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Marion Danis, Yolonda Wilson & Amina White

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Target Article

Bioethicists Can and Should Contribute to Addressing Racism

Marion Danis, National Institutes of Health Clinical Center
Yolonda Wilson, Howard University
Amina White, National Institutes of Health Clinical Center

The problems of racism and racially motivated violence in predominantly African American communities in the United States are complex, multifactorial, and historically rooted. While these problems are also deeply morally troubling, bioethicists have not contributed substantially to addressing them. Concern for justice has been one of the core commitments of bioethics. For this and other reasons, bioethicists should contribute to addressing these problems. We consider how bioethicists can offer meaningful contributions to the public discourse, research, teaching, training, policy development, and academic scholarship in response to the alarming and persistent patterns of racism and implicit biases associated with it. To make any useful contribution, bioethicists will require preparation and should expect to play a significant role through collaborative action with others.

Keywords: bioethics, discrimination, health disparities, inequity, racism, racial violence

The recent deaths related to violent interactions with police in African American neighborhoods in Ferguson, MO, Baltimore, MD, North Charleston, SC, and other cities point to unresolved problems related to racial and social justice in American society. This violence and the circumstances surrounding it are morally troubling. Yet there has been little conversation or response in the bioethics community. Here we consider why those of us who are bioethicists should contribute to addressing the problem and ways in which we might do so.

DEFINING THE PROBLEM

The police violence that resulted in the deaths of Michael Brown in Ferguson, MO, Freddie Gray in Baltimore, MD, Walter Scott in North Charleston, SC, and others have complex origins and represent a very complicated and refractory set of problems. They reflect a stage in the evolution of civil rights in the United States that is far more nuanced than prior stages. While straightforward criticisms could easily be leveled previously at the institution of slavery, the lack of voting rights, and Jim Crow laws, the criticisms that can be leveled today require more nuanced ethical analysis and more systematic evidence now that such laws are no longer in place and an African American has been elected to the U.S. presidency. Despite *de jure* racial progress, the social meaning of race still holds both explanatory and justificatory power with regard to interracial interactions (Winter 2008). An example of how the social meaning of race functions can be seen in police interactions in heavily African American communities. As Glenn Loury points out in an analysis of the death of Freddie Gray, exchanges between police and residents in predominantly African American communities involve fraught interactions between disadvantaged, disconnected youth who sometimes behave violently and police who sometimes abuse their authority, thus complicating the assignment of responsibility and highlighting the false dichotomy between personal responsibility and structural inequality (Loury 2015; Young 2011). Yet a systematic review by the U.S. Department of Justice (DOJ) of police records in Ferguson and other municipal police departments has shown a very clear pattern of discriminatory policing (U.S. DOJ 2015). In Ferguson, for example, while 67% of the population is African American, African Americans accounted for 93% of arrests made during 2012–2014. In the DOJ review, the disproportionate number of arrests, tickets, and uses of force stemmed from "unlawful bias," rather than from African Americans committing more crime.

Discrimination in the criminal justice system is reinforced by several prevailing practices aside from the disproportionate number of arrests of African Americans and greater use of violent force by law enforcement officers.

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

Jury selection often excludes African Americans jurors (Liptak 2015) and law firms hire and retain disproportionately few African American lawyers (Djordjevich 2013). The impact of incarceration leads to extensive socioeconomic dislocation for African American families.

Beyond concerns about police violence and other discriminatory features of criminal justice in African American communities, vexing societal patterns of disadvantage persistently affect the majority of African Americans. The median income of African Americans remains below that of other racial and ethnic groups at $34,598 while the median income for the U.S. population as a whole is $51,939 (2013 statistics reported by the U.S. Census bureau) (DeNavas-Walt and Proctor 2014). The prevalence of poverty has been persistently higher for African Americans at 27%, compared to 14.5% for the U.S. population as a whole. African American children have been the only children who have a stagnant rate of poverty at 38.9%, compared to 10% for children in other groups (DeNavas-Walt and Proctor 2014). Housing remains highly segregated, as do primary education and secondary education. In some areas, there is more segregation than during the Jim Crow era (Orfield and Lee 2007). Rates of attainment of higher education and rates of unemployment show similar disparities. The health impact of these social inequalities is measurable, as the experience of discrimination is associated with stress and depression (Taylor and Turner 2002). African Americans have far higher rates of chronic disease and ultimately, shorter life expectancies—even after controlling for adverse health behaviors like diet, exercise, and smoking.

