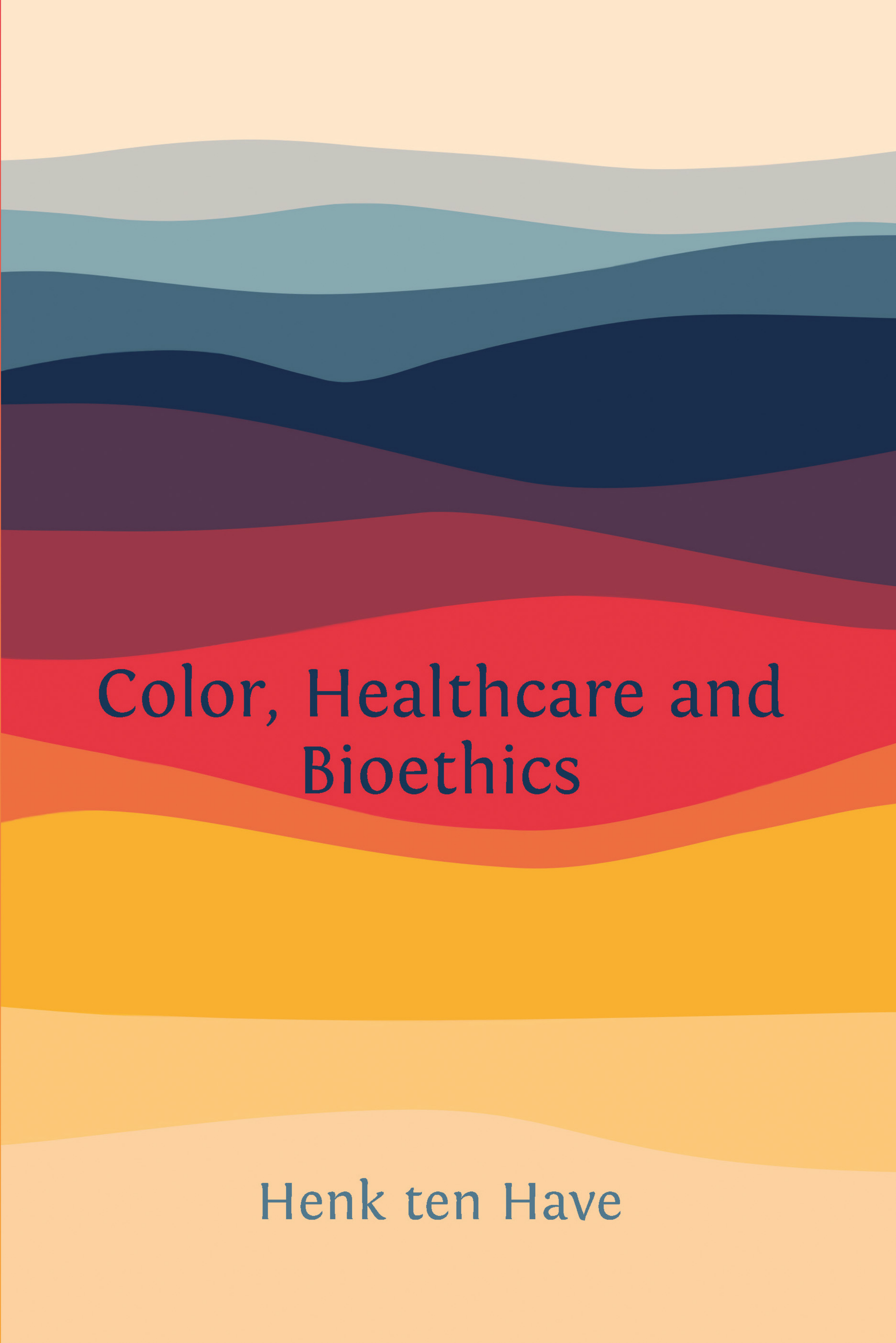

Color, Healthcare and Bioethics

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6. A Colorful Bioethics

6.1 Introduction

During the Covid-19 pandemic, attention was called to the fact that the disease is associated with a particular color. Right from the start of the pandemic, it was evident that the disease has a disproportionate impact on African Americans: they have higher rates of infection, hospitalization and deaths from Covid-19 than the White population of the United States. This disparity encouraged a search for biological factors that could explain racial differences, such as blood type or gene expression. The assumption that special African American vulnerability to Covid-19 must be due to innate biological differences demonstrates the continuing power of the idea of race in medicine and healthcare (Xue and White 2021). It exemplifies a historic line of thinking that Black bodies are different, concluding that specific 'Black diseases' can be identified. However, the color of Covid-19 is not black. Other racial and ethnic minorities are also disproportionately involved. In Australia and New Zealand, for example, Indigenous populations are more affected than non-Indigenous people (Elias and Ben 2023). Furthermore, it is evident that in the United States and elsewhere, the incidence and severity of the pandemic disease is associated with higher levels of risk among certain populations, rather than their color itself. Since minorities already experience structural health inequalities, have more co-morbidities, and less access to care, the virus has more impact on their health. During the pandemic, there was also an upsurge in racism and racist hate crimes across a wide range of countries, manifested as discrimination and violence against Asian people and foreigners (Elias and Ben 2023).

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These experiences of the recent pandemic are important lessons when we ask the question of how bioethics should deal with color. The first is that the idea of race itself is a bioethical issue. While the idea has no scientific reality, its continuing and often implicit use in medical theories and practices should be exposed and critically examined, and bioethical discourse should scrutinize how the idea operates in various contexts (Russell 2022). The second is that racism can no longer be a neglected topic in bioethics discourse. Bioethics should deconstruct the power differences in racist discourses, practices and structures (Johnstone and Kanitsaki 2010). The third lesson is that bioethics needs a wider ethical framework that will enable it to address and eliminate the deleterious influences of color on health and healthcare.

6.2 Race as Bioethical Issue

The concept of race continues to be used in contemporary clinical medicine, health research, medical guidelines and standards of care. The assumption is that categorizing patients and research participants into racial or ethnic categories is relevant for adequate diagnosis, treatment and care. Human diversity cannot be denied. Since humans are embodied beings, it is important to identify biological and genetic differences between human populations. The conclusion therefore is that "race can be a medically useful category" (Lorusso and Bacchini 2023, 452). This conclusion, however, is uncomfortable and problematic since the concept of race itself is morally problematic. Thinking in terms of race has, according to Blum (2002), four consequences. First, it is inherently divisive. Instead of what all human beings share and have in common, it focusses on fundamental and permanent differences between people, creating moral distance among human populations, and promoting ideas of "otherness." Second, it assumes that people classified in the same race share common characteristics, so that less attention is paid to the diversity within racial groups. This not only leads to stereotyping but also hinders engagement with the patient as a unique individual within their specific setting, since attributes of the group are assigned to each individual member of the group. Because the idea of race implies that there are different kinds of people with different essential characteristics, the third consequence is that these characteristics are immutable and inescapable. Finally, races are identified and classified not as neutral descriptions based on physical appearance such as skin color, but rather, every racial classification is evaluative. The color terms used to refer to races mobilize the existing normative associations within Western culture. They reflect prevailing value judgments concerning inferiority and superiority, for example, the belief that the Caucasian face is the best approximation of perfect beauty.

Blum's distinction of the moral dangers of racial thinking explains how race conflicts with the ethical framework of bioethics. It is not simply that the idea of race is harmful and has deleterious results for numerous people. The idea also defies important bioethical principles; it not only contradicts the moral principles of equality and justice but also the principle of respect for personal autonomy and responsibility. It is incompatible with the notion of human dignity which requests that all human beings deserve respect and recognition. Blum's distinction furthermore clarifies what makes the idea of race attractive, and thus persistent, especially in a medical context: it focuses on biological and genetic constitution rather than socio-economic conditions. If racial categories are features of the natural world, science can discover and describe those properties and make them relevant for medical treatment. Interpreting itself as an objective science, medicine primarily examines and elucidates the physiological basis of conditions that affect various racial groups. It assumes that this scientific approach does not imply a value judgment though concerns exist about possible misuses of this objective information. It is taken for granted that the use of the notion of race in research, medicine and biotechnology is not harmful in itself, and that potential abuses can and should be prevented. This assumption, however, is false since what motivates scientists to search for scientific explanations of racial differences is the fundamental belief that races exist. However, there is no scientific evidence that they do exist, and genomic studies show that genetic variation within racial populations is greater than between racial populations. For example, when it is argued that obesity in Black women has a physiological basis due to a genetically determined metabolism, this is not founded on an objective, value neutral hypothesis but presupposes the idea of race, i.e. the belief that Black bodies are essentially different, and have "innate" genetic abnormalities compared to White bodies (Tsai et al. 2020).

The continuing use of racial categories furthermore illustrates that racial categorizing is attractive since it favors a particular type of explanation. While obesity is a complex phenomenon, the focus is exclusively placed on biological, and specifically genetic explanations, disregarding the extensive literature on the influences of the social environment. Evidence that healthy food and food security are severely restricted because of racial inequities in income, wealth and distribution of community resources is not taken into account. Neither are the physiological effects of chronic stress due to interpersonal and systemic racism. This example illustrates that the persistence of the idea of race is linked to a particular self-interpretation of medicine as an objective natural science focused on biological explanations. Moreover, what the example clarifies is that racial distinctions have a particular practical purpose. While in the past, the category of race was used to classify conquered peoples, and to justify the control, domination, exploitation or enslavement of others, it is still useful nowadays to serve specific purposes. According to Roberts, applying this category to human beings introduces a political division: "... a system of governing people that classifies them into a social hierarchy based on invented biological demarcations" (Roberts 2011, x).

