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SYMPOSIUM: INSTITUTIONAL RACISM, WHITENESS, AND BIOETHICS

The Role of Emotion in Understanding Whiteness

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Abstract This paper argues that stoicism as a central element of whiteness shapes, controls, and ultimately limits the experience and expression of emotion in public space. I explore how this may play out in particular medical settings like hospitals in Aotearoa New Zealand. I argue that working in conjunction with other values of whiteness identified by Myser (2003)—hyper-individualism, a contractual view of relationships, and an emphasis on personal control and autonomy—this makes hospitals emotionally unsafe spaces for Māori and other groups who place high importance in the collective sharing of emotion. Using death and bereavement as an example, I suggest that challenging and addressing stoicism in the structure and performance of whiteness in hospital settings may provide an important point of entry for anti-racism measures and health equity.

Keywords Racism · Colonization · White privilege · Indigenous people · Emotion · New Zealand

Introduction

Myser (2003) argues for greater recognition of the centrality of whiteness in the development and current conceptualization of bioethics. This paper seeks to firstly apply Myser's analysis of whiteness to the dominant settler peoples in Aotearoa New Zealand. This analysis illuminates taken-for-granted patterns of political and social life, family and work values, and the underlying ethos of individualism and financial acquisitiveness that together represents "normal" New Zealand society.

Secondly, I explore how whiteness through the ongoing process of colonialization is reflected in the structure of societal institutions and healthcare institutions in particular. The normalization of whiteness in these settings ensures the values of individualism and rationality are observed by all professionals irrespective of ethnicity or cultural background. In this sense, whiteness represents what is considered universal and "normal" and thus characterizes an institutional standard which is *performed* by all, not just white people. Consequently, members of the dominant group these values most accurately represent experience advantageous outcomes of these systems at all levels compared with marginalized groups, especially indigenous people. This marker of institutional racism is a crucial concern for bioethicists.

Thirdly, I am particularly interested in the positioning, discomfort, management, or outright removal of strong emotion in these spaces. I argue that stoicism, and its masculine predilection, is a core part of the structure and performance of whiteness and plays an important role in the maintenance of mistrust amongst ethnic minorities with the worst health outcomes in Aotearoa New Zealand. This may highlight to indigenous people that their cultural norms and practices of healing and well-being don't belong in these spaces, affecting not only their interpersonal experiences of the health system but also making institutional racism

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more difficult to disrupt—all of which pose serious concerns for bioethics. I contend that efforts to confront and disrupt the commonplace nature of stoicism as whiteness, particularly in the management of death in hospital settings, may provide important foundations for reducing mistrust amongst ethnic minorities, providing valuable opportunities for bioethicists committed to improving health equity.

Bioethics in Aotearoa New Zealand

Bioethics is becoming an increasingly important area of public and academic activity in Aotearoa New Zealand. Perhaps the most recent development has been the passing of the End of Life Choice Bill by the New Zealand Parliament in November 2019.[1] The bill has been hotly debated in parliament since its introduction in 2017, and the final decision on the law's implementation will be made by public referendum during the 2020 general election. Before this there have been several landmark cases that highlight the importance of bioethics to New Zealand society. Of significance for this paper are the Cartwright inquiry and the involvement of Māori in national discussions about genetic modification in the development of medical treatments.

The Cartwright inquiry sought to expose and resolve unethical practice in medical research on women presenting with carcinoma in situ (CIS), a precursor to cancer of the cervix, at the National Women's Hospital from the 1960s to the 1980s. Some of the participants, without their knowledge or consent, were denied conventional treatment for CIS so researchers could study the natural progression of the disease, leading to greater illness and even death in some cases (Manning 2009). The initial exposure of these practices highlighted by two journalists in a national magazine eventually led to a national enquiry headed by Judge Silvia Cartwright. While debate on the findings of the inquiry continue still (Manning 2009; Bryder 2009; Paul and Brookes 2015), the lessons learned from this case saw a sea change in the management of medical ethics, health research, patient care, and medical misadventure in Aotearoa New Zealand, including the establishment of government entity to monitor patient care and manage complaints (the Health and Disability Commission), the implementation of a national cervical screening programme, and affecting the role of the Accident Compensation Corporation (ACC)—a national insurance programme to compensate individuals for accidents of all kinds, including medical misadventure. Additionally, the fallout from the inquiry ensured a heightened awareness amongst health professionals, researchers, and ethicists of the need for more rigorous academic standards for, and debate about, bioethical issues. Indeed the development of the *Bioethics Journal of New Zealand* was a fundamental step towards these ends. Collaboration between the Australian Bioethical Association, the Australian and New Zealand Institute of Health Law and Ethics, and the University of Otago Bioethics committee saw this journal replaced with the *Journal of Bioethical Inquiry* in 2004 (Anderson 2005).