These patterns are not the result of chance. The history of housing in Baltimore is illustrative. In 1910, Baltimore became the first American city to require, by city council ordinance, that each residential block be segregated. During the Depression in the 1930s, the federal government bailed out more than a million homeowners but in so doing, prepared real estate risk maps for Baltimore and 238 other American cities. Most of the African-American and Jewish neighborhoods in Baltimore were "redlined," that is, deemed unsafe for development, a designation that led mortgage lenders to refuse to issue any loans on properties in these neighborhoods (PRI 2015). Thus, as Alexander notes, "Racially segregated ghettos were deliberated created by federal policy, not impersonal market forces or private housing choices" (Alexander 2012).

Racialized housing policy is an example of institutional racism. Institutional, that is, structural, racism involves creating "differential access to goods, services and opportunities of society by race" (Jones 2000). Much evidence points to such housing policies and other policies in the education, labor, transportation, and criminal justice sectors as examples of institutional racism that have contributed to economic underdevelopment, household poverty, and patterns of community violence that affect many low-income, predominantly African American communities (PRI 2015; Karner and Niemeier 2013; Williams and Collins 2001). The injustice of structural racism does not depend on the bad motives of a single actor. In fact, it is generally difficult to trace the consequences of institutional racism to a single act or actor (Jones 2000; Young 2011). The corollary to these policies is that the quality of predominantly white spaces becomes measured, in part, by the absence of African Americans. It is easy to ignore this aspect of institutional racism because it is often masked with ostensibly nonracialized language, such as the desire for "good" schools or "good" neighborhoods. It is this physical and social separation, derived from patterns of segregation and isolation, that further reinforces ideas not only of racial difference, but also of racial inferiority and superiority (DiAngelo 2011; Winter 2008).

In addition to the structural, or institutional, factors that perpetuate social disadvantage, evidence continues to emerge about the role of implicit biases that subconsciously shape the perceptions and reactions of many individuals, including law enforcement, when encountering black or brown bodies (Plant, Peruche, and Butz 2005; Correll et al. 2007). Implicit biases develop during childhood through early socialization. Even though one lacks conscious awareness of one's implicit biases, they shape and influence interactions with others (Stepanikova 2012). As a result of these often overlapping individual and institutional factors, a complex cycle of social disadvantage and community violence has emerged that has a devastating effect on youth, families, neighborhoods, and entire communities (Williams and Collins 2001; Burt, Simons and Gibbons 2012). When this is layered with evidence of "unlawful bias" and violent conflicts between law enforcement and citizens, it is clear that interrupting the cycle will require multiple points of intervention to mitigate root causes and effects of implicit bias, institutional racism, community violence, excessive use of force in law enforcement, and the long-term effects of violence-related trauma in African American communities.

Moreover, finding solutions to these problems has become even more complex as the overall picture of poverty in the United States has changed. While inner cities like Baltimore continue to have poor African American residents, poor communities are increasingly located outside central cities, spread across fragmented suburban jurisdictions (Pollack 2015). As Pollack suggests, governments in these jurisdictions are ill equipped to respond to the social service, policing, job training, and health needs of these poor suburban communities.

The distressing pattern of violent police encounters in African American neighborhoods in many cities and suburbs across the United States, and the fact that these are not isolated events but rather a reflection of a consistent pattern of problems with criminal justice and persistent social disadvantage for African Americans in the United States, has begun to catalyze policy responses. The shocking nature of video-recorded deaths of unarmed African Americans during routine police stops has galvanized a wave of public awareness. And it has triggered responses by federal agencies, state governments, and municipalities (Byers 2015; Lederman and Benac 2015; Mogul 2015; Nixon

2015). There are also organizations that have grown out of the historical movement for racial justice, such as the NAACP and the National Urban League, which have long-standing commitments to addressing racism, while newer organizations, such as the Movement for Black Lives, have picked up the torch.