Classifying people according to race has consequences. The implication is that differences between humans cannot be ameliorated or eliminated through social policies and programs. Health and disease depend on physiological differences, on innate strengths and weaknesses. Health disparities therefore do not require social and economic policies but rather biological interventions: "A chief reason why genetic explanations are emphasized over social ones is that genetic causes can be treated with a pharmaceutical product" (Roberts 2011, 146). Racial classifications, even when they are no longer based on externally visible characteristics such as skin color, but are located at the molecular level—beneath the skin, as biological or genetic differences—are still associated with ideas of privilege and deprivation, superiority and inferiority, normality and abnormality, and thus have differential practical implications (Zack 2023). This is evidenced, as will be discussed below, in the idea that people of different races suffer from specific diseases. When Black bodies are viewed as biologically inferior to White bodies (which are taken as the norm, and control group), specific Black diseases can be distinguished (Yearby 2021). This is evidenced, for instance, in the idea that Black bodies have a higher tolerance of pain, resulting in reduced need for anaesthesia in surgery, or at least lower dosages of pain medication (Akinlade 2020; Ray 2023). It can also be seen in contemporary diagnostic algorithms and practice guidelines, with the practice of adjusting outcomes according to race (Vyas, Eisenstein and Jones 2020).

Given these consequences, it has been advocated that the concept of race should be eliminated in medicine and healthcare: the only way to end racism in healthcare is to stop using all references to race (Blum 2002; Yearby 2021). Particularly in some areas, such as medical genetics, the use of concepts of race is problematic and harmful and should be discontinued (Yudell et al. 2016). The counter-argument posits that the notion is medically useful, not because race as a biological category exists, but because it is indispensable to study the effects of racism on health, for example in epidemiological studies of the consequences of racism for health and health inequalities. Racism is a fundamental cause of health inequalities, either directly or indirectly through its impact on social-economic status, and it cannot be addressed without the notion of race. Thus, paradoxically, the concept is necessary to fight systemic racism in healthcare (Lorusso and Bacchini 2023). However, this strategy is precarious since the continuing use of the notion can strengthen the belief that biological and genetic differences are racially determined. If the notion is used it should be well-considered, explained and critically examined, avoiding any suggestion that there are hierarchical differences among human groups.

Nonetheless, the problem remains that a standard definition of race in medical, epidemiological or health services research is lacking, and that racial groups are heterogenous and not clearly demarcated (Braun et al. 2007). In biomedical publications it is often not clear how and why information on race (and also ethnicity) is collected (Kaplan and Bennett 2003). While many geneticists assume that human biology differs by race, they have difficulties in defining race and are unclear about the meanings of the race categories used (Fullwiley 2007). Reports on associations between genetic phenomena, health outcomes and race (or ethnicity) often do not mention how the race (or ethnicity) of research participants is determined (Shanawani et al. 2006). The most common method to assign race is self-identification, but it is not always clear whether it is on the basis of offered and preselected response choices or self-reporting (Moscou et al. 2003). Not all people identify with a single racial category, and self-identification may evolve over time so that responses vary in different contexts and will be difficult to compare (Kaplan and Bennett 2003). Lastly, collection of data on race and ethnicity in healthcare settings may be perceived as harmful by minority and marginalized patients themselves (Varcoe, et al. 2009). In response to these challenges, some have proposed the study of human diversity and commonality using other concepts than race (such as ancestry and geography) (Yudell 2016). But it is doubtful whether this will prevent the interpretation of these differences in racialized terms (Bradby 2012).

6.3 Race under the Bioethical Microscope

The conclusion so far is that the continued use of race in medicine should be regarded as a morally problematic practice. Bioethical discourse must therefore not just identify where and how the concept is employed but critically explore the reasons for its use, and seriously scrutinize it. This will require a shift in bioethical thinking and a critical stance towards routine practices of clinical medicine and biomedical research (James and Iacopetti 2021). Such a shift will contribute to the transformation of race-based medicine into a race-conscious, and ideally race-free medicine.

First of all, critical bioethical discourse should focus on the language used in clinical and research settings. Already in 1998, Bhopal and Donaldson argued that racial labeling of patients is misleading, inaccurate and superficial. Such labeling is often done on the basis of color with "white" referring to people who do not belong to specific racial and ethnic groups and who represent normality in comparison to others. They contended that we should abandon the use of terms like "White," "Caucasian," "Western" and "Asian" (Bhopal and Donaldson 1998). More than two decades later, racial classification and race names continue to be used in medical publications (Jablonski 2021). The label "Caucasian" has been used more than 7,000 times per year in publications since 2012; it was used 6,814 times in 2018, and 6,991 times in 2023 (according to a PubMed search in May 2024). Medical and science journals have recently updated guidance for the use of language and terminology referring to race and ethnicity (Flanagan et al. 2021). The term Caucasian should not be used as synonymous with White, but only to refer to people from the Caucasus region.

Fig. 6.1 Caucasian Biosphere Reserve in the vicinities of Sochi, Russian Federation. Photo by SKas (2016), Wikimedia, https://commons.wikimedia.org/wiki/File:Caucasian_Biosphere_Reserve.jpg#/media/File:Caucasian_Biosphere_Reserve.jpg, CC BY-SA 4.0.

Many other language indications are provided, for example racial and ethnic terms should be used in adjectival rather than noun form (e.g. Asian women rather than Asians). Giving more attention to language may not only reduce unintentional bias in scholarly literature but also reflect the significance of fairness and equity. The effect of editorial language policies remains to be seen. An example of change in medical terminology is Down's syndrome. Working in the 1860s with children with learning disabilities, John Langdon Down noticed that they shared a common appearance. On this basis he classified this congenital condition as "Mongolian idiocy" or "mongolism." Referring to Blumenbach's racial taxonomy, he assumed that these children were a regression or degeneration towards a lower race (Gould 1996, 164–165). At the end of the 1950s when the genetic cause of the syndrome was discovered, geneticists and physicians started to argue that another name should be used (e.g. trisomy 21) in order to avoid racial connotations. The use of the term "mongolism" diminished progressively (Rodríguez-Hernández and Montoya 2011). Since the term "mongol" is derogatory in many languages, the government of Mongolia asked the World Health Organisation to revise the naming, whereupon the Organisation in 1965 decided to abandon the term (Howard-Jones 1979). In 1975, Medical Subject Headings replaced the term with 'Down's syndrome'. However, the term "mongolism" continues to be used, especially in publications since 1980 (rising from 306 publications in 1980 to 2,054 in 2022, according to a PubMed search in May 2024). This example shows that racial terminology persists and that bioethical scrutiny of language will remain necessary.

Another area where the idea of race is influential concerns the perception of diseases and medical conditions. There is a long history of associating race with disease conditions and of regarding some diseases as specific to certain racial groups. A classic example is sickle-cell anemia, which was regarded as a "Black disease" in the United States, where it is most common among African Americans. This was viewed as evidence of essential differences between Black and White groups. Later discoveries showed that the sickle-cell gene provides some resistance to malaria; the difference is geographical and due to natural selection. The same gene is found in populations with different skin shades, and sickle-cell disease exists in Arab countries and India. In some parts of Africa where malaria is not prevalent, the incidence of sickle-cell anemia is lower. While in the US, there is a statistical correlation between Blackness and this disease, the explanation is not race (Blum 2002). Similar correlations have been found between asthma and hypertension: in these cases too, the idea has been put forward that racial groups have structural vulnerabilities due to their biological or genetic constitution, rather than accepting that these groups have higher exposure to harmful socio-economic conditions and systemic racism (Saini 2019). The high mortality of tuberculosis among Black populations, especially after the Emancipation Proclamation in the United States, was attributed not to deleterious living and working conditions, but rather to a racial predisposition, with the lung capacity of Black people presumed to be reduced and thus inferior (Braun 2014).

A more recent example is schizophrenia, which was constructed as a "Black disease" in the 1960s (Metzl 2009).

Another idea is that diseases manifest differently in Black bodies. Indeed, the rationale behind the Tuskegee Syphilis Study was the presumption that syphilis was a different disease in Black people: the view was that this group was especially prone to venereal diseases and also indifferent to treatment, thus anti-syphilitic treatment was unnecessary (Brandt 1978). The assumption that certain diseases are peculiar to specific races continues to influence contemporary medicine. Cystic fibrosis is underdiagnosed in African Americans today because the general idea is that this is a typical disease of White people (Rubin 2021). The same is true for autism. The stereotypical image of this disorder is that it primarily affects White children. In the United States, Black autistic children receive an accurate diagnosis years later than other children, although they present the same clinical symptoms (Fombonne and Zuckerman 2022). Delays in diagnosis lead to later access to quality intervention services (Constantino et al. 2020). In the Netherlands, the same is true for people with a diverse immigration background (Morocco, Turkey and Surinam). If they manifest atypical behavior, it is often attributed to their cultural origin (Stift 2024).

The idea of race is furthermore observable in the clinical setting. The notion that racial groups have different lung capacity and function, and that in particular Black people have lower lung function than White people, produced the practice of "race correction" or "ethnic adjustment." Since the value for normal lung capacity is based on measurements for White bodies, the values for other racial groups are adjusted and mostly reduced. Braun, who studied the history of the spirometer, the main instrument to measure lung function, shows how race correction is already programmed in the instrument itself (Braun 2014). Since "non-White" lungs are assumed to be inferior to the standard of normality, the spirometer can "objectively" demonstrate why they are predisposed to respiratory disease. It also means that disability claims in case of occupational hazards, for example in mining, are limited. The emphasis on innate differences in lung capacity implies that social and environmental factors can be ignored. The employment of separate standards in clinical medicine, based on the idea of racial differences, has come under increasing scrutiny, and has become a significant issue on the agenda of bioethics. It is evident that the establishment of "normal" values since the early nineteenth century has been based on studies of White populations (Crenner 2014), with Black subjects rarely included in research populations. The resulting White normality is now increasingly recognized as biased. In June 2023, for example, the American Medical Association decided that the body mass index (BMI) is an imperfect measure of healthy bodyweight. It is established on an imagined ideal of the "average" man, based on a sample of White, European men. Used for racist exclusion, it cannot predict the risk of disease on an individual level across different racial and ethnic groups (Berg 2023). Race norming is apparently embedded in numerous diagnostic algorithms and practice guidelines, predicting, for example, that Black patients are less likely to have a kidney stone, or have lower risk of osteoporosis. Such race-adjusted algorithms have harmful consequences since further evaluation of complaints may be postponed, and diagnosis and intervention delayed (Vyas et al. 2020). Measures used to calculate kidney function, including an often-criticized algorithm, are adjusted because they suggest that Black people have better kidney function. This implication often results in delayed referrals for specialist care or transplantation (Braun et al. 2021). Using different standards of normality in clinical medicine to account for disparities in health outcomes in racial populations may be justified if they are the result of genetic differences. But this is, according to Vyas and colleagues "exceedingly unlikely" (Vyas et al 2020, 879). In fact, adjustments presuppose the idea of races that are inherently dissimilar. Racial disparities in health outcomes most likely reflect the effects of racism. "Race correction" will only perpetuate and exacerbate the existing disparities since it will impede access to clinical services (Neal and Morse 2021). Artificial intelligence is now increasingly used in medicine, but since it relies on historical data based on biased data generation or clinical practices, the risk is that existing biases are propagated (Parikh et al. 2019).