In more recent times, Gray (2014) argues that the code of ethics for the New Zealand Medical Association—based entirely on the model established by Beauchamp and Childress (2009)—is not fit for purpose for those groups disproportionately affected by ill health in Aotearoa New Zealand: Māori, Pacific people, and the poor. The primacy of individual autonomy of both patient and physician as the core of ethical practice comes under particular scrutiny (Gray 2014, 69). He argues that the assumption of this ethical standard as universal to all, irrespective of social or cultural background, is in direct conflict with codes of cultural competence that require the practitioner to *not* impose their own values and beliefs onto those of patients. Indeed the establishment and development of *cultural safety* (Ramsden 2002) as part of best practice for health professionals invites the practitioner to use critical self-reflection to examine their own backgrounds, beliefs, values, and cultural norms to ensure they don't make impositions onto patients whose social or cultural background may be dissimilar.

Māori, too, have long been engaged in public discourse concerning bioethics. Jackson (2004) offers an engaging account of the philosophical and ethical processes involved in knowledge creation and innovation of Māori institutions like *whare wananga* (schools of learning). He argues that *tikanga* (correct processes for the given context) were integral to answering "why we need to know" and that the ethics and potential risks of knowing should be clearly understood before a course of action is undertaken. In applying this analysis to Māori positioning on the new technology of genetic modification, he laments that the Māori intellectual tradition remains a "perspective" to be heard but not

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[1] End of Life Choice Bill - Member's Bill 269-3. http://www.legislation.govt.nz/bill/member/2017/0269/latest/DLM7285905.html.

listened to—asked for well after the work is underway. He suggests that "mainstream" ethical and moral models for understanding new technologies are often driven more by the assumption of economic reward than the betterment of human health. Māori have sought to apply this intellectual tradition to other bioethical issues of relevance, including the "warrior gene" controversy (Hook 2009), biobanking (Hudson et al. 2016), embryo cryopreservation (Fitzgerald et al. 2019), and the End of Life Choice Bill (Hipango 2019).

And while a Māori presence in national debates about bioethics and membership of particular ethics committees has become more common, the centrality of whiteness to the ethical landscape in Aotearoa New Zealand remains. Came (2014) identifies numerous sites of institutional racism within the public health environment that offer some insight to Māori engagement in bioethics. Key amongst these is the "tyranny of the majority"—decision-making practices that, despite statutory representation at a governance level, ensure Māori will always be a structural minority; their disparate experience of disadvantage can and often is "out-voted" for majority Pakeha effect. Consultation practices are also shown to woefully underrepresent Māori evidence and expertise, and, when given, it can be easily dismissed or minimalized. Gray's (2014) analysis of the incongruity of cultural safety standards with current medical ethics appears to illustrate how, without significant increases in coordinated action across multiple areas, the backdrop of whiteness will continue to undermine efforts that seek to improve health outcomes for marginalized groups. This contributes to the differential access and quality of healthcare delivery and further entrenches institutional racism (Came 2012).

Understanding Pākehās—Whiteness in Aotearoa New Zealand

In her seminal paper about the pervasiveness of whiteness in the development of bioethics, Myser (2003) supports her analysis using a table that aligns the key characteristics of bioethics as described by Fox (1990) with the value base of white Anglo-Saxon protestant Americans as defined by McGill and Pearce (1982, cited in Myser 2003). A timely addition to this analysis could include alignment with descriptors of Pākehā (New Zealanders of European origin) life, values, and beliefs. One such offering emerges from a pivotal moment in New Zealand history that would see the migration of thousands of new settlers from around the Pacific Islands. The manufacturing boom of the 1960–70s and the subsequent labour shortages that followed saw the government of New Zealand actively seek out Pacific people to migrate as workers in agriculture and manufacturing and as domestics. In an attempt to manage and mitigate potential misunderstandings between these new workers and their largely Pākehā employers, the Vocational Training Council and their Pacific advisors produced a series of booklets throughout the 1970s (Vocational Training Council 1975). "Understanding Samoans" and "Understanding Polynesians" were written for prospective employers to better understand the background, values, and beliefs of this new workforce. "Understanding Pakehas" was produced and translated into six Polynesian languages to "help Polynesian migrants understand the European New Zealander's way of life and work" (Vocational Training Council 1975, 1). This booklet marks an interesting departure from understanding race relations at the time as it names Pākehā as a distinct group with clear descriptors of their values and beliefs and makes explicit the cultural specificity of New Zealand institutions that are otherwise viewed as universal. Descriptors of political life include paragraphs on elections, political parties, national and local governance bodies, central government departments, the ombudsmen, the law, and the police. Family life, home, school, and religion are all included under a top heading "Pakeha Society."