Some might argue that these troubling events and the persistent problems they reflect are so far outside the bioethicist's familiar territory and ways to address them fall so squarely in the domain of others that bioethicists need not pay any attention or participate in addressing them. But there are grounds for arguing otherwise.

WHY BIOETHICISTS SHOULD CONTRIBUTE

Bioethics scholars readily train their attention on the ethical issues that arise in medical research and clinical practice. Clinical ethics consultants regularly respond to requests from clinicians, patients, and families regarding ethical dilemmas arising during illnesses and their medical management. Bioethicists have also addressed issues of social justice in medicine. In their remarkable book *Medicine and Social Justice*, Rosamond Rhodes, Margaret Battin, and Anita Silvers have brought together scholarship on injustices involved in the distribution of health care and the health policies that lead to unfair access to medical care (Rhodes, Battin, and Silvers 2002).

Yet there are several arguments for broadening the scope of the bioethicist's attention. As the violent events in Ferguson and elsewhere illustrate, some of the most morally troubling ethical dilemmas affecting the health and well-being of society's most vulnerable individuals lie outside the health care setting.

One argument for this broadened scope is the reality that certain life events can be profoundly detrimental to a patient's health and well-being. The social determinants of health are well recognized as contributing as much as or more than medical care to the health and well-being of patients. As scientific understanding of the social determinants of health increases, it becomes untenable for clinical ethicists to ignore or fail to appreciate these social factors (Daniels 2008; Bassett 2015). In paying attention to the social determinants of health, the adverse consequences of discrimination cannot be ignored (Priest et al. 2013).

A second argument pertains to the fact that leaders in medicine and public health are already considering how they should change practices, and bioethicists should be in step with them. As awareness of persistent institutional racism has come to the fore following the many instances of police violence, a number of publications in the medical literature have focused on recommending changes. Primary care providers have argued for modifying the delivery of medical care to the population of young African American patients—those who live in the most affected communities and are hard to reach—by expanding services to accommodate them (Martin et al. 2015). The need to recognize and change the implicit biases that prevail during medical education has been pointed out with a call to teach differently (Brooks 2015). The need for medical and public health experts to acknowledge and address the impact of racism has been articulated by Dr. Mary Bassett, the Director of the New York City Health Department (Bassett 2015). Likewise, it behooves bioethicists to take stock of how to proceed differently.

Third, aside from keeping pace with medical science, clinical practice, and teaching methods, perhaps the most compelling justification for paying attention and contributing to ameliorating the devastating effects of the events in African American communities is inherent in the discipline of bioethics itself. Concern for justice has been one of the core commitments of bioethics. This commitment is manifest in an obligation to promote health equity—to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives. Differences in health that are avoidable, unfair, and unjust represent inequitable health. As such, the discipline of bioethics has at its core mission a mandate to pay attention to and help address social injustices affecting African Americans. It is not sufficient to merely observe and record statistical disparities. Rather, we must understand how these disparities arise and are maintained (Garcia 2007). This mission is incorporated into the Code of Healthcare Ethics Consultants (HCEC) as one of the responsibilities of healthcare ethics consultants: "Promote just health care within HCEC. HCE consultants should work with other healthcare professionals to reduce disparities, discrimination, and inequities when providing consultations" (ASBH 2015).

Perhaps the extent and the basis of the call for bioethicists to participate in efforts to address racism may differ inside and outside the health care setting. Insofar as the explicit general goal of HCEC is to improve the quality of health care, it behooves consultants to do everything possible to eliminate discriminatory attitudes, behaviors, and practices within the health care setting. When the racism happens in places outside the health care setting, the bioethicist's role may be less direct but not less important or compelling.

WHAT BIOETHICS AND HUMANITIES SCHOLARS CAN CONTRIBUTE

Bioethics scholars and ethics consultants have an array of functions through which they might contribute to addressing racism and racially motivated violence, which we refer to as racial violence (Table 1).

Scholarship and philosophical analysis. Bioethics as a discipline is devoted to advancing analysis of ethical issues in biomedical research, medical practice, and public health. Bioethicists have focused heavily on philosophical implications of biological and medical procedures, technologies and treatments, particularly organ transplantation, novel methods of enhancement, genetic engineering, and use of life-sustaining technologies. But their analytical

Table 1. How bioethics scholars and ethics consultants can contribute to addressing racism and racial violence.