Biomedical research is another area where the notion of race continues to be used. In order to improve the inclusion of persons from racial and ethnic minority groups in clinical trials, many guidelines have been issued since the 1990s. In the US, regulatory bodies and funding agencies such as the National Institutes of Health request the use of racial and ethnic categories in clinical research (generally using the categories of the Office of Management and Budget of the US Census Bureau) with the aim of expanding diversity and inclusion in research (Callier 2019). These classifications are now widely used in other countries, although terms and approaches to define population subgroups may vary considerably. In the United Kingdom, for example, eighteen options are offered with five main groups, including "Arab" and "Indian." While in the United States, race is distinguished from ethnicity, this is not the case in other countries. Most countries (65%) enumerate their populations by national or ethnic group, and only 15% employ the notion of race (mostly New World societies with histories of slavery). The term "nationality" is mostly used in countries in Eastern Europe and the former Soviet Union (Morning 2008). In countries such as France, Germany and Spain, ethnic classification as well as the use of "race" is legally prohibited (Gombault et al. 2023).

This diversity of classifications is problematic, especially for global research and cross-country comparisons. Terminologies and criteria differ substantially, and labels for racial and ethnic groups are often simplistic, but this is not merely a methodological problem, as Morning (2008) argues. Populations are mainly classified because of political concerns, and the debate about the (in)appropriateness of such classifications is primarily a normative one. Classification schemes are divisive, stigmatizing and marginalizing. They also promote the interpretation of human diversity in terms of biological and genetic differences, distracting from the examination of other determinants of medical conditions (Gombault et al. 2023). The basic ethical quandary is reflected in the ongoing debate about the use of racial and ethnic categories in biomedical research. On the one hand it is argued that such categories should be abandoned since they perpetuate the idea of race as an explanation of human diversity (Fullilove 1998; Yudell et al. 2016). On the other hand, the argument is that without reporting these categories, the underrepresentation of minority populations in research cannot be addressed, health inequities and different risk profiles cannot be understood, and effective health policies cannot be designed (Burchard et al. 2003; Dessie and Chen 2023). Although this last argument is ethically motivated, and certainly not racist, the risk is that it will sustain the idea of race as an explanation of human diversity. That this risk is not imaginary is shown in a conceptual analysis of recent publications about Covid-19 in which there is a prevailing tendency to biologize the categories of race and ethnicity (Malinowska and Żuradzki 2023). Despite the recognition that these categories correspond to genetic, socio-cultural and environmental differences, they are most often solely explained in terms of biology and genetics. Social and environmental factors influencing differences in health are usually ignored and not explored. The categories of race and ethnicity are not simply described but used as explanatory tools to analyze human diversity. Biogenetic reductionism may also clarify the fundamental paradox that the limitations and inadequacies of racial and ethnic designations are commonly known in the research community but nonetheless extensively used and reported. Although researchers desire to eliminate racial health disparities, biomedical research continues to promote a biogenetic rather than social interpretation of racial variation (Gutin 2019).

The last area where the idea of race persists is medical education. Examination of the content of courses in the preclinical medical curriculum shows that race is often misrepresented as a biological category. The language used to discuss health disparities may be imprecise and antiquated; racial and ethnic differences in disease burden are presented without context and critical discussion of underlying causes, such that they are attributed exclusively to genetic predisposition; race is portrayed as risk for disease, linking diseases to racial groups, and pathology in general to race; race-based clinical guidelines are taught without questioning their interpretation and evidence (Amutah et al. 2021). The various ways in which race is used in medical education therefore reinforces already existing implicit biases among students and physicians, and also makes the systemic racism embedded in biomedical approaches of health and disease invisible. Students have argued that medical education should be reformed in order to have a more critical evaluation of race (Tsai et al. 2016; Nieblas-Bedolla et al. 2020). What is needed is an examination of the historical and social context of race-based medicine (Braun and Saunders 2017). Programs to eliminate racial bias are necessary but not sufficient; attention should also be given to systemic racism, and to the tools and measures connecting this to negative health outcomes (Futterman et al. 2024).

This overview of where and how the notion of race is used in medical language, in labeling disease conditions, in clinical guidelines, in biomedical research and in education demonstrates how critical bioethical thinking can contribute to transforming race-based medicine. First, it is not sufficient to argue that the term "race" should not be used; it has generated and structured much of the scientific knowledge with which medicine operates. It is an ethical responsibility to critically re-assess the scientific basis for many contemporary theories and practices. Given the history of abuse, and the many imperfections in the use of racial categories, the evidence of past research involving racial variables should be re-examined and validated, while for future investigations the first question should be why such variables are used at all (Ioannidis et al. 2021). Second, employing the notion of race implies categorization and homogenization; it diverts attention from the unique situation of individual patients. Codes of medical ethics generally declare that the primary duty of physicians is to promote the health and well-being of the individual patient. The consequence is that it is important to know first of all the patient's history, family history and social context instead of assessing his or her race (Braun et al. 2007). To diagnose patients and understand differences in disease risk, it is better to work from symptoms, history and context than from racial assumptions (Futterman et al. 2024). Third, the notion of race persists due to the domination of biomedical perspectives that give priority to biological and genetic explanations. Too little attention is often paid to structural, social and cultural mechanisms that shape medical knowledge, so that the root causes of illness, and the sociopolitical and historical foundations of health inequities are not considered. This is often the result of lack of interdisciplinary approaches, as is particularly manifested in scientific research and medical education (Braun and Saunders 2017). The remedy is not only training in cultural competency and in awareness of bias and prejudice—since these are primarily focused on changing individual attitudes and behaviors—but emphasis should also be placed on social determinants of health. This requires "structural competency": the ability to discern how mechanisms and forces in society produce health inequities, social vulnerabilities and poor patient care (Metzl and Hansen 2014). The implication is that bioethical analysis should not only use a microscopic but also a macroscopic perspective.

6.4 Racism as Bioethical Issue

As explained in the previous chapter, the concept of race emerged in the seventeenth century, whereas the term "racism" has only been in use since the early twentieth century.. This recent history, however, does not imply that the phenomenon of racism did not exist before the term was coined. The practice of racism can be traced back to the late medieval and early modern periods of European history (Fredrickson 2002). Following the atrocities of the Second World War, racism was generally condemned and prohibited in national and international legislation. However, it is remarkable that in most cases and documents the term is not defined. For example, the Council of Europe set up a European Commission against Racism and Intolerance in 1993 to monitor action against racism, discrimination, and intolerance in Europe, but it does not describe what is regarded as racism (Council of Europe 2024). In response to questions from the European Parliament, the European Commission defined racism as "Ideas or theories of superiority of one race or group of persons of one colour or ethnic origin" (European Commission 2024). In the United Kingdom, the Equality Act 2010 relates racism to less favorable treatment on the basis of race, skin color and ethnic or national origin (Gov.UK 2015). According to the Dutch government, racism is a theory, idea or opinion implying a subdivision of human beings on the basis of presumed race, and considering one or more groups as superior or inferior (Ministerie van Binnenlandse Zaken en Koninkrijksrelaties 2022). The most extensive description is provided in the *UNESCO Declaration on Race and Racial Prejudice*: "Racism includes racist ideologies, prejudiced attitudes, discriminatory behavior, structural arrangements and institutionalized practices resulting in racial inequality as well as the fallacious notion that discriminatory relations between groups are morally and scientifically justifiable" (UNESCO 1978). As argued in the previous chapter, this formulation highlights two characteristics of racism: inferiorization and antipathy. It clarifies that racism concerns not only an ideology or worldview but practices and behaviors resulting in differential treatment, stigmatization, marginalization, exclusion and discrimination.

Race and racism are closely connected. It is evident that the first is presupposed in the second. Racism assumes the belief that people are intrinsically different because they have innate and unchangeable characteristics due to a specific biogenetic constitution or ethnic identity. The assumption that removing any references to race would eliminate racism is too simplistic. For decades, it has been argued that races have no biological or genetic reality; but racism persists as long as people assume that they exist, even if it is clear that they do not exist. Moreover, the idea of race is not merely an individual belief but is embedded in practices, structures, organizations and policies, as the previous section of this chapter has demonstrated. Most people in contemporary societies do not endorse the idea of race, and will reject explicit and implicit racial bias. Nonetheless, systemic racism subtly, covertly and unconsciously sustains the significance of race. Scholars have therefore argued that race is, in fact, the product of racism (Roberts 2011; Bonilla-Silva 2022). As long as the racial ordering of the world continues, race will remain a relevant notion. This is the reason why colorblind policies—pretending not to see the color of somebody's skin—are inadequate to eliminate racism. While it is crucial to deconstruct the notion of race and its uses in medical settings, it is equally, perhaps more, important to morally denounce, challenge and eliminate all forms of racism at all levels in healthcare.

