



Bioethics, Race, and Contempt

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Abstract The U.S. healthcare system has a long history of displaying racist contempt toward Black people. From medical schools' use of enslaved bodies as cadavers to the widespread hospital practice of reporting suspected drug users who seek medical help to the police, the institutional practices and policies that have shaped U.S. healthcare systems as we know them cannot be minimized as coincidence. Rather, the very foundations of medical discovery, diagnosis, and treatment are built on racist contempt for Black people and have become self-perpetuating. Yet, I argue that bioethics and bioethicists have a role in combatting racism. However, in order to do so, bioethicists have to understand the workings of contemptuous racism and how that particular form of racism manifests in U.S. healthcare institutions. Insofar as justice is part of the core mission of bioethics, then antiracism must also be part of the mission of bioethics.

Keywords Racism · Contempt · Institutional racism · Personhood

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Barbara Dawson was having difficulty breathing and sought help at Calhoun Liberty Hospital in Blountstown, Florida (near Tallahassee, Florida). After an examination, the emergency department physicians treated her and, once they determined she was stable, discharged her. However, Ms. Dawson refused to leave. She was still experiencing breathing difficulty and pled to be examined further. But,

... [h]ospital staff responded by calling the police, who promptly arrested her for trespassing and disorderly conduct. Even after she collapsed outside of the arresting officer's patrol vehicle, the officer assumed she was faking and can be heard on the dashcam video telling an unresponsive Dawson, “Falling down like this, laying down, that's not going to stop you from going to jail.” Within hours, Ms. Dawson was dead from a pulmonary embolism, a blood clot in her lungs. (Wilson 2019b, ¶5).

What happened to Barbara Dawson is but one example of how medical racism and the carceral state converge and end Black lives. I want to be clear that in citing Ms. Dawson's case, I am not making any claim about the “hearts and minds” of individual actors at Calhoun Liberty Hospital. Nor am I making any claim about the specific policies of that particular hospital. Rather, this case is worth discussing precisely because, although appalling, it is not unique. Black patients

experience less attention to symptoms, sometimes to deadly effect (Tait and Chibnall 2014). Indeed, U.S. healthcare has a long history of displaying racist contempt toward Black people. From medical schools' use of enslaved bodies as cadavers with the blessing of local and state governments (but without the consent of Black people whose loved ones were used) (Wilson 2018), to the infamous Tuskegee Syphilis Experiment funded by the U.S. Public Health Service, to the widespread hospital practice of reporting suspected drug users who seek medical help (even during labour and delivery) to the police (Roberts 2014), the institutional practices and policies that have shaped U.S. healthcare systems¹ as we know them cannot be minimized as unfortunate coincidence. Rather, the very foundations of medical discovery, diagnosis, and treatment are built on racist contempt for Black people and have become self-perpetuating.

Yet, I do not believe that change is an impossibility, and I think that bioethicists should have a role in making this happen. We have argued elsewhere that by broadening the scope of the bioethicist's research and clinical attention that bioethicists can effectively address this issue (Wilson et al., 2016). In that paper, my colleagues and I offered three arguments why bioethicists specifically need to address racism:

1. Taking seriously the social determinants of health means that bioethicists cannot ignore the reality of the role that racism plays in health status and health outcomes (Wilson et al., 2016). The stress of living with racism has been linked to hypertension and cardiovascular disease. Additionally, Black people are more likely to live near power plants and landfills, in older buildings with peeling lead-based paint, and in food deserts far away from grocery stores—all of which contribute to conditions like asthma and obesity. Furthermore, the current global pandemic brought about by COVID-19 highlights

the high-risk, low-status work that Black and Latinx people disproportionately do—such as grocery store clerks, food processing plants, and custodial work—that make social distancing and self-isolation nearly impossible, thereby increasing risk of exposure and also increasing the risk of serious illness or death as a result of contracting COVID-19.

