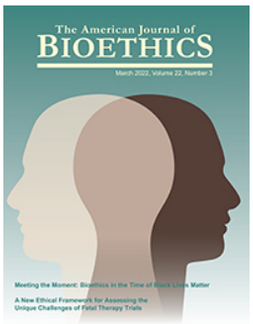

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Making Structural Discrimination Visible: A Call for Intersectional Bioethics

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Making Structural Discrimination Visible: A Call for Intersectional Bioethics

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In her evocative article "Meeting the Moment: Bioethics in the Time of Black Lives Matter," Camisha Russell (2022) comprehensively illustrates why racism should be considered an important bioethical issue. Her position is based on three main arguments. The first argument is a rather direct one in that racism works as a barrier to health itself. The daily experience of racism thus negatively impacts one's health, for example, in leading to higher levels of chronic stress. More indirect aspects include barriers to health care in the realm of social and economic factors related to "the long history of legal and political discrimination that deliberately stripped BIPOC communities of material resources and capacities for self-determination" (11). Second, racism functions as a barrier to good health due to "poorer-quality medical care" and "unconscious bias on the part of health care providers" (12) when treating, for example, Black people. Third, racism also poses barriers to better health care systems through creating opposition to reforms as part of large-scale conservative politics and public resentment. Beyond all that, Russell explains how the *concept* of race is a bioethical issue itself. She further points toward the individual commitment against structural racism in research as well as in health care provision. In this commentary we would like to underline Russell's argumentation in adding two main aspects from an intersectional perspective and strengthen the role of bioethics in working against structural discrimination.

In her article Russell refers to powerful stereotypes and "racial myths" (13) creating a "category of the undeserving poor" (14) when it comes to health care. These stereotypes such as the "Black welfare mother" (13) or the "Mexicans or welfare queens" (14) are not only racialized but gendered at the same time and are thus best captured in taking an intersectional perspective. The concept of intersectionality points to the importance of looking at the overlap and interaction between categories such as race, sex, gender, or class, for example, in the reproduction of stereotypes. It is important to highlight that biases might be unconsciously present in everyday work, for example, of health care workers and other professionals, but also manifest in actual discriminatory behavior. Intersectionality shows that the convergence of multiple social dimensions shapes actual lived experiences (Crenshaw 1989). In referring to Ikemoto, Russell underlines that for health care personnel the need to

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make decisions in time-pressured situations with high stress levels increases the impact of stereotypes. Also in less time-critical encounters, intuition and noncognitive treatment biases play a major role in clinicians' judgment and decision making (Salloch et al. 2018). An intersectional perspective stresses the need for self-reflection of health care providers, which makes intersectionality "a powerful tool for examining how health care can be delivered in a manner that is more inclusive and empowering" (Cheema, Meagher, and Sharp 2019, 1).

Our second argument relates to race as a socially constructed concept, which makes structural racism an issue for bioethics. Russell argues that "if we understand the concept of race to be socially constructed, *race* isn't a scientific or medical issue, *racism* is" (15). From an intersectional perspective it is interesting to analyze how also other categories such as age or (dis)ability can be argued from biological and social constructivist perspectives. This way it is possible to develop a comprehensive understanding of how racism interacts with sexism, ageism, ableism, classism, and other forms of institutional and structural oppression and, for example, to investigate the physiological effects of these interactions or their impact on individual health. Moreover, Wilson and colleagues point out that categories "like social class and disability status may change several times in one's life" and are therefore fluid over time (Wilson et al. 2019, 17). An intersectional perspective fosters discussion about the risks of homogenizing a certain group and essentializing their characteristics. Therefore, a task for bioethicists could be to highlight how relevant categories for health care and research are socially constructed and to make visible the tensions between self-identification and attribution by others, for example, with regard to gender identity. In this context the concept of intersectionality is useful to challenge researchers to reflect on how their analytic categories are defined and used (Cho, Crenshaw, and McCall 2013).

Bioethics as a discipline is situated between clinical and life sciences, as well as between the humanities and social science. Researchers working in bioethics often unify competencies from more than one of these scientific branches. Therefore, they are well equipped to function as "translators" or "interpreters" of the socially constructed and biologically shaped dimensions contributing to the intersectional viewpoint. From a normative view, intersectional perspectives should complement the work of bioethicists to make structural discrimination visible, to make marginalized voices heard, and to work toward more self-reflection, as well as a diversification of bioethics itself (Cheema, Meagher, and Sharp 2019, 1). With Cheema, Meagher, and Sharp (2019, 1), it can be added that "[given] its dual empirical and normative aspirations, an intersectional approach aligns nicely with the historical aim of bioethics and might provide a robust foundation for some types of empirical bioethics research."

Own currently ongoing research (Brünig, Kahrass, and Salloch 2021) on intersectionality identifies the different ways of referring to the concept in bioethical debates. First, the ethical principle of justice can be used as a starting point for intersectional approaches to broaden the discussion of health research ethics to strengthen the links between research and action toward social justice (Rogers and Kelly 2011). The main rationale underlying this type of research is related to the always present goal of intersectionality research to actually promote social justice, "unveil power inequity and build knowledge that eliminates unjust ideology, practice and research" (Rogers and Kelly 2011, 405). Second, Grzanka, Dyck Brian, and Shim (2016, 28) describe intersectionality as a form of ethics itself due to "its focus on social action and social justice." They argue that it could therefore be "taught alongside key bioethical theories, such as principalism [sic], utilitarianism, and virtue ethics" (ebd.). Even if this position might be up for further discussion within the discipline, the concept of intersectionality may inspire all phases of bioethics research, such as setting a research agenda (e.g., including rather neglected topics), selecting research tools and methods (e.g., including multiple social and biological factors), and analyzing the data (e.g., reflection of researchers' own social position) (Cheema, Meagher, and Sharp 2019). With reference to Hankivsky, it can be argued that "an 'intersectionality shift' encourages researchers to reflect on the complexity of their own social locations, how their values, experiences, and interests shape the type of research they engage with, including the problems they choose to study, and how they view problems and affected population" (Hankivsky 2012, 1715).

All in all, we would like to endorse Russell's demands to no longer treat racism and its interaction with other systems of oppression as "niche" topics in the field of bioethics. Rather, it is important to strengthen self-reflection, diversify the voices in the discipline, and make intersectional discrimination a relevant topic for bioethics researchers, health care ethicists, and ethics committees to find new ways of doing research and practicing medicine in a discrimination-sensitive way.

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