Racism as an ideology and practice influences relations among human beings as well as the functioning of human societies. It promotes certain ideas about racial purity, superiority and inferiority with practical consequences for how human beings live together. Ethical discourse is concerned with the quality of human co-existence, and reflects on what ought to be done to make the human condition better, or at least to counteract its deterioration. Against this backdrop, racism is definitely an ethical issue since it negatively impacts how human beings live together. There are several arguments why racism is morally wrong from the perspective of bioethics.

The most common argument is that racism is harmful. Through direct and indirect discrimination, implicit biases in personal interactions, and systemic racism embedded in structures, organizations and practices it harms people physically and psychologically—and within the context of healthcare, patients in particular. Such harms are preventable if attitudes, beliefs and behaviors, as well as structures and systems were not racist. However, harmful effects of racism also have a specific characteristic since they are not incidental but occur in a more permanent and durable manner. Harms arise "in enduring ways" since they are the result of historical legacies which have created disparities, socio-economic and power differences that continue to determine how people relate to each other even today (Johnstone and Kanitsaki 2010, 491). For bioethics it is relevant that racism produces harm at three levels (Russell 2022). Health is dependent on a range of physical, social and environmental conditions such as employment, healthy food, safe living conditions, educational opportunities and unpolluted environments. However, some groups of people experience negative influences of socio-economic determinants of health because of residential segregation, lack of decent employment, food deserts, less access to education and public transportation, and contaminated drinking water. Reduced capacities and resources for health are associated with socio-economic status, but even when socio-economic status (and individual behavior) is taken into account, disparities between White and Black populations continue to exist in the United States (Yearby 2021).

Reducing health disparities should also attend to racism as a source of inequality, particularly the negative health effects of pervasive discrimination. The harm of racism is also manifested at the level of healthcare. Earlier, many examples were given of lack of access to healthcare and lower quality of care for racial minorities. Such disparities are often explained in terms of health illiteracy, lack of cultural competency and socio-economic context, but not in reference to racism. Finally, racism is harmful at the level of the healthcare system. Russell argues that it explains the resistance to the development of more equitable and inclusive healthcare systems in the US. Neoliberal policies and the ideology of free-market competition perpetuate stereotypes that portray some groups, particularly White individuals, as motivated and responsible, while depicting others, especially non-White individuals, as lazy, dependent and irresponsible (Russell 2022). This argument illustrates that the harms of racism not only impact racialized groups but everybody in need of equal and competent healthcare (Yearby 2021).

Another bioethical argument that racism is objectionable emphasizes the ethical principle of justice. Racism implies differential and unfair treatment, and is therefore unjust because it violates the notion that all humans should be equally treated. On this basis, racial discrimination is nowadays explicitly prohibited. When racial attitudes, beliefs and behaviors still occur, they are usually considered as incidental and exceptional, and as symptoms of prejudice and implicit bias. However, this interpretation of justice as equality does not address systemic racism. Racialized minorities face unjust social arrangements as a result of historical systems of oppression, domination and exploitation which have produced deep inequalities in wealth, political power, employment and educational opportunities which still exist today. In order to create a just society, it is not sufficient to treat people equally (on the basis of the notion of equality) but it is necessary to provide equal opportunities (on the basis of the notion of equity). Rather than equal treatment, it is necessary to remove inappropriate and unjust barriers that obstruct people of color more than others in society (Shelby 2014). It is important therefore to recognize different concepts of justice to counter racism. Frequently used is the concept of distributive justice: equal distribution of harms and benefits. It acknowledges that different parties are in unequal positions and aims to establish a fair distribution of goods and services. But the underlying causes of maldistribution of resources are usually not taken into consideration. Resources must be distributed fairly, but why has the need to (re)distribute arisen in the first place? That injustice is more than maldistribution is, for example, argued in environmental justice movements (Ten Have 2019). Dumping toxic waste in minority neighborhoods is wrong because it disregards the health and well-being of racialized minorities and does not respect them as citizens. Without addressing the context of oppression and inequalities of power, the interests of racialized groups are ignored, and fair distribution of resources will not ameliorate the injustices. Respect and dignity are preconditions for distributive justice.

Given these critical considerations, the concept of social justice is better applicable in relation to racism. It highlights the social structures and mechanisms that produce systemic racism. Instead of discussing issues of access to healthcare and distribution of resources for those who are harmed, it primarily accentuates how people are made vulnerable and how their health is negatively impacted. Focusing on the social and institutional conditions that produce inequalities will enable critical analysis of the power differences and inequal structures that make racialized groups more vulnerable than others, and will also provide insights into how these structures can be transformed and remedied. The perspective of social justice furthermore directs attention to the fact that the racial structure of society disadvantages racialized minorities and benefits the White majority. Existing social structures, practices and relations reinforce White privilege, which is regarded as unjust since it results from a historical legacy of slavery, colonialism and exploitation (Bonilla-Silva 2022). A third concept to remediate racial injustices is restorative justice. This concept articulates that it is more important to identify who is hurt by racism and who is accountable and obligated to amend the harm done, than to search for who or what is to blame and deserves retribution. Addressing and repairing the harms of racism requires recognizing the suffering of individuals and understanding the ongoing, damaging influences of the past (Minow 2022). Such healing efforts can target both interpersonal and systemic racism. Only recently (July 2023), the King of the Netherlands officially apologized for the country's role in slavery. In several countries, slavery monuments and museums have been established, memorializing the history and legacy of slavery and the slave trade. Commemorative events, such as Juneteenth in the United States, mark the end of slavery, while the United Nations General Assembly designated March 24 as the annual International Day of Remembrance of the Victims of Slavery and the Transatlantic Slave Trade.

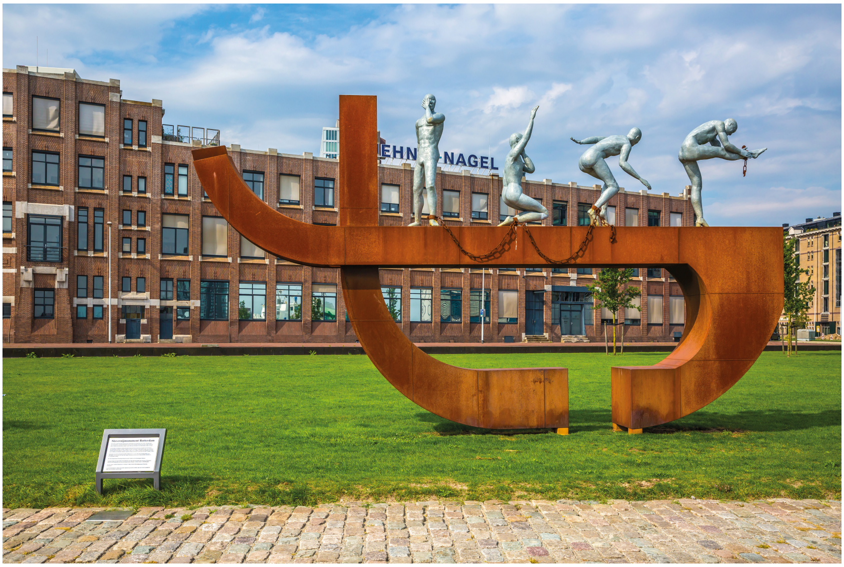

Fig. 6.2 Alex da Silva, *Slavery Monument* (2013), Rotterdam. Photo by GraphyArchy (2020), Wikimedia, https://commons.wikimedia.org/wiki/File:GraphyArchy_-_Wikipedia_00706.jpg#/media/File:GraphyArchy_-_Wikipedia_00706.jpg, CC BY-SA 4.0.

A third bioethical argument against racism is rooted in the principle of human dignity. The notion of race originated during the Enlightenment as a means to justify persistent inequalities in Western European societies, where equality was proclaimed as a moral and political ideal (Malik 2023). The discrepancy between ideal and practice was bridged by categorizing people into racial groups and associating different qualities with each race. This idea of race was attractive since it not only explained inequality but was also actionable: if some groups are deemed subhuman, they are not entitled to the same treatment as those considered fully human. Moreover, if differences are based on race, they are permanent and inalterable, and policies to change the social context or educational efforts are futile. The basic moral problem with this view is dehumanization: members of a subordinated group do not have the same moral standing as others (Shelby 2014; Bonilla-Silva 2022). This clearly violates the notion of human dignity, which posits that all human beings have intrinsic dignity and equal moral worth. While this concept is not exclusive to Western thought, with deep roots in various religious and cultural traditions (Andorno and Pele 2016), the modern notion of human dignity emerged in the mid-twentieth century. Before that time, more limited conceptions were advanced, such as the idea of moral dignity in Western Antiquity (emphasizing that humans are capable to develop moral ideas and virtues), and spiritual dignity in Christian theology (the human person as created in the image of God) During the Enlightenment, the idea of dignity was related to rationality.

Nonetheless, these ideas of dignity were limited and not universally applied to all human beings. For example, as discussed in the previous chapter, Immanuel Kant accepted a fundamental difference between White and Black races, assuming only the White race to be capable of moral progress, such that moral agency is primarily a characteristic of White European men. This changed in the twentieth century with the growing significance of the human rights discourse, resulting in the *Universal Declaration of Human Rights* (1948). Article 1 of this Declaration states that "All human beings are born free and equal in dignity and rights" (United Nations 1948). This transformed the concept of human dignity not only into a universal moral principle but also a legal and political one, incorporated into national and international legal documents. It has also been accepted as an overarching principle in modern bioethics.