2. Academic medicine and public health have begun to think about how practices are informed by implicit bias, and bioethicists should be in step with others in the health sciences (Wilson et al., 2016). There is much to criticize about implicit bias—including how useful it is to study implicit bias in the absence of any significant institutional change, whether focus on implicit bias masks what is actually explicit bias, and whether the sudden interest in implicit bias is mere window dressing. That is, there is concern about whether implicit bias merely makes [white] people feel good about “addressing racism” without actually doing much substantive work. However, to the extent that bioethics has not as a field taken even these minimal steps places bioethics behind the curve.
3. One of the core commitments of bioethics is concern for justice, and this must include concern for racial justice (Danis, Wilson, and White, 5). So, bioethicists have an obligation to work to be actively antiracist, particularly as racism leads to healthcare disparities.

But beyond the general charge to bioethicists, what does this look like, and does it make a difference that I frame a particular manifestation of racism within U.S. healthcare systems as contemptuous? While some who read our paper objected that what we proposed overstepped the appropriate domain of bioethics, we contended then, and I reiterate now, that bioethics does not exist in a vacuum (Wilson et al., 2016). To the extent that at least some varieties of racism reflect contempt (Bell 2018) and that institutions can exhibit contempt (Hoskins 2013), I argue that institutions can harbour specifically racist contempt. In addition to attempting to change institutions themselves, one challenge for the bioethicist will involve navigating the appropriate response to racist contempt, especially in clinical settings.

¹ By “U.S. healthcare systems,” I am thinking broadly about the complex network of healthcare delivery institutions, educational institutions, private businesses, and public policies that comprise healthcare in the U.S. Of course, the details are going to vary between specific types of institutions and other factors. However, the ways in which healthcare happens (or doesn't happen) in the U.S. reflects broader systemic racism. Thanks to the anonymous reviewer who encouraged me to clarify this point.

In order to do that, I first explore features of contempt before turning specifically to racist contempt. My focus on racism as contempt, especially with regard to institutions, is not an attempt to suggest that contemptuous racism is the only account of racism (Levy 2017). Paternalism, for example, could underlie racism. That is, the target(s) of racism could be perceived as incapable of managing their own lives and in need of special help. Nor am I suggesting that contemptuous racism is morally worse than other accounts of racism. Moreover, I acknowledge that multiple rationales can operate simultaneously or that some rationale may be more salient depending on the specific circumstance. To be sure, contempt can go hand in hand with paternalism, for example, and it may not always be possible to tease out which is operating.

I am interested in racist contempt because I think its explanatory power is especially relevant in the context of healthcare generally and of bioethics specifically. If bioethicists are serious about addressing racism, then it is important to understand how and why racism operates in order to respond competently. Furthermore, contemptuous racism is important because healthcare settings are supposed to be sites of healing, and contempt specifically expresses a disdain for the contemned patient that cannot be overcome. On my view, racist contempt does not necessarily involve a “withdrawing from” the contemned but may instead (or in addition) involve paying “too much” attention to Black people. Although I think specifically about U.S. healthcare systems as institutions, I do not think one can draw a firm line between interpersonal contempt and institutional contempt, as individuals comprise institutions. This may seem at first blush to be a fairly trivial point, but I hope to make that clearer later in the text. Finally, I consider appropriate responses to racist contempt and how the bioethicist can respond in such a way that upends the contemptuous racism of U.S. healthcare.

Features and Varieties of Contempt

Macalester Bell argues that there are four central features of contempt: (1) “negative appraisal of the status of the object of contempt” (Bell 2018, 4); (2) “globalist emotion,” i.e., “not only is the proper object of the contempt the person as opposed to her action, but contempt takes the whole person as its object” (Bell 2018, 4); (3) “comparative or reflexive,” i.e., a comparison

between oneself and the contemned that “takes the contemned to be inferior,” (Bell 2018, 5), and (4) “psychological withdrawal or disengagement for the target of contempt” (Bell 2018, 5). For my purposes, the notion of contempt as a globalist emotion is especially salient. That the feeling contempt encompasses “the whole person” as its target, rather than any particular act that the person has committed or attribute(s) of the person means that it will be difficult if not impossible to revise one’s view of the contemned. To borrow from Hoskins, contempt “permeates” interactions with the contemned (Hoskins 2013, 3). That is, any interaction with the contemned will confirm the already disfavoured view that one holds of the contemned. So, even an interaction that with someone other than the contemned might be viewed positively or at least neutrally, such an interaction with the contemned will also be viewed through the lens of the negative assessment that one holds of the contemned.

