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Response to Commentators on “Bioethicists can and should contribute to addressing racism”

Yolonda Wilson,

Howard University

Marion Danis, and

National Institutes of Health Clinical Center

Amina White

National Institutes of Health Clinical Center

Abstract

The commentaries on our suggestion that bioethicists can and should contribute to addressing racism highlight a tension within the field of bioethics regarding what the role of bioethicists ought to be and how best to fulfill it. While two commentators were concerned that our proposal would result in overstepping the boundaries of the roles and expertise of bioethicists, the others endorsed the proposal and even expanded upon it. In response, we would reiterate that morally troubling social factors that affect the health of people in the communities where bioethicists work pose issues that bioethicists should not ignore. As such, collaborating with others and contributing to addressing the causes and consequences of racism should be considered within the bounds of the bioethics profession and bioethicists should be well prepared when doing so.

We appreciate the ten thoughtful commentaries on our target article “Bioethicists can and should contribute to addressing racism.” Two of these commentaries challenged us to consider whether our recommendations for confronting racial bias ventured too far outside the scope of clinical bioethics. On the other hand, the remaining commentaries suggested going farther and outlined additional ways that bioethicists can play a substantive role. These responses highlight a larger tension within the field regarding what we understand our role to be and how best to fulfill it. We will frame our response to our commentators as an exploration of this tension. Whereas Baker and Weddle are concerned that some of the interventions we propose would result in overstepping the boundaries of both our roles and our expertise, Grzanka and colleagues, Ho, Karkazis and colleagues, Kuczewski, Rattani and colleagues, Sodeke, and Stone each see interesting opportunities to go even further than we articulated in the original article. Additionally, Rattani, Sodeke, and Stone highlight the important role that historically black institutions can play in addressing these issues.

Address correspondence to Marion Danis, MD, Department of Bioethics, National Institutes of Health Clinical Center, Building 10, RM, 1C118, Bethesda, MD 20892, USA. mdanis@nih.gov.

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Baker (2016) expresses reservations about our view that bioethicists can and should address racism “in settings beyond the usual home of the bioethicist: in municipal governments, police departments, prisons, schools and other community institutions” (Danis et al. p.14). Baker argues that bioethicists should not attempt to overextend their expertise beyond the scope of biomedicine and healthcare. We would suggest that it is within the scope of bioethics to address those complex factors and social determinants that significantly affect health outcomes. When the World Health Organization Commission on the Social Determinants of Health called for addressing socio-economic factors as a matter of health and social justice, this was a call for working outside of silos (WHO 2008). Bioethicists would do well to join in. Moreover, bioethicists include professionals from many disciplines: educators, philosophers, theologians, lawyers, physicians, social scientists, public health and policy experts, and historians (as Baker exemplifies). It is therefore likely that their range of expertise and the settings in which they practice will make it quite likely that they can contribute to addressing racial injustice in very diverse ways that remain within their scope of expertise. To the extent that medicine focuses on achieving good health outcomes and that health outcomes are the results of many social factors, the practice of medicine and the bioethicists who work beside them have a role to play in examining, analyzing and critiquing social factors such as racism.

Like Baker, Weddle believes we go too far in our assertions. Weddle argues that bioethicists are not equipped with the training and skills needed to address racism and racial violence. Weddle contends that we are proposing too much and that other disciplines are more prepared to address problems of discriminatory policing, the exclusion of blacks from juries, low numbers of African American lawyers, income inequality, poverty in the black community, unemployment, and education disparities. But Weddle is misreading us. We are not arguing that bioethicists are in a position to tackle these complex socio-political issues alone. However, we assert that as bioethicists, we should not only collaborate with others to address discriminatory practices that exist in the biomedical sciences and in healthcare; we should speak out about the adverse health effects that beset patients as a result of unhealthy and unfair social circumstances. This may require that we consider the impact of poverty, education, and unemployment as social determinants of health that cannot simply be ignored as subjects outside the sphere of our expertise. Furthermore, Weddle’s response seems to presume that there are no bioethicists who are already working on issues of race and racism. This is simply not true as some of the authors we cite and some of our commentators themselves demonstrate. However, we argue that bioethicists in general can and should do more.

In contrast to the cautionary critiques, a number of commentaries we received suggest that we either did not go far enough or needed to consider additional issues in our thesis. While our article posed the question of whether and to what extent bioethicists should adopt an advocacy or activist role, Fuller (2016) asserts that we were overly tentative, for both roles are critical in addressing implicit bias. Fuller urges bioethicists to encourage implicit association training as an intervention that may be effective in overcoming certain implicit biases that are prevalent among healthcare practitioners. We appreciate Fuller’s suggestion that bioethicists should actively promote such training, support research that demonstrates

implicit biases among practitioners, and advocate for institutional change where there is evidence of racial bias.

Grzanka and colleagues (2016) argue that in order for bioethicists to have a meaningful impact in addressing racial injustice, it is important to avoid a one-dimensional approach focused solely on race. Rather, an intersectional approach that takes into consideration the complex interplay between racism, sexism, classism, and other forms of discrimination is necessary to avoid oversimplifying or further perpetuating the problem. We acknowledge that the experience of racism is not homogeneous. It will be a different experience for men, women, and gender minority individuals; for poor and financially well off individuals; for more and less highly educated individuals; and for individuals whose ancestry is identified as African American to varying degrees. While we grant this, we believe it is important to delineate the problem of racism among these other forms of discrimination as an issue that bioethicists should be expressly prepared to confront. We agree with a second important assertion by Grzanka et al that “many of the answers to questions of how to do bioethics antiracism will come not from privileged academics, but from the actual individuals, organizations, and advocacy groups already fighting against racism, sexism, classism, and other intersecting forms of health inequality in the U.S. and worldwide” (Grzanka et al. 2016).