For the ethical context, it is important to notice that human dignity has two aspects. As an abstract and theoretical notion, it applies equally to each individual human being, regardless of characteristics or conditions such as race, age, gender or (dis)ability. It is an intrinsic quality that does not depend on whether it is respected or recognized, or whether it is disregarded by authorities or political systems. The other aspect is that human dignity is a practical phenomenon, a lived experience (Bieri 2017). It is not merely an intrinsic but also a relational quality, since it refers to how humans are and should be treated. Human beings can experience how their dignity is disrespected, denied or lost. Social science research clarifies that the most salient experiences of racism are those of being disrespected, underestimated and ignored (Lamont 2023, 65). The principle of human dignity emphasizes that persons and things are different. Because they have intrinsic and equal dignity, human persons are subjects who should be respected and protected; they should not be used as things that can be owned, exploited for various purposes, or exchanged as commodities. The principle protects subjects against objectification, inferiorization and exploitation. Racism is therefore morally unacceptable since it negates the two aspects of human dignity: denial of the intrinsic moral worth of all human beings, and alteration of human interaction into experiences of humiliation, disrespect, lack of recognition and discrimination. Both aspects derive from the awareness that all human beings share fundamental needs and vulnerabilities, making human dignity the basis for mutual respect and care in decent societies across the world.

6.5 The Color of Bioethics

In dealing with issues of race and racism, bioethical discourse generally follows the policy of colorblindness that has become prevalent in many Western countries. The assumption is that over the past sixty years, due to the civil rights movement, social welfare policies and stringent legislation, racial discrimination and inequality have ended: the idea of race has become obsolete and racism discredited. Since the law requires that individuals should be treated similarly, racial identity is irrelevant and race should not play any role in social life. Against this background, it is preferable not to see color, demonstrating that racism is history. When instances of racism nevertheless occur, they are explained from the perspective of individualism. Persistent racial discrimination is due to the biases and prejudiced attitudes of some individuals, and continuing racial inequalities are the result of failure and lack of effort of individuals who do not take responsibility for their lives. The general change in normative climate in the 1960s and 1970s that made overt and explicit racism unacceptable and instigated the rise of colorblind policies has also resulted in the emergence of bioethics. In this new discipline, respect for personal autonomy has become one of the most important ethical principles. It articulates the rights and responsibilities of individuals as well as the value of individual choice. Race and racism do not play a significant role in bioethics discourse because ethical principles such as respect for personal autonomy but also justice (and equal treatment) provide a normative perspective that makes these notions irrelevant. Colorblindness as the prevailing policy in Western society is thus reflected in bioethics, and may be the reason for neglect of race and racism in bioethical discourses and practices.

Since the turn of the millennium, colorblindness has faced growing criticism. Numerous studies show that racism is not merely a relic of the past but continues to play a significant role in many societies, although in a more subtle and covert way (Neville et al. 2013; Bonilla-Silva 2022; Brown et al. 2023). There is a serious difference between what people say about its unacceptability and their actual behaviors, as explained in the previous chapter. More importantly, critics argue that colorblindness is based on a specific understanding of racism. It regards racism as an individualized phenomenon, and associates it with prejudices and behaviors of individual persons, but does not consider it as a systemic phenomenon, produced by "systems of advantages and exclusion that generate privilege for one racially defined group at the expense of another" (Brown et al. 2023, 43). Most importantly, pretending not to see colors results in denying racial inequalities and discrimination in societies, and in ignoring the different practical experiences of racialized groups. Critical discussions of skin color, racism and discrimination are avoided because the dominating belief is that everybody is similar and equal. By asserting that everyone is equal, colorblindness effectively overlooks racism and therefore sustains inequalities.

Another view is that bioethics should be race-conscious and accept that it has a particular color, namely white. This is the argument discussed in the last chapter. Bioethics should recognize that it has emerged in a particular social and cultural context that takes the norms and values of White people as a self-evident starting point. It should interrogate the underlying assumption of White privilege in its normative framework. Rather than being blind to colors, bioethics should name and recognize differences between people, starting with an acknowledgment of its historically situated perspective. Here, Whiteness refers not merely to the skin color of practitioners but to a cultural norm that influences its normative framework. This shift requires reversing the usual focus: instead of primarily emphasizing the deprivation and discrimination of people of color, attention must also be directed to how the White population is systematically advantaged.

The idea that bioethics has or should adopt a particular color is gaining popularity. In April 2024, the University of Bristol organized the first conference on Black and Brown in bioethics (University of Bristol 2024). There are also advocates of green bioethics, focusing on environmental values and the impact of healthcare practices on the environment (Richie 2018). What these differently colored notions of bioethics have in common is that they direct attention to issues that are relatively underdeveloped in the current theory and practice of bioethics. They generally do not argue in favor of a more narrow or particular view of bioethics focused on one specific issue or theme, resulting in what has been called "balkanization" of bioethics (Baker 2003). What the attribution of specific colors to bioethics illustrates is the necessity of a broader perspective that does more justice to the diversity of people and viewpoints in bioethical theory and practice. Labeling bioethics as White can be taken up as a call to incorporate in bioethical discourse and practice voices, values and visions of populations other than White. It can furthermore be regarded as an appeal to expand moral criticism beyond the perspective of the individual person, and to focus on the cultural, social, political and economic context of health and healthcare, and the underlying systemic mechanisms that produce injustice, inequity and vulnerability—just as labeling bioethics as green refers not to skin color but to the need to attend to environmental concerns that are relevant for health and healthcare. The question posed by these differently colored notions of bioethics is whether they can sufficiently address the socio-cultural and ecological challenges of diversity and difference as they exist across the world. This question has motivated the recent emergence of global bioethics. The confrontation with a range of ethical issues in various contexts as well as divergent normative standards in different parts of the world has instigated a search for shared values and common ideals, while at the same time recognizing that not every global citizen is the same and neither has equal power to cope with the challenges of health and healthcare. In this global perspective, bioethics should be conscious of racism and its consequences, and thus colorful, rather than colorblind or associated with a specific color.

6.7 Ethics and Aesthetics

The theory of color relationism, presented in Chapter 2, postulates that colors are situated between the objective and subjective world. They are first experienced before they are analyzed and interpreted. Quintessentially, they directly address our emotions and feelings because they evoke immediate associations and meanings. Perceiving colors is not merely an observation of the surrounding world but at the same time a normative and aesthetic experience. Taking seriously this typical character of colors has implications for the conception and methodology of ethics.

Bioethics is commonly regarded as a conceptual and abstract system of moral principles and rules, elaborated in ethical theories and codified in legal statements and guidelines. Its general method is to analyze moral dilemmas on the basis of rational reflection and arguments, using clear and transparent procedures for decision-making in medical practice. Although facts and values in healthcare are often emotionally charged—for example, with fear, sadness, anxiety, grief and also disgust, indignation and moral outrage—emotions and feelings are usually regarded as obstacles to rational analysis; they must be controlled before the proper deliberative process can take place. This conception of bioethics is nowadays increasingly criticized (Ten Have 2016; Ten Have and Pegoraro 2022). One argument is that principles require interpretation and cannot directly be applied to moral problems in order to provide clear-cut answers. For instance, when a treatment is recommended, an assessment should be made of possible benefits and harms. But what is beneficial or harmful might be different from the perspective of the patient or the healthcare provider. If the patient does not want a treatment that is clearly beneficial, the healthcare provider should balance the ethical principles of respect for patient autonomy, beneficence and non-maleficence. Another argument is that ethical decision-making is not an abstract and decontextualized process but always takes place within a specific and concrete context and clinical practice. Because human beings are necessarily situated, ethical reasoning draws heavily on the moral experiences of the persons involved. A more fundamental criticism is that moral judgments and decisions are not merely rational but influenced by values and emotions which determine what is morally relevant and significant. Before a moral judgment can be made and before moral reasoning and rational deliberation can take place, situations with which we are confronted must be perceived as important from a moral point of view. These critical views point to the crucial role of moral perception in ethical discourse. Perception requires moral sensitivity. It is also facilitated by the moral imagination that enlarges perspectives and that situates the moral subject in the specific conditions and concrete circumstances of other people. Before engaging in rational analysis, it is important to articulate why a particular situation, experience or problem ethically matters, why it affects us as moral beings.

The role of moral perception in ethical discourse highlights the connection between ethics and aesthetics as the science of sensory perception (Macneil 2017). The ancient proverb *verum, pulchrum et bonum convertuntur* ("truth, beauty and goodness are interchangeable") expressed that, in traditional philosophy, truth, beauty and goodness refer to the same underlying reality, and that science, aesthetics and ethics are thus interconnected. In modernity, these domains of human activity are usually separated. Ethics is practical reasoning concerned with what is good and right. Its aim is to determine what ought to be done with the help of moral principles to guide rational arguments and deliberations. Aesthetics is concerned with beauty and it involves the senses rather than rationality, especially when colors are concerned. Because senses are considered to be less reliable than reason, aesthetics is regarded as a matter of affection and intuition, thus personal taste. Science aims at approximating the truth of reality with empirical methods and with systematic reasoning based on facts and data. However, the distinction is problematic and inconsistent. For example, in science the separation from ethics is contested since scientific theory and practice is influenced and shaped by values and normative presuppositions (Ratti and Russo 2024). At the same time, scientific theories, methods and results are frequently chosen, preferred and presented on the basis of aesthetic criteria such as simplicity and elegance (Derkse 1992). The connection between science and aesthetics is also evident in eighteenth-century racial taxonomies. For Blumenbach, the White race comes first because it is the most beautiful, and for Kant this race has the most beautiful body. Conceptions of beauty at that time were based on classical art, with white marble Greek and Roman statues as the primary examples. It was also the reason why Blumenbach used the term "Caucasian", a region he associated with the most beautiful people. Aesthetic preferences continue to play a role in present-day "colorism" as a basis for racial discrimination. Cultural preferences for lighter skin are motivated not only by ideals of beauty but also social advantages associated with whiter skin tones. These ideals have generated a widespread global practice of skin bleaching (Hunter 2007; Jablonski 2012). In many countries, cosmetic preparations are advertised and used with the promise that lighter skin may bring relief from discrimination, and contribute to social advancement, as if a dark skin is a disease to be cured.