Although for Bell (and others), one must withdraw from the contemned, David Sussman rejects (4) as a necessary feature. On Sussman’s view, the contemned might be the target of disengagement but need not be. Instead, Sussman claims that the contemned can also be treated as a subject of mockery. Far from withdrawing from the contemned, to treat the contemned as a target of mockery requires engagement through treating the contemned as “something ridiculous or impotent” (Sussman 2018, 161).

While I find Bell’s first three features of contempt compelling, like Sussman, I do not find (4) to be a necessary feature of contempt. While Sussman understands mocking derision as an instance of contempt that rejects (4), I think that contempt can also manifest as paying “too much” attention to the contemned, which would also be a rejection of (4). I will develop this idea later in the paper, but for now I will say that to the extent that contempt is an expressive emotion (one has to *do* something in order to show contempt), some instances of expressing contempt require attention to the target, and that attention must be focused and sustained in order to properly express to the target that the contemnor finds the target contemptuous.

Institutions can also be sites of contempt. Zachary Hoskins has argued for an account of contemptuous institutions by focusing on the institution of punishment (Hoskins 2013, 2). He argues that the institution of punishment, through its use of supermaximum security (“supermax”) prisons, treats those who have been

convicted of crimes contemptuously. With isolation twenty-three out of twenty-four hours a day, minimal exercise, and minimal sunlight, supermax prisons send the message to those who have been convicted of crimes and sentenced to supermax facilities that they, not the crimes of which they have been convicted, are beyond redemption. Whereas by their very nature, punishment via supermax prisons express contempt for prisoners, healthcare systems do not, as a fundamental feature, express contempt for patients. Indeed, their *raison d'être*, is to improve the lives of patients. That contempt creeps into healthcare institutions, signalling to some patients that they are “beyond redemption,” makes the contempt all the more pernicious.

Racism as Contempt

Racist contempt depends on belief in racial superiority, white supremacy. White supremacy is the organizing principle that whiteness has an inherent value over and above others and that others are disvalued—perhaps even to the point of having no value. The racist desires that whiteness be recognized and esteemed at all costs, and they work to preserve the high status afforded whiteness. For the white supremacist, races exist as a hierarchy with whiteness at the top and blackness at the bottom.

The contemptuous racist, then, negatively appraises those who are not white. They regard those who are not white as inferior, and this sense of negative appraisal and inferiority holds for anyone who is not white. Interestingly, the contemptuous racist need not himself be white. One could conceivably be Black and also hold whiteness in high regard while negatively appraising other Black people. This phenomenon is sometimes referred to as internalized racism. Bell writes of the contemptuous racist,

Race-based contempt is focused not just on the supposed *actions* of members of racial groups but on *persons* themselves. If you are seen as low in virtue of your race, attempting to win esteem by outperforming others is unlikely to be successful; under these conditions, your successes are not likely to redound to your favor. Instead, you will likely be interpreted as the beneficiary of good luck or some other external factor (Bell 2013, 205)

In other words, the contemptuous racist hates members of disfavoured racial groups, not for what they do, but for who they are. This is not to say that the contemptuous racist would never give behaviour-related *reasons* for their hatred of non-whites. However, those reasons would not likely hold up to close scrutiny. Indeed, one of the features of contempt in general is the unwillingness to re-evaluate the contemned in the face of contrary evidence.

Given what I have said about the contemptuous racist, then, it seems that the view Bell and Hoskins hold about contempt in general, that the contemnor would want to withdraw from the contemned fits the contemptuous racist perfectly. Certainly, the sense that disvalued races are not worth engagement or the sense of non-whites' status as “fundamentally subpar” (Hoskins 2013, 4-5) is consistent with the desire to withdraw from the members of racial group that the contemptuous racist deems inferior. I think this will certainly be true in some cases, perhaps even many cases. However, I think Sussman is correct to contend that contempt can also manifest as derision. Although Sussman does not say much about the contemptuous racist, one does not require a particularly vivid imagination to construct examples of mocking race-based contempt. Some forms of racist jokes, including minstrel performances and the caricature of Serena Williams that dominated the Australian press (Davidson 2018)², are certainly expressions of mocking contempt for those who are not white.