Perhaps of most interest to this paper is the section "Pakeha Character." Within this section Pākehā are described under three subheadings: Individualistic, Money-minded, and Organised. Individualistic is described to these new migrants as the preeminent value in the Pākehā character. It emphasizes that Pākehā put the individual before the group, that each person must make their own way in the world, and that the status of the individual is linked to what one can succeed in doing and owning. Economic life in Pākehā society is based on individual ownership and looking after oneself. Emphasis is placed on the importance of individual responsibility and self-reliance. These explanations were necessary as they mark a sharp departure from the value base of many Polynesian migrants, who navigate social status through their duty to extended family and community, embracing concepts of collective sharing and service. "Money-minded" describes the Pākehā character in terms of the importance of money to identity, security, and sense of self-esteem. Money is a measure of success for Pākehā people. Emphasis is placed on Pākehā looking after themselves without assistance from wider family and community networks. It points out that Pākehā do not value interdependence with their extended family members in the same way as Polynesians and that this may make them appear mean and selfish. "Organised" describes the everyday reality of Pākehā lives, that they like orderliness, value the privacy of the home, and queue in line. Their hospitality may seem sedate in comparison to Polynesians. Pākehā are also viewed as future-focused in that they budget carefully and set aside money for regular expenses. It states that Polynesians will need to conform to these practices to make their way in Pākehā society.

Aligning these values of the Pākehā character with those outlined in table 1 (Myser 2003, 6) is relatively straightforward. McGill and Pearce (2005) emphasize the importance of "work" to Anglo-Americans' identity and discourse—most things in Anglo-American lives can be tied to their concept of work in some way. It's fitting then that "Understanding Pakehas" is written as a primary resource to improve cross-cultural relations in labour settings. "Individualistic" as the primary descriptor of the Pākehā character aligns precisely with the "basic values" and "concept of self" sections in Myser's table. The value base of the Polynesian migrants—service, devotion, caring, and sacrifice—would align with "values not emphasised." "Money-minded" is a more colloquially written summation of what Myser situates as the contractual framing of the concept of relationship, that links between individuals tend to be in-kind transactions. What may appear mean and selfish or cold to Polynesians are considered virtues to Pākehā people. It reiterates notions of personal responsibility to one's livelihood, lawfulness, independence, and structure. Overall the booklet's descriptions of Pākehā life, character, and society imply an emotional rigidity to Pākehā people perhaps best summed up in the following description of Pākehā social attitudes and customs:

> When Pakehas get together with friends for a chat, they like to have a few drinks. This is because many Pakehas find it hard to relax and a little alcohol helps them to loosen up. (11)

In much of the scholarship about whiteness—and as clearly marked by Myser (2003) in the area of bioethics—racism, of which whiteness and white privilege are a feature, is more about relationships to societal structures and systems of power, opportunity, and status than it is about white-skinned people per se (Jones 2002; Paradies 2006; Sleeter 2014).

That does not mean skin tone has no meaning, as even within the same ethnic group those with lighter skin experience less discrimination, an effect known in sociology as colourism (Monroe 2017). Harris, Cormack, and Stanley (2013) also found that irrespective of how one self-identified, Māori who were more likely to be socially ascribed as white (i.e., Pākehā) did incur a health advantage compared to those most often socially ascribed as Māori.

Whiteness, Stoicism, and the Status of Emotion

Stoicism has its origins in ancient Greek philosophy as an ultimate expression of personal control over one's emotions. This included an indifference to death and imperviousness to strong emotions evoked from pleasure, pain, and fear. While principles of stoicism also feature in non-western philosophy, in Buddhism and Confucius teachings for instance, it is generally understood as a primary antecedent to the values, beliefs, and ethics of "western" civilization (Graver 2007). In contemporary times, stoicism has come to also include taciturnity and self-reliance (Pathak, Wieten, and Wheldon 2017) as important manifestations.