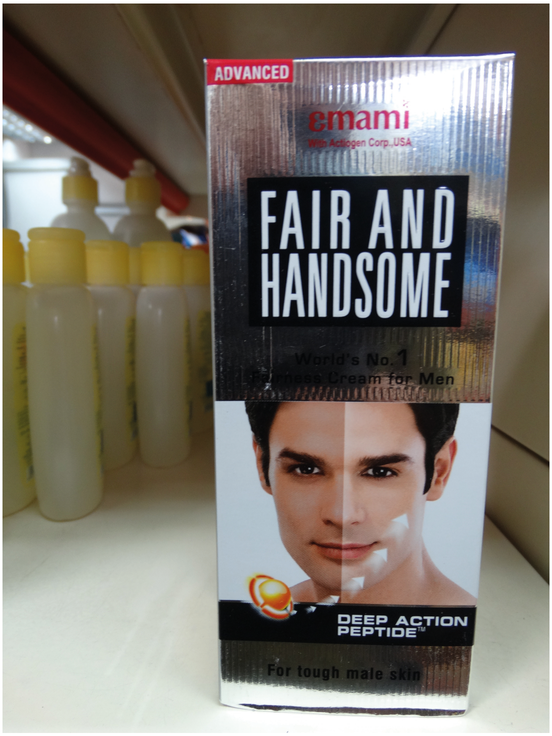

Fig. 6.3 Skin-whitening product in supermarket in Sri Lanka. Photo by Adam Jones (2014), Wikimedia, https://commons.wikimedia.org/wiki/File:Fair_and_Handsome_-_Skin-Whitening_Product_in_Supermarket_-_Bandarawela_-_Hill_Country_-_Sri_Lanka_(14122094934).jpg#/media/File:Fair_and_Handsome_-_Skin-Whitening_Product_in_Supermarket_-_Bandarawela_-_Hill_Country_-_Sri_Lanka_(14122094934).jpg, CC BY-SA 2.0.

That ethics and aesthetics can be connected is furthermore argued by Bueno Pimenta and Garcia Gomez (2023). In their view, the organization of global ethical principles in the *UNESCO Universal Declaration on Bioethics and Human Rights* is a display of beauty. Contemplating these principles is like an aesthetic experience since it transcends cognitive relationships and reveals the various dimensions of being human and the possibilities of human improvement. Aesthetics is not simply picturing, detecting or seeing but evaluating, seeking to see the world anew. It moves from seeing to seeing differently. It is "a general engagement with value, and so it is an ethical undertaking" (Noë 2023).

The term aesthetics is derived from the Greek *aisthánomai* which means perceiving, feeling and sensing. What is beautiful or ugly has an immediate sensory presence, unlike what is true or good. Aesthetic impressions and judgments are based on human sensitivity, imagination and intuitions, and as such assumed to be possible sources of error. Colors provide a standard example: they can be attractive or repulsive, warm or cold, and immediately evoke certain feelings and emotions. But they can also be deceitful; depending on the context they may be illusory or concealing. Colors are like a skin that covers an underlying reality. In the distinction usually made between ethics and aesthetics a similar contrast between the profound and the superficial seems to be at work. Proceeding from rational arguments and deliberation, ethics is the search for goodness, and it identifies reasons for and against acts and decisions that should ultimately convince everyone and provide justifications independent from personal beliefs and preferences. Aesthetics, on the other hand, aims to understand the nature and appreciation of beauty. The aesthetic experience, for example when we view a painting or listen to music, is first of all subjective, eliciting emotions and feelings, or influencing our mood or attitudes. The pleasure that we feel is immediate, and not the product of conceptual thought, analysis or reasoning. Detecting and evaluating are entangled in the aesthetic experience (Noë 2023).

Conceiving ethics as a rational and deliberative activity has currently become problematic. Cognitive psychology research shows that there are in fact two cognitive processes for making a moral judgment. One is a reasoning process as exercised in moral deliberation. It is a conscious process that is analytical, controlled and unfolds in subsequent steps. This is the process generally presented as the paradigmatic method of bioethics. However, there is a second process that, in practice, is more frequently used: it is an intuitive process which is immediate and automatic, based on feelings and emotions, and operating more quickly than reasoning and deliberation. Empirical studies demonstrate that most moral judgments are made through this intuitive process (Haidt 2001). It is therefore problematic to argue that moral judgments are the product of reasoning; they are, in most cases, more correlated to moral emotion than to moral reasoning. At the same time, moral reasoning is used but after a moral judgment has been made. While emotions trigger an intuitive response and result in an immediate moral judgment, moral analysis and deliberation start *post hoc* to offer justifications to others for our moral judgments. This point of view offers a new appreciation of emotions and feelings in bioethical discourse, and as such obliterates the usual separation of ethics and aesthetics. Emotions and feelings should no longer be regarded as obstacles to rational and disinterested moral decision-making but are a necessary and prior ingredient of moral judgments. Moral perception and sensitivity are at least comparable to aesthetic experience; they not only determine what is morally significant but they also provide, so to speak, the "material" for subsequent rational analysis and deliberation.

When we admire a painting and tell a friend that it is beautiful, she might ask why. When we are uneasy, and perhaps angry, with the conduct of a health professional who does not show respect, we comment to a friend that such behavior is wrong and should not happen. Again, she may ask us why. In both examples, an intuitive judgment is directly made which then triggers an exchange leading to a reasoning process. Aesthetic and moral experience are comparable in the sense that both accentuate the role of emotions and feelings in judgments about beauty and goodness. Simultaneously, it is clear that the analytic reasoning that clarifies the judgments made differs. In the first case, the friend might answer that beauty is subjective, a matter of taste, and that she does not like the painting at all. In the second case, a similar answer would not be satisfactory. If our friend points out that the health professional is a nice and competent person who has no intention of offending us, we will feel not be taken seriously. Our emotional response is motivated by moral concerns; something has happened that ought not to happen, whether or not the person involved is nice or competent. The reasons we provide for our uneasiness and indignation go beyond the level of psychological interaction or individual taste; they refer to what is wrong and unacceptable in any interaction of this kind in the setting of healthcare, whoever is involved and wherever it takes place. The intuitive judgment that this is not how healthcare providers and patients should interact with each other is justified with reasons and arguments that apply to human interaction in general. At this *post hoc* level moral deliberation is used to analyze the various aspects of the problem, to distinguish facts and values, and to identify the relevant ethical principles.

It is important to note that moral reasoning and deliberation take place in a social context. We develop arguments in response to the comments of our friend, and in general when confronted with the reasons of other persons. Facing the perspective of others, we might actually change our intuitive judgments. Ethics necessarily is a social activity, which is not evident for aesthetics. Perceptions of beauty may differ among persons, and it may be difficult to convince another person that they should appreciate a painting because I find it so beautiful. In the search for goodness, views may also differ, but at least arguments can be exchanged as to why certain behaviors are good, desirable, commendable or not. These arguments do not express my personal preferences but appeal to what is good for all human beings. Ethical discourse assumes that human beings are not isolated, self-reliant individuals but social beings, connected with others, embedded in social and cultural contexts, and sharing common interests. With moral reasoning and deliberation, humans try to identify the values that they share and that provide a common framework for society. The capacity for moral deliberation is "a kind of social cement" that binds groups together because it confronts the first-person perspective with the perspectives of others and appeals to common perspectives (Christakis 2019, 409).

If moral experience is like aesthetic experience in the sense that it immediately and automatically implies emotional responses producing an intuitive moral judgment, the significance of color in bioethical discourse should be re-evaluated. The prevailing assumption that color must not play any role in normative assessment is the conclusion of moral reasoning. But this conclusion follows after a moral judgment has already been made on the basis of an immediate intuitive response to color. We have discussed in earlier chapters how colors in general evoke immediate associations which are then analyzed and reflected upon. Colors are associated with specific virtues such as honesty, rationality or dignity, or on the contrary, with different vices. This is particularly true for black and white. Colors express meaning and significance; they symbolize normative values. This has been visible in dress codes used to indicate social status and class. They were also used in a more negative way to stigmatize and exclude others from normal social life. Colors therefore play also a social role since they have a particular purpose of ordering, identifying and classifying human and social environment. In this sense they help us to orientate ourselves in the world. The symbolic value and functional role of colors are clearly noticeable when colors are connected to the idea of race. Their meanings are projected onto human beings through their skin, influencing perceptions of their appearance; and colors have been functionally used to construct taxonomies of human races based on judgments of superiority and inferiority. Studies show that the implicit evaluative associations with the colors white and black are systematically correlated with evaluative racial associations (Smith-McLallen et al, 2006). The suggestion is that color preferences form the primary basis for racial preferences, and may well precede racial biases since they are learned early in life.

The main conclusion earlier from historical analysis of the influence of colors is that meanings and associations are changeable. They are not so much determined by the colors themselves, as well as mediated and reinforced in social and cultural interactions and learning processes. The significance of colors has changed over time, as well as in different cultures. During the Reformation, black was regarded as the most dignified and sincere color, while in the Victorian era white was considered as the epitome of beauty. The color blue was, for a long time, not appreciated in Western cultures. Viewed in Ancient Rome as the color of barbarians, in the Middle Ages it became a divine color. Yellow, on the other hand, was adored in European Antiquity when it was associated with gold, the sun, and energy, power and joy. It was also omnipresent in daily life in Eastern cultures. In China, the home of the Yellow Emperor, it was reserved for the emperor. In the Middle Ages in the West, it was transformed into a symbol of treason, deception, envy, jealousy and dishonesty and used to stigmatize and exclude people such as heretics, prostitutes and the mentally ill from society. It also referred to Jewishness and the synagogue. Medical practice amplified the bad reputation of yellow: doctors used uroscopy to diagnose diseases, and associated yellow with liver disease, malaria, pus and putrid fluids, and mold. The chromophobia of Protestant reformers made yellow almost disappear from public life. In Islamic cultures yellow was similarly unfavorable, being considered the color of lying and treachery, as well as of disease and ageing. In surveys on color preferences in the West, it has been the least popular of the basic colors consistently since the 1880s (Pastoureau 2019).