In addition to agreeing with Sussman that mocking/derision also can be a form of contempt, I argue that contempt can also take the form of “too much attention.” As I have stated, I agree with Bell and Hoskins that contempt can take the form of withdrawing. In fact, an interesting feature of the institutional account of contempt that Hoskins argues for with regard to supermax prison facilities is the prisoner's report that the cold impersonal nature of the treatment, “like dealing with automatons,” is part of what makes the experience “like not living” (Hoskins 2013, 2). In my own work, I've highlighted the lack of touch that Black patients receive from healthcare personnel at the end of life as a manifestation of medical racism (Wilson 2019a). Although I did not use the language of contempt, the sense of Black patients not being worthy of the dignity of touch and

² I am indebted to Christopher Mayes for this insight.

other human comfort care at the end of life could certainly count as contemptuous.

However, there are other instances that I would identify as racist contempt that are neither mocking derision nor withdrawal. Far from regarding Black people (especially) as “beneath notice or engagement,” the contemptuous racist is, at times, deeply preoccupied with noticing and engaging with Black people. And it is the fact and/or the intensity of the engagement that serves to send the clear message that Black people are contemned. Charles Mills uses the term “subpersonhood” to describe the status of non-white people in relation to those who are white under a system of white supremacy; similarly, Imani Perry uses the term “nonpersonhood” to describe this status. Each term reflects the fact that non-whites sit outside the moral community in important ways. I consider two examples of how contemptuous racism manifests as “too much attention”—slave patrols and what Koritha Mitchell terms “know-your-place aggression.” But it is first important to understand how whiteness factors into “paying too much attention” to non-whites for the contemptuous racist.

Building on the idea of “subpersonhood” or “nonpersonhood” white racial identity is constitutive (Harris 1993, 1734). That is, a necessary feature of fully being a “person” is whiteness. So, the value in whiteness lies in its presumption of personhood—just as nonwhiteness carries with it the stigma of sub- or non-personhood. As legal scholar Cheryl Harris points out, whiteness itself is historically a legal status. U.S. jurisprudence is rife with cases of people suing to become *legally* regarded as white and the courts attempting to determine both how to make individual judgments and how to develop a theory of race and racial classification. The legal doctrine emerging from one class of these kinds of lawsuits is that “to call a white person Black is to defame” them (although the converse is not true) (Harris 1993, 1735–1736). Because of the privileges afforded to those who have been legally determined to be white, those who would be white also have a vested interest in whiteness (Harris 1993, 1725). This would be the case regardless of whether one’s grasp on whiteness is firm or tenuous.

Still, the more tenuous the grasp on whiteness, the greater one’s investment might be in preserving whiteness via white supremacy. According to Harris,

Whiteness retains its value as a “consolation prize”: it does not mean that all whites will win, but simply they will not lose, if losing is defined as being on the bottom of the social and economic hierarchy—the position to which Blacks have been consigned. (Harris 1993, 1759)

Imani Perry states the matter thusly,

Lower status possessors of personhood [as whiteness] were enlisted to maintain the boundary between personhood and nonpersonhood, both structurally and ideologically, even as their own personhood felt fragile. The boundary formed was always porous, giving those on the margins of personhood even more reason to jealously police it, for fear of slipping under the bar altogether. (Perry 2018, 52)

I turn to my first example, slave patrols, in order to show how the inextricable connection between whiteness and personhood can lead to the contemptuous racist paying too much attention to Black people. During the period of U.S. slavery, municipalities often employed slave patrollers to maintain order on plantations. These patrollers were generally poor white men, men whose class status rendered their own grip on whiteness a bit slippery. However, these poor white men were vested with the authority to “stop, torture, whip, and even murder” any enslaved person who was thought to be in violation of the law (Perry 2018, 51). Perry quotes Sally Hadden’s description of the authority granted to patrollers. Slave patrollers

had full power and authority to enter any plantation and break open Negro houses or other places when slaves were suspected of keeping arms; to punish runaways or slaves found outside their plantations without a pass; to whip any slave who should affront or abuse them in the execution of their duties ... (Perry 2018, 51)

Hence, the practice of white people intervening and interfering in the lives of Black people was codified in the law, a practice that survives by convention if not by statute. Thus, slave patrollers could have been motivated by simple hatred, or perhaps they were merely doing their jobs. However, if I am right about the nature of racist contempt, the slave patrollers’ actions would certainly fit. The slave patrollers used their power relative to enslaved

Black people in order to assert the supremacy of whiteness.

