide people into racial categories?” The way scientists answered such questions would then shape scientific practices, influencing, for example, how, if ever, a concept of race should be incorporated into human research, pharmaceutical research, or medical practice.

However, the current scientific consensus is that race does *not* have a biogenetic reality, or that, if it is to be considered a biological concept, that concept is a false one. The opposite pole, then, sees the concept of race as a social construction. On this account, when we are talking about race, we are talking about something real, but the nature of that reality is social. Like money, which is also not “discovered” in the natural world, race is a socially-created idea that takes material form through the social assignment of meaning/value to naturally occurring phenomena like precious metals or diverse human phenotypes (Stubblefield 2005, 86). However we may feel about the meaning/value so assigned, we must learn and use the rules created surrounding both money and race in order to function in most societies.

If we understand the concept of race to be socially constructed, *race* isn't a scientific or medical issue, *racism* is (as described above and argued by Yearby 2021, Tsai 2021 and James and Iacopetti 2021). This suggests it is the task of scientists to disprove and denounce race as a biological concept whenever necessary, to stop using race as a biogenetic category in scientific investigation, and to study racism and its measurable physiological effects. Meanwhile, it would be the task of physicians *not* to use race as a proxy for biogenetics in individualized medicine and, instead, to adjust medical practice to provide equity in medical care, where that will often require accounting for the negative health effects of racism.

While I do believe race *is* a social construction, when I speak of race as a bioethical issue, I am thinking about race in an additional way: as *the race idea*. Historically, the race idea has understood racial differences and interactions between races as cultural drivers. In other words, the race idea views the temperaments and talents of certain races (and their interactions in encounters between different races) as determinative of the path of human progress (or decline).

The race idea more accurately describes the thinking involved in the historical emergence of the race concept than does the theory of race as biological, as exemplified by British statesman Benjamin Disraeli's (1852) claim that: “All is race. In the structure, the

decay, and the development of the various families of man, the vicissitudes of history find their main solution” (331). Moreover, the race idea has continuing relevance that rarely appears in current academic and popular discussions of race. Claims by present-day white nationalists in the US are frequently based in the belief that American achievements and positive characteristics are the product of white talent and temperament and, therefore, that America should be considered a white nation. Analogous justifications are to be found among various nativist and white nationalist movements around the globe.

I take this term, *the race idea*, from Eric Voegelin, a German-born political theorist working in Austria during the rise of National Socialism. Voegelin distinguishes between *race theory*—his name for scientific theories of race produced by people working in the natural sciences—and the *race idea*, which he describes as a powerful political symbol used to define and shape communities. For Voegelin, it is not that *race theories* lead to the use of the race idea, but that the persistence of the *race idea* in organizing our worldviews and social relations is responsible for the continuing attempts by scientists to prove the existence of race scientifically (Voegelin 1940, 283–4). That is, race scientists were not discovering race in their study of the natural world, but searching for a scientific explanation to justify existing beliefs in race as a powerful force shaping our world and its history.

With this understanding of the real source of belief in race, Voegelin argues that the essential task to undertake is not to disprove the scientific basis of race (which is easy and has been done many times), but rather to study systematically the way that the *race idea* operates in various contexts (1940, 285–86). If we take up Voegelin’s charge within the realm of science and medicine, I argue, the race idea becomes a *bioethical* issue.

To approach the race idea as a bioethical issue, one must first recognize that practitioners of science and medicine do not stand apart from the societies in which they are embedded. That is, despite a strongly held commitment on the part of scientific communities to rational and methodical investigation in pursuit of objective knowledge about the natural world, because the race idea persists in broader society, the race idea will continue to influence science and medicine, often in ways that are hard to detect. This influence will then lead to scientific frameworks which unwittingly strengthen the race idea in broader society, creating a feedback loop (Perez-Rodriguez and de la Fuente 2017; Tsai 2021; Yearby 2021, 20–1).

Thus, one task for bioethicists concerned with the race idea is to uncover and detail this continued influence of the race idea in science and medicine and the reification of the race idea that results. This work has been notably performed by Dorothy Roberts (2011) and Jenny Reardon (2005), among others. Moreover, this recognition and identification comes with a moral imperative to *challenge* pernicious influences of the race idea in medical and scientific assumptions and frameworks, with the aim of reducing the individual and social harms that come from such assumptions and frameworks.