Ho suggests that in order for bioethicists to effectively address racism and promote health equity, a paradigm shift is needed in both our healthcare delivery system and academic institutions that provide little funding for scholarly work on race relations and health disparities. Ho’s commentary argues that while it is a noble idea for bioethicists to address racial injustice, we are part of a system that perpetuates the very power imbalances that give rise to patient distrust. Such imbalances are not just a function of skin color, for they may persist even among individuals of the same race. As long as the bioethicist is a hospital employee, a power imbalance is unavoidable between the privileged employee and vulnerable patient; distrust is therefore inevitable. Furthermore, as employees, bioethicists may not have the freedom to address discriminatory institutional practices. We share Ho’s concerns about power imbalances and patient mistrust. In response to this worry, we would suggest that one potentially useful intervention is to introduce peers into the healthcare delivery process. This has been successfully done in behavioral health and CenteringPregnancy, a model of group prenatal care, in which the support of peers has been associated with improved outcomes (Ickovics et al. 2007). While we agree with Ho’s assertion that there are constraints wherever one works, whether in an academic or clinical setting, these constraints do not relieve us of the responsibility to confront unjust practices when we are in a position to do so.

Karkazis and colleagues further emphasize the significance of power imbalances and structural aspects of racism that bioethicists must address if they are to make any impact on systemic patterns of racial injustice. The authors argue that unless bioethicists focus on the underlying power relationships and challenge the very notion of race as an inappropriate social construct, they may end up reinforcing the problem. For example, the authors suggest that in using the language of race in our article, we have perpetuated the static, objectifying notions of race. We understand this concern and grappled with this very issue in writing our

article. On the one hand, we were cognizant of and tried to emphasize structural and institutional injustices that have historically and disproportionately affected African Americans. Yet we chose to use the terminology of “race” because often the first step in solving a problem is to name it, even if the term is problematic. Reframing racial discrimination as a problem of power may be helpful in analyzing the history of race relations. However, we would argue that hierarchies and power dynamics are in some sense unavoidable, particularly in the biomedical and healthcare sectors where privileged practitioners and vulnerable, disadvantaged patients must interact. Simply renaming the problem may not serve to bring us closer to achieving equity in our healthcare institutions. The task for those who wish to address racism is to identify the ways in which those in positions of power may be abusing their authority, to hold them accountable, and to empower those who were previously disempowered. When this does not occur, racial injustice continues as well as the ongoing moral distress of knowing what one *ought* to do but being unable or unwilling to do it.

Kuczewski broadens the subject of racial injustice to consider the plight of undocumented immigrants and gives an instructive example of how bioethicists can lead the way in promoting institutional change. Such change can be challenging in the face of environmental constraints such as pressure from hospital administrators or academic institutions to avoid controversial advocacy work that may alienate financial stakeholders and patrons of a health system. Kuczewski’s perspective leads us to consider that some environmental constraints may be legitimate worries. For example, Kuczewski states that attracting “many such patients who have no access to insurance or other means to pay for their care” could be a downstream effect of public activism that would concern a hospital CEO. This highlights the need for addressing constraints realistically, collaborating with stakeholders, and proposing feasible solutions to problems of health inequity.

Rattani and colleagues add that historically black medical schools are underfunded, lack formal bioethics departments, and often lack bioethicists. This is an important point that we did not address in our article. At stake is a larger issue about the lack of diversity within the field of bioethics. When bioethicists are scarce at historically black medical colleges, medical students at those institutions have few opportunities to learn about or contribute to the field. Given that the longstanding mission of historically black medical institutions is to provide care for underserved populations living in predominantly black communities, the unique resources and perspectives of people working in these institutions are missing in the bioethics dialogue about racial injustice. This is an especially salient point for authors Wilson and White who have both worked at Howard University, a historically black university with a medical school, and for Wilson as an alumna of Howard University. While some suggestions by Rattani and colleagues are beyond the scope of our paper, we agree that they are extremely important in addressing racism.

Sodeke argues that moral courage is necessary to address racism and racial violence. He provides a response to many of the worries described by Ho. Sodeke illustrates efforts by the Tuskegee University National Center for Bioethics in Research and Health Care to broaden the scope of bioethics and encourage diversity. We particularly agree with Sodeke’s point that moral theory alone is inadequate and that the perspectives and experiences of those who

have experienced racism need to be incorporated into the conversation. We also endorse Sodeke's suggestion that while there will be skeptical and distrustful reactions to any efforts by bioethicists to contribute to addressing racism, the effort ought to be made nonetheless.

Finally, we appreciate Stone's personal account of gradually recognizing and overcoming certain implicit biases in his own career as a white medical professor and ethicist. In confronting stereotypes at Tuskegee and being open to opportunities for collaboration with a diverse group of colleagues, Stone provides examples of how the challenges of venturing into "racism work" enriched his knowledge, skills, and growth academically and personally. Given the inherently interdisciplinary nature of bioethics and the range of disciplinary backgrounds of bioethicists, we understand the bioethicist to be uniquely situated to contribute to addressing problems of racism. Health outcomes can be attributed to a variety of social factors, and while it is not the role of the bioethicist to attempt to address every one, we should not be hesitant to lend our expertise where appropriate. The thematic thread tying the commentaries together is an attempt to clarify the circumstances under which extending the bioethicists' expertise would be appropriate versus where it might be more appropriate for the bioethicist to take a back seat. We have argued for a more expansive notion of the proper role that bioethicists can play in addressing race and racism, and we agree with many of our commentators that addressing these issues will not be the sole domain of the bioethicist. Rather, we must partner with other scholars, medical professionals, community members and other stakeholders in order to bring about change.

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