One might suggest that contemptuous withdrawal does not require complete physical withdrawal from the contemned. There may be instrumental reasons to engage the contemned, such as when a prison guard serves food to a prisoner (Hoskins 2013). Perhaps the slave patroller is merely engaging in that sort of instrumental behaviour toward those who are enslaved. While I do not deny the possibility that some interaction between slave patrollers and the enslaved may have been of that variety, it is also the case that slave patrolling itself carried with it the validation of whiteness. The right to patrol slaves was the consolation prize, the hold on the bar of whiteness under which the patroller could assure himself that he would not slip. The authority to stop, torture, or whip any enslaved person who was suspected of violating the law not only upheld white supremacy but also provided an opportunity for the patroller to assert their contempt for Black people.

The authority to search homes, to stop people on the street, to ask intrusive questions, and to punish perceived failures of racial deference all require that the contemptuous racist pay significant and sustained attention to Black people. Yet, the intrusion is part of the insult. Just as a snub, like refusing to shake hands with one who is held in contempt would be part of the insult of a contemnor who withdraws, the contemptuous racist who intrudes into the lives of their targets sends the clear message, “I can disregard boundaries afforded other persons because you are not worthy of my moral consideration.”

My second case of how the contemptuous racist can show “too much attention” to the contemned is what Koritha Mitchell calls “know-your-place aggression.” Know-your-place aggression is “the flexible, dynamic array of forces that answer the achievements of marginalized groups such that their success brings aggression as often as praise” (Mitchell 2018, 253). While the contemptuous racist would never find cause to praise anyone non-white given the global nature of contempt, punishing the success of members of disfavoured racial groups fits the conception of racist contempt that I have sketched. While referring to her book, *Living With Lynching*, Mitchell writes,

One of the study’s major lessons is that the mob’s African American victims were most often targeted, not because they were criminals, but

because they were accomplished in some way. For example, they had managed to buy land that a white person wanted to take. Lynching African Americans of achievement sent a terrorizing message to survivors in their families and the larger community: *know your place!* (Mitchell 2018, 258)

Thus, the contemptuous racist is driven to surveil Black people/communities in order to ensure that Black people are not stepping out of their place—the place of moral contempt. Perhaps one of the most famous historical examples of this kind of contemptuous racism would be the Tulsa Race Massacre of 1921.³

Like the slave patroller, the contemptuous racist who engages in know-your-place aggression also pays too much attention to Black people, and this excessive attentiveness similarly manifests as invasiveness, surveillance, and aggression. However, know-your-place aggression is an explicit response to Black success and striving. Vandalizing Black-owned property, professional sabotage, and even physical violence are all examples of know-your-place aggression. Here, rather than withdrawing from the member of the disfavoured race, the contemptuous racist asserts themselves into the intimate personal, professional, and community life of their target. This form of racist contempt is an assertion of both racist disvalue and of white supremacy.

Contemptuously Racist Institutions

In her article on racist memorials, Bell locates the wrongness of memorials to racists (including building names, statues, etc.), not in the distress or discomfort that those who see them may feel but in the message of the honouring itself,

To honor someone is to regard or present her as a person who has comparatively high status and who is especially worth of esteem and deference. Thus, to publicly honor a racist is to reify the racist’s misplaced sense of relative superiority, and it is difficult for people to fully respect

³ See broadly #TulsaSyllabus (<https://tulsasyllabus.web.unc.edu/>) created by Alicia Odewale and Karla Slocum for resources on the slaughter of an estimated one to three hundred Black residents of the Greenwood District of Tulsa, Oklahoma. Greenwood was colloquially referred to as “Black Wall Street” for the number of thriving Black businesses there.

themselves and others in that environment. (Bell 2018, 11)