MEETING THE MOMENT

Thus far, I have argued that both racism and race itself should be taken up as bioethical issues. (This is not, of course, to say that they should be taken up exclusively as bioethical issues, but that bioethicists and practitioners of science and medicine should be among the many social actors challenging both racism and the race idea.) The question then remains, practically speaking: What does a deep and genuine commitment to the value of Black lives require from bioethicists and practitioners of biomedicine?

Such questions about practical action are complicated by the very analysis that points both to the deep and systemic entrenchment of the race idea and racism and to the great damage they have done and continue to do in American society (and elsewhere). Yet, when we speak of a moral imperative to challenge harmful systems or institutions, we imply that such systems can be effectively challenged. *Ought*, as they say, implies *can*. While I cannot provide a universal checklist for fighting systemic racism in medical institutions, in the rest of this essay, I will try to sketch a way forward as we stand at this third crossroads in America’s racial history. I will begin by discussing the concept of individual responsibility for structural injustice in general terms and conclude by considering how both clinicians and bioethicists might take up the responsibility to challenge institutional racism.

Individual Responsibility for Structural Injustice

According to Iris Marion Young (2011), injustice is *structural* when its causes are “embedded in unquestioned norms, habits, and symbols, in the assumptions underlying institutional rules and the collective consequences of following those rules.” I have offered many examples of structural nature of the racism in health care above. When we consider the question of

responsibility for structural injustice, however, what Young's definition highlights is how everyday people can carry out the actions necessary for injustice simply by following social norms and institutional rules—that is, without ill intent or even clearly identifiable negligence.

On the one hand, the concept of structural injustice has immense explanatory value. It helps us explain how, even when we might have an institution full of people who would disavow racist beliefs or personal prejudice, that institution might still operate in ways to perpetuate racial injustice. Even if bad actors *are* present in an institution, structural injustice reminds us that getting rid of those bad actors will not necessarily solve all or even most problems. It also highlights the complexities of injustice—since norms, habits and symbols permeate our lives, are often unconscious, and are rarely perfectly coherent, yet can still have serious effects. Further, it helps us understand why we can see a reduction in racist attitudes and explicitly discriminatory laws and practices over time yet still find that the life chances or life expectancies of BIPOC are significantly and predictably curtailed.

On the other hand, the increasing familiarity with and acceptance of the structural nature of many injustices risks enabling a widespread abdication of responsibility to challenge those injustices. That is, with the recognition that many major societal injustices (like racism) are not committed primarily by individuals with ill intent, we risk portraying everyone as a bystander and no one as a perpetrator. On our common liability notion of responsibility, bystanders bear very little responsibility for all but the most obvious and acute of harms. Moreover, even those who choose to consider themselves responsible for fighting structural injustice may be overwhelmed by its magnitude and resilience, leading to the feeling that there is nothing significant that any individual can do. Indeed, even if one turns to the notion of collective action as the best way to address structural injustices—which it likely is—we are not likely to get very far in improving health systems if medical and biomedical professionals only consider anti-racist activism as something to pursue outside the workplace in their free time.

As I argued at the beginning of this essay, meeting this moment will require all hands on deck, and it will require from each of those hands an *individual* commitment against *structural* racism. Functionally, I break that commitment down into three necessary parts: (1) the ability to see oneself *inside* unjust systems and/or institutions, (2) a centering of one's own

transformation rather than one's guilt or innocence, and (3) a commitment to praxis.

In her 2003 piece on the normativity of whiteness in bioethics, Myser crucially argues that whiteness is not a mere matter of the skin color of most bioethicists. As Ho (2016) describes: "it is first and foremost about the dominant cultural norms and ideologies that have come to determine how bioethics is practiced, and what principles and contexts are considered relevant in the inquiry." The same is true of many systems and institutions in the US. To see oneself inside unjust systems or institutions, especially as a professional, is to recognize that one's education, one's training and the time one spends within an institution all work to assimilate a person as a professional into that institution. This means that the biases and injustices that characterize one's institution (and the excuses that institution uses to justify them) become one's own biases and, once trained into the institutional gaze, one begins to see those injustices as unavoidable or necessary evils. In short, one must recognize rather than deny that if one is part of a system, whatever one's internal convictions, one does not stand apart from its problematic aspects.