Changes in the normative appreciation are furthermore evident for the color green. In Western cultures, green was for a long time disliked and regarded as a bad color, associated with the devil, monsters and ghosts. Its association with poison grew with the use of green pigments used in paint, which often contained arsenic. In Islamic countries, green was always a positive color, referring to paradise. For Protestant reformers, green was to be avoided as a frivolous and immoral color; it is the color of avarice. Only in the Romantic era, and the second half of the eighteenth century in Europe, did green become a more dignified color, as a symbol of life, vitality and renewal, focusing attention on nature, and as a sanitary color, pointing to health and hygiene. For scientists and painters in the nineteenth century, green became the opposite of red. Nowadays, green has strong moral connotations: ecological responsibility, sustainable development, concern for biodiversity and nature, and protection of the environment (Pastoureau 2014). Similar changes in normative associations have taken place historically and culturally in connection to the colors white and black, as discussed previously.

The normative meanings and values of colors are changeable because they are the result of social and cultural processes. They are learned since early experiences in social and cultural settings that associate specific colors with particular moral qualities. They are also expressed in language and communication. Since value systems of cultures change and because various cultures interact and exchange values with each other, the meanings of colors have been transformed.

The upshot is that when the meanings of colors are the result of social learning processes, their normative associations can be unlearned and transmuted. This is particularly relevant in regard to racial biases. When evaluative associations with white and black are learned and reinforced, and subsequently connected to racial preferences, they can be influenced by cultural, educational and linguistic practices. For bioethical discourse, this means that we should reach behind the denial or trivializing of racial biases due to the general assumption that such biases should not play any role at the explicit level of moral reasoning and deliberation. Bioethical analysis should focus on the emotional level of automatic, unintentional and unconscious processes at which color associations and implied normative evaluations arise, and that produce immediate moral judgments. Implicit associations and biases should be brought to the surface and made explicit and conscious, and we should analyze how they operate, even if we are not aware of their influence. "Automatic thinking" is now an important subject of cognitive sciences, showing how unconscious associations and implicit racial and ethnic bias are malleable (Blair et al. 2001; Rudman et al. 2001; Burgess et al. 2007; Matthew 2015). Mesman, for example, argues how associations between black and bad, white and good, can be toned down when people are made aware of the ways in which our language use evokes and reinforces certain associations. Alternative stories and images also contribute to changing the automatic associations of colors since they enrich the image of the "other" (Mesman 2021). What is needed are narratives and images that empower people, recognizing the value of their experiences, and articulating inclusion, "extending dignity to all groups" (Lamont 2023, 113).

6.8 Moral Imagination

When it is concluded that ethical reflection and moral deliberation are not entirely rationalistic processes but connected to intuitions and emotions, bioethical analysis should focus on the intuitive stage in which moral judgments immediately and automatically emerge. Methodologically, this will require not only moral reasoning but moral sensitivity and moral experience in order to understand why and how we perceive particular situations as morally significant and relevant. But it also requires moral imagination. This is the ability to detach ourselves from our actual situation, taking us beyond the limitations of our empirical experiences. The French philosopher Gaston Bachelard (2014) celebrates the imagination as a creative faculty which allows human beings to surpass and escape reality as given.

Fig. 6.4 Gaston Bachelard (1965), Dutch National Archives, The Hague. Photographer unknown, uploaded by Anefo, Wikimedia, https://commons.wikimedia.org/wiki/File:Gaston_Bachelard_(kop)_filosoof,_Bestanddeelnr_917-9599.jpg#/media/File:Gaston_Bachelard_(kop)_filosoof,_Bestanddeelnr_917-9599.jpg, CC0.

Imagination empowers us to empathize with others because it enlarges our horizon and widens our sympathies, helping us to recognize situations that demand moral reflection and action because we become aware of values that go beyond the limits of our own experience as well as the moral demands that others place upon us.

The essential purpose of imagination in bioethics can be clarified with what traditionally has been called the moral point of view. Ethics as a human activity exists because our sympathies are limited. At the same time, not everyone has similar sympathies. The object of moral evaluation is to contribute to the amelioration of the human predicament. Moral discourse seeks "to countervail 'limited sympathies' and their potentially most damaging effects", in other words, to mitigate the ill effects of indifference of persons to other persons (Warnock 1971, 26, 149). In order to reduce the potential of conflicts, we are encouraged to take the point of view of other persons. In the history of ethical discourse, the circle of moral concern has expanded: more and more beings are taken into account as morally relevant. Against this background, the crucial feature of ethics is the ability to shift perspectives. Even if we start from our own intuitions and emotions to develop a first-person point of view, our ethical life is shared with others obliging us to take into consideration second-person perspectives, initially from people to whom we are attached. The dynamics of social interaction stimulates reflexivity because we recognize that the point of view of others is different from our own. Ethical sensibilities and intuitions are formed through intersubjectivity and reciprocity: we share and exchange perspectives with one another and we are sensitive to the perspective of others. For example, the notion of dignity is not just an individual quality but emerges from interactions; there must be other persons who respect my dignity. Viewing ourselves through the eyes of others initiates a process of taking a distance on ourselves, expanding our moral sensibilities, and produces ethical reflection, generating a third-person perspective with explicit and generalized norms, reasons and justifications that apply outside our immediate sphere of interaction. According to this cognitive development model, the third-person perspective does not provide a complete understanding of ethical life since it excludes first/second-person perspectives, but neither do the last two perspectives (Keane, 2016). What is crucial is the capacity to move back and forth between perspectives. This capacity is provided by moral imagination. In distinction to the imagination that is crucial in aesthetic concerns, moral imagination has a particular direction; it is focused on the perspectives and interests of other persons than ourselves.

In moral analysis and deliberation, moral imagination is essential for two reasons. First, it is necessary for the required shift in perspectives because it enlarges our horizon, expands our sympathies, and helps to frame situations differently (Ten Have and Pegoraro 2022). Through imagination we can place ourselves in the shoes of other people in very different circumstances; we become aware of values that go beyond the limits of our own experience, and recognize situations that demand moral action. Without imagination, we cannot consider situations from the perspective of other persons and cannot understand the experiences of others.

The second reason is that imagination has creative power in that it provides various possibilities for acting, envisioning how actions might be damaging or beneficial, and how alternative courses of action are possible. Ethical reasoning and deliberation are discursive practices that move from specific cases and situations to more elaborate and abstract arguments. In this movement, imaginary processes play a role so that richer and broader views may emerge. Imagination is important to facilitate interpretation, and to generate values, ideals and worldviews to guide moral perception and action. In this way, imagination reshapes and restructures our moral experiences. It helps to understand the situations and views of other human beings, but also to envision how these might be altered and ameliorated. As the ability to make the absent become present, it conceives of alternatives to problematic situations and views. In the philosophy of John Dewey, imagination implies seeing the actual in the light of the possible (Fesmire 2003).

In bioethics theory, practice and education, moral imagination does not seem to play a role. It tends to be regarded as subjective and non-rational, and should therefore be avoided. Publications that emphasize the significance of moral deliberation as a method of ethics teaching in medical education do not refer to the imagination (Steinkamp and Gordijn 2003; Molewijk et al. 2008; Barilan and Brusa 2013). This situation is different in other areas of ethics teaching, for example, education for nursing students, engineering students and student teachers (Jantzen et al. 2023; Jalali, Matheis and Lohani 2022; Hyry-Beihammer et al. 2022). Recent studies in these areas examine the key contribution of the imagination to moral reasoning and deliberation. Jantzen and colleagues (2023) describe how a pedagogical space for the development of moral imagination can be created through simulated learning experiences. Nursing students were trained as simulated patients to confront problems of workplace violence and moral distress. Acting as an angry family member allowed them to imagine the perspective of the patients and their families as well as to identify possibilities to prevent violent situations. They also could critically reflect on the responses of the other students with whom they interacted. This experience transformed their understanding and stimulated them to imagine alternative ways of engaging with patients (Jantzen et al. 2023).

Cultivation of the moral imagination is an important component of moral analysis and deliberation. Imagination is not a subjective and irrational process that can strictly be separated from moral reasoning. Moral deliberation can be viewed as "expansive, imaginative inquiry into possibilities for enhancing the quality of our communally shared experience" (Johnson 1993, 80). Imaginative exploration and transformation of experience can be systematically encouraged in teaching programs through the use of literature, art, movies, role plays, hypothetical and sometimes bizarre cases, and active learning processes (Ten Have 2018; Gerrits et al. 2023). Imagination is, moreover, an effective tool to moderate stereotypes. In experiments conducted by Blair and colleagues, participants who engaged in counter-stereotypic mental imagery (imagining a strong woman, for example a business executive or athlete) produced substantially weaker stereotypes concerning women compared with participants who did not engage in mental imagery (Blair, Ma and Lenton 2001). Implicit bias and prejudice apparently can be reduced with the help of the imagination of counter-stereotypes. Rather than advocating policies of colorblindness to avoid or suppress stereotyping, activation of the imagination is an effective means to reduce and moderate implicit associations with color. Making people aware of implicit race bias and using the imagination as a strategy to reduce bias (e.g. by taking the perspective of stigmatized others, and imagining counter-stereotypic examples) could produce long-term reductions in implicit race bias (Devine et al. 2012).