Although her article is focused on individual responses to Confederate and other racist memorials, to the extent that contempt is at the heart of racism and memorials themselves are manifestations of institutional power, Confederate and other memorials to racists also can be understood through the lens of institutional contempt. The act of memorializing public spaces is the act of making plain who and what a community values. In general, individuals do not memorialize public spaces. Communities, organizations, and other institutions do. Although Bell's article is a consideration of how individuals respond to racist memorials, she arrives at the wrongness of racist memorials by holding institutions partly responsible creating an environment that is conducive to developing and maintaining respect for the members of its community. When institutions, whether through the creation of public memorials or through practices like punishment, engage in contemptuous behaviour, the message of contempt is sent by the community to the contemned (Hoskins 2013). When the contempt is racist contempt, then disvalue of non-white racial groups is the message that is communicated.

Let us return now to Barbara Dawson. Recall that a physician did see Dawson, and she was deemed stable enough for discharge. However, Dawson was still having difficulty breathing and did not feel ready to leave the hospital. Because Dawson grew increasingly more insistent in her demand to stay at the hospital and receive care, the nurse called the police who dragged Dawson out of the hospital despite her pleas. The nurse, who neither further assessed Dawson nor called for a physician to examine Dawson, and the arresting officer assumed that Dawson was faking her symptoms.

It is likely that the nurse and the arresting officer followed established institutional protocol. Nevertheless, protocols are not neutral, and they often allow for some discretion. Dawson was arrested because a nurse decided that police intervention was the appropriate response to Dawson's refusal to leave the hospital in the face of, what turned out to be, a deadly medical emergency. The officer who arrived on the scene concurred. The salient question for me is not solely whether the nurse, the arresting officer, or the other hospital personnel were racist. Rather, I am interested in whether U.S. healthcare systems operate in ways, through their policies and protocols, that could be reasonably described as contemptuously racist. If so, then

the insult of contemptuously racist institutions lies not only in the harm to individual patients and their families but also in the message sent to the larger community about who is valued.

The Tuskegee Syphilis Experiment is probably one of the better-known failures of medical ethics. The experiment was a natural history study funded by the U.S. Public Health Service. It was conducted in Tuskegee, AL with the institutional partnership of historically black Tuskegee Institute's (now University) John A. Andrew Memorial Hospital and was active from 1932 until 1972. The U.S. Public Health Service took advantage of the racial politics of the early 1930s, the relative isolation of Tuskegee, AL, and the economic vulnerability of the Black men who were enlisted as study participants, along with the larger community within which these Black men lived. It is clear that they were not told the aims of the study. Nor were they told of the diagnosis that precipitated their involvement. The men who participated in the study were instead told that they had and were being treated for "bad blood," a catchall term that was used to refer to a variety of maladies. The study continued as a study of disease progression, without the informed consent of its participants, even after penicillin became the standard treatment for syphilis in 1945 (with penicillin having shown promise as a treatment for syphilis as early as 1934) (CDC *n.d.*). The study ended in 1972 in response to negative press.

There is no denying the multiple ethical breaches the Tuskegee Experiment reveals. The study itself could only have occurred against a backdrop of racist contempt for Black people, and this contempt was expressed institutionally, through the U.S. federal government. Aside from the lingering direct effects of the experiment (the last survivor, Ernest Hendon, lived until 2004) (McLellan 2004), the public message of contempt for Black life, health, and well-being lingers.

As public institutions responsible for healthcare, hospitals can reinforce this message of racist contempt for Black people. While the Tuskegee Syphilis Experiment is clearly an egregious example of medical racism, and probably one of the more famous examples, it is not the only one. Even U.S. medical schools have a history of displaying racist contempt for black patients, as the historical practice of robbing graves in Black cemeteries and graveyards in order to procure cadavers to use for medical student training illustrates (Wilson 2018). Contemporary instances of refusal to treat Black patients, as in the case of Barbara Dawson, and instances of failing to properly treat Black patients, as racial disparities in

pain management and maternal-fetal health outcomes data reveal (Tait and Chibnall 2014; Badreldin et al. 2019), compound the public message of racist contempt for Black people.