Stoicism, both as an ethical framework and ideology and as patterns of personal behaviour, is a highly gendered concept. Indeed, irrespective of variation between other variables like ethnicity and age, stoicism is a heavily weighted characteristic of masculinity (Moore et al. 2013; Graver 2007). This is important to discussions about ethics in general and healthcare delivery in particular as within the interpretation of patient autonomy, for instance, the role of emotion and touch differ greatly between medicine (a classically male field) and nursing, where these are emphasized as important aspects of ethical conduct (Nursing Council Of New Zealand 2012).

There are numerous examples of how stoicism and whiteness are deeply intermeshed. Both concepts place the primacy of the individual at its core. This ethos of hyper-individualism manifests as individual autonomy, self-reliance, and independence. The importance of rationality, the power of the mind over strong emotion, is fundamental. Stoicism and whiteness emphasize self-control of all aspects of an individual experience as aspirational for wisdom and personal freedom. At an epistemic level, the knowledge of the rational knower is a more endorsed form of "truth" than knowledge produced by emotional knowers in what Fricker (2007) describes as the "credibility economy." This may have particular relevance in terms of healthcare where the rationalism of the medical model at the core of "western" approaches to health may dismiss or ignore methods of traditional healing common amongst indigenous people even when these have evidence of effectiveness (NiaNia, Bush, and Epston 2016). Whiteness and stoicism are similarly gendered towards masculinity, both in origin and contemporary articulations. Both emphasize thinking more than feeling, independence over connection, and service to self rather than others. In an absolute sense then, stoicism as a core feature of whiteness positions the expression and even the experience of emotion as a low-status value, inferior in the concept of self, an unnecessary complication to the contractual nature of relationships and indicative of a loss of control and personal autonomy.

This is not to say that stoicism is valued only in "western" states or solely by white people. Indeed, stoic principles are also present in the ancient teachings of Buddha and Confucius and other Eastern traditions. Stoicism has a focus on practitioners living "in the present" and resisting anxiety and concern over the future. This may be at odds with the future-focused descriptors of whiteness. And while it is accepted that men in general display more stoic patterns of behaviour than women, Pathak, Wieten, and Wheldon (2017) suggest that minority men score higher than white men on particular stoicism scales, though not at statistically significant levels. There is also an argument that machismo—a more visceral and emotive fear or embarrassment of appearing weak to others—may be misinterpreted as stoical, an internalized philosophy of personal control and autonomy (Moore et al. 2013; Sobralske 2006). Personal ideologies that strongly endorse stoic principles may lead to conduct that have a compromising effect on health. Stoicism has been shown to affect delays or avoidance in health-seeking behaviour, pain management, chronic stress, and coping strategies and an internal resistance to external objective health needs (Pathak, Wieten, and Wheldon 2017; Moore et al. 2013; Yong et al. 2001).

The etymology of the term emotion can be traced to Latin *emovere*—meaning "out" and from the old French *emouvoir*—"stir up". This marks emotion not only as an inner stirring but also as an outward response to affective prompts. The values, beliefs, and cultural norms of whiteness seek to manage the outward expression of emotion, particularly health stressors like pain, suffering, and grief (McGill and Pearce 2005; Myser 2003; McIntosh 2001).

Stoicism has been an important feature of Pākehā approaches to death. Schäfer (2007) argues that an increasingly medicalized approach to death in mainstream society has shifted the roles of preparation and interment of the deceased from family and relatives to funeral directors. This has increased the emphasis on death as a hidden or invisible state and removed it from public spheres to the private domain (Schäfer 2007; McIntosh 2001). This also makes an explicit link between mainstream Pākehā approaches to death and the evolving role of medical institutions. The free expression of strong emotion is to be contained within private settings. Individuals keep these to themselves in public not only as an indicator of personal control but also as a mark of respect for the privacy and comfort of others. Within this context then, the free expression of emotion within the cultural norms of whiteness may be disrespectful and out of place in public settings like hospitals.

This is not to say that white cultural norms are stoical to the point of being completely emotionless. The fundamental belief in Stoicism, that in the wise person rationality regulates emotion, speaks to the idea that emotion is part of being human (Graver 2007). Rather, I am arguing that stoicism is elemental to the structure and institutionalization of whiteness. It has endured from its roots in the ancient world into modernity and remains significant, even as more nuanced understandings of individual freedom and autonomy have developed (Illouz 2017). Working in concert with other norms of whiteness—hyper-individualism, the emphasis on self-control and personal autonomy, the contractual nature of relationship making—it affords lower value to emotion and manifests in the public sphere as compromised spaces for the free expression of emotion. Emotive expression in these spaces may be seen as a loss of control, embarrassing, or shameful. This has serious implications for the cultural safety of those spaces for groups with contrasting world views, who may not only tolerate the expression of emotion, but gain important social supports, cultural affirmation, and connection from the act of sharing emotion.