Though this truth may be difficult to accept, the useful fact about being a professional who is part of an unjust institution is that one does not need to *seek out* a site for individual or collection action against social injustice. Instead, one's individual responsibility and one's intervention can begin directly with one's institutional role. All institutional roles entail specific resources and powers—even those roles far from the top—and one can work to direct those resources and powers toward more just institutional methods and goals. If, as an individual, one pushes the boundaries of one's professional role in, for example, anti-racist directions, while other individuals are doing the same (either independently or specifically inspired by one's example), structural transformation becomes possible. If a nurse in a particular workplace, for example, works at being explicitly anti-racist in their duties, and comes to do so alongside other colleagues, over time being explicitly anti-racist can become part of what that workplace considers a *good* nurse. Creating this attention to anti-racism as an expectation of a professional role within a particular workplace or institution will encourage others to adopt the practice because, as Zheng (2018) argues in her discussion of the Role-Ideal Model (RIM) of responsibility for structural injustice, most professionals are driven to be good in their roles, whatever those roles entail (875).

In order to begin to address structural injustice through one's institutional role, one must be able to reflect on one's own norms, habits, and biases and on their implications for one's role. The key here is to center one's own transformation, rather than one's guilt or innocence. To take individual responsibility for structural injustice does not require identifying oneself as clearly guilty or clearly innocent. It requires a commitment to transforming one's actions within an institution as a way to apply positive pressure on that institution toward change. Time and energy spent trying to prove that one is not racist is time *not* spent fighting the very racial injustice that one so desperately wants to separate oneself from, and actually contributes to injustice through the displacement of responsibility (Mithani, Cooper and Boyd 2021, 15). The same goes for time and energy spent on guilt. Feeling guilty does not actually change the circumstances of the people toward whom one feels guilty. No one chooses the society into which they are born and few leave the societies into which they were born. Yet both the societies and the people raised in them are imperfect. Here, Mithani, Cooper and Boyd's reminder of Foucault's analysis of power is instructive. On Foucault's account, power is not primarily concentrated in government or law, but suffused throughout the social body. That is power is produced and consumed by everyone as they operate within their social roles (though certainly not equally) (Mithani, Cooper and Boyd 2021, 13). The question, then, is rarely one of exceptional guilt or exceptional innocence; the question is most often one of commitment to ignorance and evasion or commitment to do better.

How, then, to start doing better? Here, too, there are traps. On the one hand, trying to take action against racism without first learning about racism and about the specific racist structural dynamics common to one's field can result in more harm than good. On the other hand, because the structural dynamics of racism are so complex, trying to discover the perfect action in advance through research will delay action indefinitely. Thus, the proper method across a wide variety of situations and contexts is *praxis*. According to Paulo Freire, praxis is *the* essential human activity, and it consists of action and reflection illuminated by theory and aimed at transforming the world. Crucially, Freire (2005) also specifies that his notion of praxis "implies no dichotomy by which this praxis could be divided into a prior stage of reflection and a subsequent stage of action." Rather: "Action and reflection occur simultaneously." Further, he notes that it is not for the elite to dictate praxis for others,

but for all people to act, theorize, and reflect for themselves and in concert with others (125–8). In short, praxis is theory, action, and reflection, in a dynamic and *continuing* relationship whereby all actions taken are both the result of reflection and catalysts for further reflection, which includes learning, listening, and reflecting in community with others, and typically leads to adjustments of further actions.

Praxis in Practice

Clinicians

For clinicians seeking to take individual (and work toward institutional) responsibility for structural racism, I begin by echoing Cerdeña, Plaisime, and Tsai's (2020) discussion of shifting one's clinical framework from *race-based* medicine to *race-conscious* medicine. Where *race-based* medicine operates on assumptions of *physiological* differences between racially defined populations and risks perpetuating racial health inequalities, *race-conscious* medicine recognizes the structural sources of racial disparities in health and leads to a clinical practice that aims to reduce disparities and the structural barriers that cause them. For example, clinicians might make a conscious effort to marshal their professional discretion in favor of BIPOC patients and families to make sure their needs are taken seriously within their particular healthcare institutions. In other words, *racism* is understood as the key driver of disparities, while the *race idea* is recognized as deeply imbedded in our social imaginary and as something whose assumptions we must work to uncover and address in our practices.