Even if individual hospitals or individual hospital personnel understand themselves to act without racist contempt, continuing institutional practices, at minimum, reify the message of racist contempt for Black patients. Therefore, a full understanding of institutional racism requires “an examination of the norms, practices, and culture of historically and predominantly white institutions that may serve to reinforce racial/ethnic inequality” (McDonald and Wingfield 2008, 29). Interrogating the “norms, practices, and culture[s]” of the institutions that comprise U.S. healthcare systems is a necessary step for the bioethicist or anyone else committed to racial justice must take. Focusing solely on individual behaviour will never be sufficient because the persistence of norms, practices, and culture[s] of an institution show how institutional racism can persist even in the absence of individual racist contempt.

The Bioethicist’s Role

I began this paper attempting to grapple with what role bioethics and the bioethicist have to play in fighting the self-perpetuating racist contempt that U.S. healthcare systems continue to exhibit toward Black patients. While I think that bioethicists should work to address racism, I also worry that bioethicists have not taken seriously enough the ways in which the institutional contempt for Black people continues to permeate U.S. healthcare. Absent that important first step, bioethicists will miss the fundamental role that racism plays in every aspect of Black patient experiences and outcomes. I offered an account of one form of racism—contemptuous racism. I spent a significant amount of time constructing this account of racism as contempt because in order to address racism, as my colleagues and I argued in our earlier paper that bioethicist should, bioethicists have to understand what racism is and how it can manifest. Conceptual clarity about racism is part of the necessary preparation to address racism.

Bioethicists cannot continue to minimize the role of racism in the U.S. healthcare system—through access, care, and outcomes. It is also important to recognize that racist contempt may manifest in different forms. Racist contempt may take the form of withdrawal. Racist

contempt as withdrawal may look ignoring symptom reports or failing to offer comfort care to the dying. Derisive contempt may include mocking or insulting patients. And racist contempt as paying “too much” attention to Black patients may look like being driven by a negative appraisal of Black people generally to report suspected drug-seeking to police. The bioethicist has to be willing to see racist contempt within U.S. healthcare systems.

In light of the discussion of how institutions engage in racist contempt, I return to the three avenues that my colleagues and I presented in the earlier paper as ways for bioethicists to think about how to contribute to combatting racism and offer more thoroughgoing suggestions for the role of bioethics and bioethicists in combatting racism.

First, bioethicists have to understand not only *that* the social determinants of health play a role in the health status of Black patients but *how* things came to be the way they are. It is not accidental that Black people disproportionately work in high-risk jobs or live in substandard housing. Rather, many of these social determinants of health are attributable to structural racism, racism that exists as a result of the convergence of public policy, institutional practices, and broader cultural practices and custom. Black patients have been and continue experience the effects of structural racism, and it is reified within healthcare institutions. The bioethicist who is concerned with combatting racism must be intentional about first acknowledging that institutional practices within healthcare systems can function as expressions of contemptuous racism, in particular.

Second, implicit bias training can be a useful tool to address interpersonal instances of racism. However, addressing racism cannot begin and end with implicit bias training. While this training can reveal unconscious attitudes, the cumulative effect of small acts of bias, such as interrupting more (Brownstein 2016, 765), or harbouring negative attitudes toward Black patients. In his review of the literature on implicit bias, Brownstein observes, “At present, [the implicit bias literature] suggests that people are often aware of the content of their implicit attitudes, largely in the form of ‘gut feelings,’ but are often unaware of the effects their implicit attitudes have on their behavior” (Brownstein 2016, 770). If this is the case, then one useful intervention for the bioethicist is not necessarily to dispense with talk of implicit bias altogether but to explore how it might be a useful tool among others for fighting racism. One

practice grounded in the literature is to challenge the value of listening to one's "gut feelings" over listening to patients because one's gut can lead one to believe that a Black patient seeking relief from pain is really an addict looking to score.