Role of Emotion for Māori

> In indigenous frameworks, relationships matter. Respectful, reciprocal, genuine relationships lie at the heart of community life and community development. (Smith 2012, 210)

In this passage, prominent Māori scholar Linda Tuhiwai Smith speaks to the importance of relationships to the identities of indigenous people. For Māori, important concepts such as *whanaungatanga* (extended family relatedness), *manaakitanga* (nurturing and caring for others), and *wairua* (restrictively translated as spirit or spirituality) encompass a fundamental set of values based on collective connection and the maintenance of relationships (Mead 2003; Moewaka Barnes et al. 2017). In this sense then, the experience of emotion in an individual is of limited importance. Rather it is the act of *sharing* those experiences with others that is of the greatest value. Smith (2012) also speaks of this method of connecting with others:

> To be able to share, to have something worth sharing, gives dignity to the giver. To accept a gift and to reciprocate gives dignity to the receiver. To create something new through the process of sharing is to recreate the old, to reconnect relationships and to recreate our humanness (188)

While it is often argued in stereotypes of Māori that there are no "full-blooded" Māori left (McCreanor 2009, Moewaka Barnes et al. 2012) and that for some Māori their connection with customary markers of Māori identity see them positioned as culturally "disconnected" (Borell 2005), the temerity of Māori to embrace the expression and sharing of emotion, particularly grief, appears to transcend region, upbringing, background, even nationality (Potiki 2018; Edge 2017). *Tangihanga* is defined as the "complex of culturally defined mourning practices and rituals through which Māori respond to death" (Nikora and Te Awekotuku 2013, 170).

The importance of the emotions of grief and mourning to the maintenance and affirmation of Māori identity places enormous significance on the treatment of the *tupaapaku* (body of the deceased) not only as the catalyst for the sharing of emotion but also because the *tupaapaku* is a sacred *taonga* (treasured thing) in its own right. Interference of any sort with the *tupaapaku* may evoke suspicion, confusion, and anger from kin. Coroners, pathologists, the police, and hospitals, in particular, have to negotiate very carefully their statutory and institutional responsibilities with maintaining respect for the needs of the affected families and communities. This inevitably brings Māori into conflict with these institutions. In 2018 the Māori Affairs Select Committee of the New Zealand government held an inquiry to highlight Māori concerns about access to and treatment of *tupaapaku*. They recommended the cultural importance of *tupaapaku* to Māori be more formally recognized to improve relationships with affected agencies and Māori communities leading to, amongst other things, an amendment of the *Coroners Act 2006*.[2] The ability for Māori who live elsewhere (Australia for instance) to meet their obligations to the deceased is also an area of growing concern (New Zealand Herald 2016; Edge 2017; Nikora and Te Awekotuku 2013; McIntosh 2001). Mead (1997) characterized the expression of grief for Māori in the following way:

> What characterises the tangihanga ceremony is the respect paid to those who are weeping and the care taken not to stem the flow of tears. The mourners have the right to weep in public. There are no limits set on age or sex, but there is a clear expectation that it is the old women who lead the mourning and who set the cultural standards for the occasion. The British value placed on the stiff upper lip in the face of adversity has no place in the tangihanga. Instead, grief is given expression in tears, wailing and talking. (216)

He contrasts the British value of more-stoical practices as inappropriate for Māori as the avoidance of emotion prevents one's ability to share with others, nurture connectedness, and initiate healing of the loss of a loved one. Nikora and Te Awekotuku (2013) also stress the importance and expectation of open lamentation by the closest kin of the deceased. While the expression of grief is the primary emotion in *tangihanga*, laughter, joy, and singing are all expressed and welcome when reminiscing on the life of the deceased. In this way, the freedom of emotional response marks a kind of cultural authenticity to being Māori that appears to transcend other markers of customary identity.