Scholarship: philosophical analysis:	Broaden the focus of ethical analysis, paying more attention to the social determinants of health, and to the effects of racism on health and well-being.
Ethics consultation	Take a community-oriented perspective in performing ethics consultations. Apply skills in conflict resolution, mediation. Address communication breakdown and mistrust. Clarify obligations of authority figures toward populations they serve. Cultivate awareness of and sensitivity to the harmful effects of past traumatic experiences on both victims and perpetrators.
Teaching	Teach about the prevalence and moral significance of discrimination, racism and racial violence. Emphasize empathy gap literature. Teach at various levels of education.Teach mediation techniques in classrooms. Broaden the cannon of taught material, including African American scholars.
Policy	Help institutions develop organizational policies that promote patients' and citizens' rights, including those involving housing, education, criminal justice, and other social determinants of health.
Research	Study approaches to less biased decision making.
Outreach	Collaborate with others disciplines to address the problem. Work with health care professionals to reduce disparities, discrimination, and inequities in health care delivery. Facilitate public engagement in deliberation about how to reduce and eliminate discrimination.
Training	Include more minority scholars in bioethics training programs. Incorporate formal training in mediation into bioethics training programs.

tools lend themselves to studying moral issues across a broader landscape. While the field of bioethics often puts a heavy emphasis on analyzing technological advances, it can just as well focus on social factors. As social scientists have increasingly appreciated the broader determinants of health, bioethicists have offered ethical analyses of the social arrangements required for health (Daniels 2008). These analytical approaches lend themselves well to examining the injustice done by racial violence and institutional racism.

While we have not referred to medical humanities scholars, they too have a role to play. Their work in narrative inquiry and the arts certainly have a place in reflecting the experiences and worldview of African Americans and the struggle to overcome racism.

Ethics consultation. Bioethicists who serve as ethics consultants may be particularly well suited to engage these issues of injustice since we have many required competencies that may lend themselves to addressing institutional racism and racial violence (ASBH 2011). The health care ethics consultant skill set, including conflict resolution, mediation, negotiation, and facilitation of public engagement, might quite aptly apply. As consultants, we use these skills to help reestablish trust between patients and health care providers, between members of a clinical team, and between other parties that have become divided by miscommunication and mistrust. Such divisions can be especially pronounced when an inherent power imbalance exists between parties, whether between privileged clinicians and more vulnerable, underprivileged patients or between armed police officers and unarmed citizens in the community. It behooves those of us who provide ethics consultation to pay special attention to conflicts involving power imbalances, communication breakdowns, and mistrust in the setting of certain institutional practices or behaviors that may be perceived or experienced as discriminatory. Recent data suggesting that even in the absence of overt bias, unconscious racial biases among physicians can be associated with a negative emotional tone, more clinician dominance in medical encounters, less patient-centered care compared to other patients, and subsequent distrust among African American patients (Cooper et al. 2012). Racist attitudes may come from many corners, for example, patients and families with racist sentiments who refuse care provided by African American and other minority providers (Reynolds et al. 2015). In light of this, it is especially important in ethics consultations involving conflicts that the consultant be prepared to elicit the perspective of all parties and be prepared to mediate in ways that are respectful and equitable among the parties involved.

Even beyond the scope of official consultation requests, ethics consultants may have opportunities to act both reactively and proactively to institutional practices that may tend to marginalize individuals from minority racial and ethnic groups either seeking or providing care within those institutions. When we witness hospital town hall meetings or gatherings of experts to address staff concerns, which many health care institutions have encouraged in the wake of the violent incidents in Ferguson, ethics consultants have a role to play in ensuring that the voices of patients and hospital staff who have been affected by violence and who wish to speak are heard (Bassett 2015). If it becomes apparent that certain racial or ethnic groups have been inadvertently excluded from institution-wide initiatives or forums, ethics consultants can help to facilitate a prompt response that acknowledges the oversight, offers an apology, and welcomes those individuals to participate as valued members of the institution. The ability to promote patient rights, the ability to help with development and promotion of organizational ethics, and the ability to teach health care trainees and practitioners about ethical issues are seen to be important skills that ethics consultants already exercise and may have useful applications in combatting subtle racial biases at the institutions in which we work