Third, because concern with justice is fundamental to the mission of bioethics, the bioethicist must also be concerned with the ways in which the discretionary application of institutional policies reflects racist contempt. In her classic work, *Killing the Black Body*, Dorothy Roberts argues that Black women's bodies, particularly with regard to issues of reproduction and motherhood, are subjected to racist intervention that often goes unremarked as such. These interventions can only happen where structural racism (as public policy), institutional practices, and individual judgments converge. She criticizes drug policies that disproportionately punish pregnant Black women who use drugs. In order to show how it is that Black women seem to be ensnared in drug policies at rates that exceed rates of actual drug use, Roberts writes,

To charge drug-dependent mothers with crimes, the state must be able to identify those who use drugs during pregnancy. Because indigent Black women are generally under greater government supervision—through their associations with public hospitals, welfare agencies, and probation officers—their drug use is more likely to be detected and reported. These women are already enmeshed in a social welfare structure that makes them vulnerable to state monitoring of every aspect of their lives. Hospital screening practices are particularly to blame. The government's main source of information about prenatal drug use is hospitals' reporting of positive infant toxicologies to child welfare or law enforcement authorities. This testing is performed almost exclusively by public hospitals that serve poor minority communities (Roberts 2014, 172–173).

That hospital personnel work in tandem with the government to report the drug use of pregnant Black women is an example of how racist contempt as "too much attention" and institutionally racist contempt converge.

The Black women about whom Roberts writes find themselves under immense surveillance and scrutiny as a result of public policies regarding public housing, welfare, and public hospitals. This contempt, driven by the idea that Black women are nonpersons in the way that I

articulated earlier, serves as justification for this undue scrutiny. However, a necessary feature of the account that Roberts offers is that hospitals actively participate in reporting Black women who use drugs to police or welfare agencies. In contrast to private physicians who are less likely to test their patients—patients who are more likely to be white and affluent—hospitals engage in drug testing according to criteria that are more likely to capture Black women, such as lack of prenatal care (Roberts 2014, 174). Roberts continues, "Worse still, many hospitals have no formal screening procedures, relying solely on the suspicions of health care professionals" (Roberts 2014, 174). In other words, racist contempt can seep into patient interactions interpersonally, as the "suspicions" of a healthcare worker, and through institutional contempt, either through policies that disproportionately affect Black women or as a result of lack of any formal policies, which leave Black women vulnerable to the "gut feelings" of healthcare professionals.

What is important for the bioethicist in this scenario is the clear understanding that healthcare professionals have and exercise discretion with regard to not only who is tested for drug use, but also who is reported to authorities in the event of a positive result. Just as in Dawson's case, the healthcare personnel *decided* to involve the police rather than address Dawson's symptoms, thereby turning a medical crisis into a police matter. Whether there was *some* clear hospital policy that was racially discriminatory or *no* formal policy, thus leaving Ms. Dawson at the mercy of a hospital worker's "gut," the fact remains that the call to police was the result of someone's discretion. Under circumstances of racist contempt within racially contemptuous institutions, to support institutional practices that reveal themselves to be contemptuous of Black people is to abandon the principle of justice that undergirds the *raison d'être* of bioethics. This understanding of racism coupled with the bioethicist's mediation and conflict resolution skills can ideally help diffuse some fraught scenarios before authorities are involved.

At this point one might object that even if the case I make theoretically falls within the realm of matters with which the bioethicist should be concerned, bioethicists rarely have the kind of institutional power to intervene when circumstances arise nor do they tend to be directly involved in creating or instituting policy. While it is true that in many clinical settings bioethicists tend to arrive on the scene only when someone specifically calls for a bioethics consult, this moment of global pandemic that

has disproportionately affected populations of colour and the simultaneous global protests calling for racial justice, potentially provides a unique opportunity if bioethicists have the will to truly commit to justice. Industries from fashion to sports to media to municipalities, are grappling with their histories of racism and how the legacies of racism continue to shape their practices in ways that disadvantage people of colour.

The crushing weight of the COVID-19 pandemic in the U.S. has laid bare just how broken U.S. healthcare systems are and how Black patients bear the brunt of the history of medical racism that has contributed to sicker, shorter lives for Black people. This could be the perfect time for bioethicists to formalize relationships within their organizations that had previously been only or mostly informal (Kuczewski 2020). There may be change in the wind, especially those who are committed to racial justice, can certainly make the case for the value of such expertise. But the bioethicist must also have the vision to connect the dots within the institution. To argue, as I have, that explicit attention to racism is the domain of the bioethicist has been met with scepticism—even from fellow bioethicists (Wilson et al., 2016). However, if this moment doesn't reveal the importance of fighting racism, then none will.

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