Interestingly, Māori death rituals are gaining increasing recognition amongst non-Māori (Ritchie et al. 2013; Nikora and Te Awekotuku 2013; McIntosh 2001). It's not unusual for Pākehā to adapt and reclaim particular practices more commonly practiced in Māori mourning ritual but that have roots in an earlier colonial history that predates the influence of funeral directors and saw

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[2] Coroners (Access to Body of Dead Person) Amendment Bill 33-1. http://www.legislation.govt.nz/bill/government/2018/0033/latest/versions.aspx.

immediate families more intimately involved in death rituals (McIntosh 2001; Schäfer 2012, 2007). For instance, some Pākehā may have their loved one brought to the family home or other location rather than solely at a funeral home. For some there is increased importance given to the last night before burial. Even having an open casket for the deceased to be viewed is becoming more common. Schäfer (2007) explains these more personalized funerary practices amongst Pākehā are increasingly superseding more customary Anglophone approaches to death that were more austere and intransigent, that may have kept death hidden or distanced from mainstream New Zealand society (McIntosh 2001). The use of *haka* performed by Māori and non-Māori to accompany the coffin of the deceased to an awaiting hearse is increasingly common, be they rugby stars like Jonah Lomu (Manhire 2015) or a school mourning the loss of a popular student or teacher (Smith 2015). Māori rituals of mourning have also taken a central role in the national response to intense domestic tragedy, including the terrorist attack on the Muslim community in Christchurch in March 2019 (1 News 2019; New Zealand Herald 2019) and the eruption of Whakaari (White Island) in December 2019 (Dunlop and Murphy 2019; Fusitu'a, Murphy, and Scotcher 2019). Analysis of Māori engagement on the national stage is perhaps best articulated by Delahunty (2019):

> Tangata whenua [Māori] bring their spirituality, their aroha [emotion] and their rituals to help everyone, to honour everyone and to uplift the unthinkable into a collective moment of love. This is more than generosity, this is the authority of the people of the land whose obligations to both place and people are maintained to everyone’s benefit.

Discussion

There has never been a better time to begin addressing stoicism in the structure and performance of whiteness as it plays out as everyday practice in hospital settings. Some important steps are being made. The legislative amendments mentioned here are one example. The establishment of specific bereavement care services is another, although this generally means sending condolence cards and follow-up phone calls (Mitchell, Coombs, and Wetzig 2017; Paediatric Intensive Care Unit 2019). Middlemore hospital located in South Auckland, an ethnically diverse region of Auckland with high health needs, operates the only twenty-four-hour bereavement unit in the country (Counties Manukau Health 2019). In addition to improved staff training regarding the needs of such a diverse community, the unit also has a specified space set aside for families to remain with their deceased loved ones so particular cultural obligations can be met, a greater number of family members can be accommodated, and necessary arrangements can be made. These changes to the way death and mourning are being managed should be commended as they may go some way to creating emotionally safe spaces for groups who place high value on its expression. Indeed, primarily because particular groups place high value on the sharing of emotion, even small structural and institutional changes may have disproportionately greater impact on outcomes like trust. As such, addressing stoicism in hospital settings with the view to improving trust, particularly among non-white ethnic groups, seems a sound investment of limited resources for disproportional affect.

Yet it would be a mistake to assume the provision of these emotional safe spaces are wide-spread. While some sort of bereavement support is common, the provision of emotion-safe spaces for bereavement in hospital settings is not. The resourcing required for appropriate improvements in training and workforce development of staff also appears more ad hoc than systemic (Macdonald 2019). So while it is important that these considerations to emotional and cultural safety are being considered, the potential to apply these learnings more broadly across the sector remain. It’s also prudent to bear in mind that because death and bereavement induce greater sympathy generally amongst the public, and given the growing familiarity and respect for the diversity of death systems nationally, particularly those of Māori, the political risks of a dominant group backlash to adaptions in this area are lower than perhaps any other area of the hospital experience. Dominant group narratives about anti-racism measures being positioned as “special treatment” of ethnic minorities (McCreanor 2005) may appear particularly mean-spirited in this context. In such risk averse times this may affect the appeal of such anti-racism measures for medical institutions with a view to expanding emotion-safe space from end-of-life to all prior interactions with health systems.

Conclusion

Bioethics is concerned with addressing institutional racism. Understanding the uniform consistency of the ethos, value base, and cultural norms of whiteness within the field of bioethics is significant to addressing institutional racism. The centrality of white cultural norms like stoicism plays an important role in how valued, comfortable, and accessible medical institutions are to communities that are increasingly diverse. If bioethicists are concerned with addressing institutional racism to eliminate mistrust of medicine and medical institutions by these communities, then structural and cultural adaptations that may reclaim emotion as a measure of health seem to be a solid foundation from which to instigate greater change. A bioethics that is critical, reflexive, and responsive to the centrality of whiteness must, as a matter of expediency, be at the heart of these efforts.

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