Teaching. In our educational activities, it would be valuable to explore how many bioethicists teach courses in medical, nursing, and allied health programs, four-year colleges and universities, community colleges, and increasingly at the high school level. Bioethicists might include in their course content material about the effects of racism and violence, and engage their students in dialogue about how to overcome them. Bioethicists might borrow from many of the teaching materials available for fostering understanding of racial equity. Some of these issues are explored in *African American Bioethics: Culture, Race and Identity*, a volume edited by Prograis and Pellegrino, and the now classic *Mama Might Be Better Off Dead*, a work by Laurie Kay Abraham that follows for three years four generations of a Chicago family. Both books highlight the complexity of social, cultural, and institutional processes that contribute to health disparities and shape how patients and their families view themselves and their health status. Another helpful text is Karla Holloway's *Private Bodies, Public Texts: Race, Gender, and a Cultural Bioethics*, a call for cultural sensitivity with the explicit understanding that bioethics does not and should not occur in a vacuum. However, even when we incorporate this important scholarship into our teaching, it is important to remember that the inclusion of these texts is not alone sufficient to render us experts. Additionally, we must remember that African American communities are not monolithic. There is a diversity of experiences that will shape how any individual patient presents to us. Many online teaching resources might also be useful, such as Racial Equity Tools (Racial Equity Tools 2015).

Teachers of medical ethics are particularly in a good position to help in teaching cultural competency. All too often, teaching about cultural competency simply reinforces stereotypes. Bioethics teachers are well suited to helping students appreciate that individuals each have a unique history, view of the world, and life plan that is not merely a function of their race or culture. This more complex understanding of the relationship of an individual to her or his culture is particularly important to teach to students in the health professions who will be in a position to pursue shared decision making with their patients (Towle and Godolphin 1999).

Policy. In our role in helping with policy analysis and development in the institutions where we work, bioethicists might contribute to addressing implicit bias among employees. Health systems employ many African Americans who personally experience racism in the health care facility itself and communities in which they live. Ethicists might contribute to making sure these employees have a voice at the table as solutions are developed. Ethicists might work with leadership in our health care organizations to be more responsive to the populations we serve. We might help in finding ways to engage with the local community. As health care organizations struggle with competing concerns regarding financial viability and the obligation to serve patients who are underinsured, bioethicists might help to identify policies that balance these concerns. For example, bioethicists might point out the inadvertent racial segregation that follows from separating patients by payer status onto more and less luxurious hospital floors.

Bioethicists who study the ethics of health policy or the ethics of public health might focus their attention on the impact of racism and institutional violence on health. And those who focus on health policy might arguably broaden their lens to look at the ethics of public policy in general, as we recognize that discrimination is manifest across all policy sectors. Bioethicists who may already address the social determinants of health should concentrate as well on the detrimental interactive effects of poverty and race. A particularly stark instance of this problematic interactive effect is the reality that African American and Latinos gain far less wealth after earning a higher education degree than their white counterparts (Boshara et al. 2015). Addressing this disparity will require policy changes that reduce educational debt of minority students, broaden the type of assets minority families invest in beyond home ownership, and help poor families to rely less on their newly educated adult children for financial support (Boshara 2015).

Those bioethicists who are trained in law might pay attention to addressing the many ways in which the legal system contributes to discrimination. Aside from prison reform and changes in sentencing policy, they might explore how to expand the pool of African Americans who

practice law and the need to improve jury selection (Liptak 2015).

Empirical research. As we bioethicists increasingly engage in empirical research, our investigative skills might be effectively applied to exploring solutions to reducing discrimination and health disparities among disadvantaged populations. Efforts involving primary data collection, observational studies, interventional studies, and secondary data analyses that are aimed at understanding and reducing discrimination might justifiably fall within the bioethicist's research portfolio or might be the focus of a bioethicist's research collaborations. Collaborations may be found in unexpected places. Consider, for example, the possibility that the work of computer scientists, such as Cynthia Dwork, who explore how computer search algorithms can help to mitigate or exacerbate bias might be brought to bear on improving job opportunities for disadvantaged young adults (Miller 2015). Some existing bioethics programs such as the Center for Urban Bioethics at the New York Academy of Medicine already exemplify efforts to address urban disadvantaged populations (New York Academy of Medicine 2004).