Uncovering such assumptions, particularly in how they shape the often unspoken values within healthcare systems, will be most successful as collective (rather than individual) work. The collective who undertakes such work should include patients, community members, activists, and/or others outside the institution and profession, since outsiders are the most likely to spot hidden assumptions, since they may not share them (Grzanka, Brian and Shim 2016, 28–9). Such a collective will also be in a position to recognize the way problems in medicine and healthcare intersect with, reinforce, and are reinforced by other unjust institutions. This type of collective work is particularly important given the emphasis placed on evidence and rationality in medical training. As Fuller (2016) notes, the fact that health care practitioners are "highly trained professionals charged with making complex, authoritative decisions on the basis of their

considered judgements” is likely to make it difficult for them to acknowledge unconscious or irrational bias (30). Ultimately, to the extent that clinicians and other healthcare workers are actively engaged in trying to reduce racist harms in front of them or under their direct control, they are also more likely to become attuned to the upstream and intersectional causes *beyond* their control and to begin to help organize against them (Grzanka and Brian 2019, 23).

Moreover, clinicians should be on guard against the deep drive to mastery often present in medical and scientific fields, which often supports the persistence of eugenic thinking (see Russell 2018). Biomedicine tends to provide a particular kind of solution to inequalities that often aims to overcome perceived bodily or physical limitations. This can be very well meaning, but can also lead to the proposal of scientific or technological solutions to social problems. Yet, social problems sometimes require challenging and messy *social* solutions, rather than the hope of medical miracles.

One might suggest that both types of solutions should be encouraged, and this is not necessarily wrong, but as Françoise Baylis argues, it matters whether we direct our “time (energy), talent (skills), and treasure (finances)” (2019, 33). What kind of future are we envisioning? Which populations do we have in mind in what we do and who might deserve more of our attention? For example, what does it mean that reproductive biomedicine spends so much time developing new and expensive fertility treatments for those who can afford it rather than fighting preventable causes of infertility among the poor and marginalized?

Bioethicists

These questions about our background biases and assumptions, the future we envision, and where our attention is most needed should also serve to guide the praxis of bioethicists, both clinical and academic. As King, Henderson and Churchill (2021) advise, bioethics must begin to *set its own agenda for meaningful work*, rather than simply continuing to follow the path pursued by science and medicine and exploring the problems they self-identify. This must include examining how bioethics-as-usual contributes to problems with racism in medicine and healthcare and expanding analysis beyond individual patient care and toward structural barriers to health (King, Henderson, and Churchill 2021, 53). So, too, would I call upon us to expand our clinical and academic work to consider things like historical context and the often intangible

harms to socially defined groups caused by standard research methods and clinical practices (even in areas one might consider purely objective and scientific).

This will require making our own social positions as academics and/or ethics professionals more transparent to ourselves in order to reflect critically on our deepest background assumptions and the very framing of our ethical questions. As with clinicians, such reflection should be undertaken as collective work, which should include outsiders to the profession/discipline. Toward this end, Baker (2016) shrewdly suggests that we move beyond euphemistic engagement with abstractions such as “health care disparities,” “minority health care,” or “social justice,” and speak directly of *racism* in our bioethical discourse (16). To this, I would add that bioethicists should be learning to consider racism in all their bioethical work, not just that which concerns BIPOC patients or subjects. Particularly in the US context, there is no subject of bioethical inquiry who is not racialized, even or perhaps especially, when that subject is racialized as white. Thus, as Mithani, Cooper and Boyd (2021) argue, “bioethicists ought to examine instances where racism is clearly mentioned, but also all of the other times when race is conveniently omitted in order to create policies and guidelines that are informed by the populations that bioethics aims to serve” (14). Race and racism must no longer be considered “niche” topics in the field of bioethics (James and Iacopetti 2021, 56).

Finally, as I argue elsewhere, bioethicists should be helping physicians, scientists, and health care workers to study theories of racial inequality, engage in critical self-reflection, and generate practical steps for improving their practices (Russell 2021). Danis (2021) discusses the role that healthcare ethics consultants might play in centering anti-racism, suggesting not only increased awareness of when bias and structural racism may be relevant to consultations, but also proactively organizing anti-racist educational sessions in one’s healthcare organization and collaborating with organizational leaders to reflect on the role of social justice in the organization’s mission. Danis, Wilson, and White (2016) outline these suggestions around consultation and education as well, but also include scholarship/philosophical analysis, policy, research, outreach and training as possible contributions of bioethicists against racism and racial violence. Under “training,” they specifically call for a diversification of the field of bioethics, and the inclusion and proliferation of minoritized voices in the discipline (8).

There is much to be done across the health care system and beyond and it will require many hands. It is when we take seriously the deep structural racism that shapes our world *and* the ways that we can learn to name, reflect upon, and work against it in our everyday personal and professional lives that we will begin to meet this moment.

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