Outreach. As we have already noted, many of the efforts to address racism and racial violence will necessarily need to be carried out by many others across policy sectors and settings beyond the usual home of the bioethicist—in municipal governments, police departments, prisons, schools, and other community institutions. But we bioethicists can complement many of these efforts by bringing our skills to the task, since many of our skills in ethics consultation, conflict resolution, negotiation, and community engagement, when honed properly, might make a valuable contribution.

Bioethicists might partner with communities directly, as exemplified by Temple University's Center for Bioethics, Urban Health, and Policy, which partners with community members, health care providers, and policymakers to create programs and practices aimed at eliminating health care disparities in the urban setting (http://www.temple.edu/centers/cbuhp).

From the organizational standpoint, to date, ethics consultation services have been largely based in in-patient programs. We could make our services more widely available in the outpatient setting, in clinics where ambulatory care providers care for many African American patients. When available in such settings, bioethics consultants might more readily help to engage in community dialogue about the experience of violence. The very process of sharing the experience of violence or trauma may serve to provide some relief from the fact that surviving family members, friends, and neighbors are not alone. Building a support network of peers with similar life experiences can thereby help to build community resilience in the wake of violence (Walsh 2007). While some peer networks already exist, bioethicists can work with communities to establish them in places where they do not. Moreover, consider the role bioethics and humanities scholars might play in fostering dialogue in educational institutions. Consider as well how ethics consultants might help in mediation training or in actual mediation among police and residents in communities where there have been high levels of police violence.

Bioethicists can begin and have begun to write about racism. Derek Ayeh, a student in the Columbia University Master's of Science in Bioethics program, has written an illuminating article for Columbia University's online journal, *Voices in Bioethics* (Ayeh 2015).

Training. The discipline of bioethics needs more diverse representation. Far too few bioethicists come from African American or other minority communities and few practice in African American and other minority communities. And far too few of these bioethicists hold leadership positions in organizations like the American Society for Bioethics and Humanities. Diversification will help the field of bioethics be more attentive to African American and other minority concerns. It will allow us to bring the vantage point of African Americans and other minorities to bear on the array of functions we have outlined here. Taking diversity within bioethics seriously will require thinking beyond merely changing the demographics of the profession. In her important 2003 article, Catherine Myser notes that one effect of what she calls the "normativity of whiteness" within bioethics is the potential to marginalize those scholars (disproportionately bioethicists of color) who address these issues (Myser 2003). It is the responsibility of the profession as a whole to think about how the perspectives of diverse scholars can and would shape the field. The perspectives of diverse scholars should not merely be perceived in contrast to dominant views without questioning the normative weight that dominant views have held (Myser 2003).

PREPARING TO CONTRIBUTE

Addressing racism and its effects will require some preparation. Bioethicists should be conversant with a range of readings on social justice. We should be familiar with the philosophical works of African American scholars who have written about the foundations of Black solidarity, for example (Shelby 2005). These writings, which offer a variety of views about the ways that African Americans should assert themselves and achieve the full range of opportunities, ought to be more readily part of the canon of literature that bioethicists read and teach to their students.

Additionally, to be prepared, bioethicists might be more familiar with the existing empirical evidence regarding poverty, racism, and racial violence. The physical and psychological effects of racial discrimination on those who experience it are profound: stress, anxiety, depression, hypertension—responses that are mediated through increasingly well understood neurobiological mechanisms

(Berger 2015; Priest 2013). Being prepared will require understanding the long-standing effects of racism on disconnected youth who are the victims of so much of the police violence that has recently taken place. Living in communities where opportunities have been few, options for employment are low, and treatment by authorities has been disrespectful has created a culture where violence has become much the norm (Patterson 2015). Perhaps bioethicists can contribute to conversations that engage those youth whose lives are affected and who are seeking alternatives (Shelby 2015).

If not already familiar with the evidence, bioethicists will need to be more knowledgeable about unconscious racial biases and behaviors that are prevalent both within and outside the health care setting. In health care settings, these biases are unwittingly perpetuated through medical education (Brooks 2015). Implicit bias affects the manner in which clinicians make decisions for patients, but strategies to reduce such bias do exist (Dankwa-Mullan 2015). Beyond the health care sector, policies and regulations have perpetuated the effects of racism in policy sectors, particularly criminal justice, but also in education, housing, and transportation (PRI 2015).

Aside from becoming familiar with this evidence, being prepared to take on the task at hand may require a shift in thinking about the role of bioethicists and clinical ethics consultants. Often the focus of bioethics scholarship and consultation involves the examination of a complex ethical quandary where the right outcome seems unclear. The bioethics scholar is skilled at analyzing the range of morally acceptable options in a given situation. But what role could a bioethicist play where the moral analysis seems clear? Discrimination, racism, and racially based violence, in the view of morally reasonable persons, are clearly wrong. Little argument can be generated in support of these behaviors, and the right outcome is the reduction and elimination of them. If bioethicists are to be more involved, this requires recognizing that we may have a role beyond mere analysis. We would suggest that bioethicists have a role in considering the course of action to take in eliminating these behaviors. Here is another point of departure from the usual. Bioethics scholars and consultants tend to pursue a discussion about the possible courses of action based on reasoned argument. But the behavior involved in discrimination, racism, and racially based violence is not rational. If bioethicists are to play a role, it will require being more involved with understanding and changing implicit biases and unconsciously driven behaviors. This is a task that is as morally important as offering rational argument.

This is a shift that seems appropriate for bioethicists to undergo. Consider how much scholarship among bioethicists currently focuses on neuroethics and on philosophical implications of the science of cognition and decision making. There is increasing appreciation of the extent to which emotions precede rational argument. Bioethicists might contribute to exploring how this understanding might be brought to bear in helping overcome bias, discriminatory behavior, and racially based violence.

While we assert that bioethicists can help to eliminate racism and mitigate its effects, we leave as an open question whether and to what extent bioethicists should play an advocacy or activist role in addressing these issues. Bioethicists have traditionally leaned toward roles that involve analyzing a problem, exploring solutions, and serving as neutral mediators rather than advocates who take sides with particular stakeholders. Yet when power imbalance leads to unfair treatment, there may be compelling reasons for taking more assertive roles as activists who push for institutional change and challenge the balance or exercise of power. Both neutral and advocacy roles can be valuable, but under some circumstances the former or the latter types of roles may be more appropriate.

A RECOGNITION OF LIMITATIONS

While we have argued that bioethicists ought to participate in addressing the pattern of racism that persists in the United States and have explored a wide range of possible ways in which we might do so, we should exercise humility in what we bring to the table. While bioethicists have many skills that might be useful, we have little experience. If bioethicists become involved it will require preparation and the realization that good intentions are not enough. We also have to recognize that dismantling institutional racism and overcoming bias have comprised a frustratingly intractable problem that will require multidisciplinary engagement and persistent attention.

CONCLUSION

Ultimately, the problems of racism and racially motivated violence in African American communities are complex, multifactorial, and historically rooted. They are also deeply morally problematic. In this article, we have presented a number of reasons for considering why and how bioethicists can offer meaningful contributions through research, teaching, training, policy development, and academic scholarship and thus add to the public discourse and emerging response to alarming patterns of racial violence and implicit biases associated with it. Those of us who work in the field of bioethics are likely to encounter some element of implicit or explicit racial bias in the course of ethics consultation in ourselves, in our institutions, in academic circles, or elsewhere. We have a responsibility to confront these issues when they arise, and our bioethics skill set would enable us to do so in many cases. We also have an opportunity to pursue independent scholarship and to collaborate proactively with experts in other disciplines who have already been engaged in studying and pursuing solutions to these complex problems. We hope that our willingness to engage in efforts to address racism and racial violence can contribute meaningfully to the very difficult task of reducing these inequities in American society.

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CONFLICT OF INTEREST

The authors have no conflicts of interest to report.

DISCLAIMER

This work is a reflection of the views of the authors and does not necessarily reflect the policies of the National Institutes of Health or the U.S. Department of Health and Human Services. ■

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