6.9 Expansion of Bioethical Discourse

The experience that the world is full of colors influences our relations with other people and our environment. Colors present the surrounding world in specific ways and pervade our interaction and communication with other beings. They convey particular emotions, values and judgments, and therefore influence our beliefs, attitudes and behaviors. So far, it has been argued that the typical character of colors has implications for the conception and methodology of bioethics. Perceiving a color or range of colors produces an immediate and intuitive response which generates a value judgment prior to moral reasoning and rational deliberation. Ethics already starts in the concrete experience of perceiving which then necessitates critical examination and explanation with the help of systematic theory and moral reflection. Bioethical analysis should therefore begin with scrutinizing how associations and intuitions emerge, and explore the role of moral perception and moral imagination, especially in regard to ideas of race and practices of racism.

However, there is also the upstream level of bioethical theory where principles, rules and norms are formulated and elaborated that are consolidated in guidelines and legal documents. Recognizing that colors are associated with moral appreciations has consequences for this theoretical framework and its concomitant practices. It not only requires that topics such as racism, structural violence, vulnerability and discrimination should be higher on the agenda of contemporary bioethics, but it demands that the field of ethical inquiry should be expanded by employing a broader framework of ethical approaches and principles.

In Western moral philosophy, human beings are usually conceived as rational and abstract actors, divorced from bodies, feelings and emotions. Rational choice theory assumes that human beings are chiefly concerned with self-interest, motivated by minimizing costs and maximizing gains for themselves. The rational individual makes choices according to what they prefer or value most. They should achieve self-management, i.e. showing responsible conduct and self-regulation. This individualistic ideology, dominating economic and social policies, is reflected in the common view of bioethics. Through their bodies, humans are situated in the world as independent selves, acting on their surroundings. This individual autonomy should be respected. The life of an individual belongs to themselves. The individual person chooses their values, and has the right to live as they would like, being their own master. The moral vocabulary of bioethics is therefore limited: focused on individual rights, self-determination, consent and privacy, rather than social responsibility, solidarity, cooperation and social justice. According to this approach, bioethics should be colorblind, since the prevailing moral principles apply to every individual regardless of race, color and gender. Yet, erasing color as a relevant ethical consideration removes the possibility of exploring why disadvantages and injustices exists, and of analyzing why and how people are treated differently. Ignoring color and pretending "not to see" it does not eliminate difference in reality, and especially differences among people, such as disparities in health and healthcare. Colorblindness, as Anderson argues, is "epistemologically disabling: it makes us blind to the existence of race-based injustice" (Anderson 2010, 5).

As a normative standard for law, policy or ethics, colorblindness accommodates and reinforces the dominating individualism in Western societies. If racist acts and opinions occur, they are regarded as anomalous and unacceptable, and the involved persons will be blamed. But systemic, institutional racism that is embedded in organizations, structures and policies will not be addressed (Neville et al. 2013). Anderson (2010), for example, argues that segregation is the principal cause of racial inequality, providing numerous examples in the area of housing, employment, education and healthcare. Racial prejudices and biases are the effect, rather than the cause of segregation, and reducing or moderating them will not eliminate inequality, stigmatization and discrimination without eradicating the underlying structures of segregation. The consequence of this critique of colorblindness is that ethical analysis should be orientated towards contextual and structural conditions rather than focus on the individual perspective of rational and autonomous persons. Bioethics discourse should transcend the usual emphasis on the moral principle of respect for autonomy. Since racism is the expression of power differences, critical attention should be directed at the power constellations and structures that determine the social, economic, political and environmental conditions in which people live (Johnstone and Kanitsa 2010). Racism is also the production and exploitation of differentiated vulnerability since power disparities deprive racialized groups from the resources required to ensure and maintain health (Russell 2022). Like other ideologies, racism is a dehumanizing system of oppression, domination and exploitation that legitimizes unjust social relations (Shelby 2014). The notion of power is therefore a crucial concept in an expanded bioethical discourse aimed at addressing issues of race, racism and color. The second concept is diversity. Evidently, human beings are not identical; they show significant differences with tremendous biological and cultural diversity. The challenge is to recognize and respect differences without leading to inequality. Racial theories explain differences by categorizing humans on the basis of biology or genetics with the result that differential treatment is necessary and that inequalities are regarded as natural and ineradicable. The paradox is that the ideal of equality which is core to modern societies since the Enlightenment only applies to a specific section of the population. The history of racism and colonialism is, in fact, a corruption of the Enlightenment legacy, as Frantz Fanon (2021) argues. But this legacy should not motivate a retreat from the universalist standpoint. The universalist ideal of shared humanity with respect for dignity, human rights and equality is not dependent on the color of skin. It is the respect of fundamental values that makes the world human. To avoid corruption, the Enlightenment ideals should be "wrenched away from European hands and made the possession of all humanity" (Malik 2023, 170).

The beginning of the previous chapter refers to a world without color that has lost much of its attractive and pleasant qualities. Instead of eradicating color, a broader perspective of bioethics acknowledges that color is perceived in a range of nuances and that accepts that human life is colorful. Such perspective takes power and diversity as fundamental to critical analysis, and utilizes a theoretical framework that is genuinely intercultural and global, i.e. relevant for all people, ethnicities and cultures around the world. It is remarkable that the discipline of bioethics, that in the 1970s in Western countries replaced traditional medical ethics, is currently being transformed into a more inclusive approach that encompasses the globe. It presents a system of ethics that is worldwide in scope. This has become unavoidable since many of the ethical challenges in healthcare nowadays are global (e.g. pandemics, organ trade, malnutrition, migration and environmental degradation). These problems affect the whole of humankind, regardless of where people live, and they threaten not simply individual health and well-being but the health and survival of humanity. They also require global cooperation and action, necessitating a search for common ground, even when moral values in specific countries and regions will differ (Ten Have and Gordijn 2014). The global dimension of today's moral challenges also requires a broader ethical perspective. The confrontation with a new type of problem that is no longer localized in character but global in scope demands an approach that transcends the views and values of the Western culture in which bioethics originally emerged. Global bioethics in this sense not only refers to an expanded field of work but at the same time to an inclusive and comprehensive ethical orientation that departs from the usual emphasis on individual, medical and short-term perspectives.

Global bioethics as an encompassing, inclusive and planetary perspective is inspired by the ideals of cosmopolitanism: the unity of humanity, solidarity, equality, openness to differences and focus on what human beings have in common (Ten Have 2016). In this philosophy, human beings are considered as citizens of their own community, state (polis) or culture, as well as citizens of the world (cosmos). In the first, they are born and grown up; they share a common origin, language and customs with co-citizens. In the second, they participate because they belong to humanity; all human beings share the same dignity and equality. Being a citizen of the world liberates the individual from captivity in categories such as culture, tradition and community, but also gender and race. Cosmopolitanism acknowledges that human beings are connected to other beings and the surrounding world.

This anthropological experience of "connectedness" and "togetherness" is taken as the starting-point for global ethical reflection. If human beings not only interact with each other but also belong together and are mutually dependent, then relationships and shared responsibility in shaping the world play a defining role in who a person is. The notion of individual autonomy as used in mainstream bioethics should then be redefined as a relational concept. Community, mutual support, social responsibility, cooperation and solidarity should have a significant role in inclusive and comprehensive bioethical discourse. Furthermore, being situated in a web of connections is a precarious experience. Because their bodies position them in the world, human beings are exposed to the world and other persons, necessarily implying vulnerability.

Relationality is therefore the core notion of global bioethics. It is a more fundamental characteristic of being human than relatedness and connectedness. A human person is continuously engaging in relations, but this is often conceived from the viewpoint of the individual. The notion of relationality expresses that individuals not merely connect and interact with each other but belong together and are mutually dependent, taking responsibility and shaping their lives together. As integrated wholes of body and soul they are embedded within communities, and they exist in a web of relationships with other beings and the environing world. The first experience of humans is that the world is shared with others. Authentic human being is being-together.

Against the background of new global challenges and the need for a broad and inclusive approach, global bioethics works with a range of ethical principles. Without disregarding the value of personal autonomy and individual rights, it develops a moral discourse with a more extensive horizon. First, it argues that human beings are not abstract and de-contextualized individuals: they are necessarily embedded in social structures. Beneficial social, cultural, economic and political conditions make flourishing in health possible. This implies that power differences and structural violence should be critically addressed, and that principles such as justice and equity play a major role in bioethical debate. The concept of the common good is rehabilitated since individual persons are citizens concerned with shared interests that are not simply the aggregation of private interests. Furthermore, new forms of collective engagement and agency will be necessary to influence the systemic conditions that produce global problems. Over the past few decades, neoliberal policies have made life more precarious for most human beings (as well as for other living creatures). They have created a context of structural violence and multiplied opportunities for injustice and exploitation. Though individual actions and concerns are important, they will not be sufficient to bring about social transformation. The power structure of neoliberal globalization as the source of bioethical problems should be criticized with a broader set of moral concepts such as human vulnerability, social responsibility, equity, justice, sharing of benefits and future generations within bioethics discourse. These concepts will direct bioethical attention to structural determinants of health and disease rather than individual decisions concerning care.

Second, diversity has become a central concern in global bioethics. Previously, we have discussed how Western culture has tended towards chromophobia in its attitude towards colors. Colors are distrusted and reality is often presented as black and white, which are not regarded as colors themselves (Batchelor 2000). This traditional way of thinking—of moving black and white outside of the world of colors—seems to be reiterated in the current ideology of colorblindness. The idea that colors are better ignored also corresponds with the antirealist theory of the nature of colors: they are illusory, intrinsically subjective and only exist in the mind. Assuming that colors essentially reside in the human mind is coherent with the ethical priority of individualism. The individual subject can indeed act as if colors do not matter since they do not belong to the surrounding world but are our own product. In this book, I have argued that this view of colors does not recognize the phenomenological experience of color in human existence. It is theoretically unsatisfactory because it discounts the functional role of colors in our relationship to the world, and how colors express identities. People communicate through color; it is a language without words, evoking an impressive range of meanings, and conveying various values and ideas. Colors also make the world beautiful and good in an aesthetic as well as ethical sense. For artists such as Kandinsky, colors are not a medium between observer and object, but they are the atmosphere in which the observer dwells (Riley 1995).

The effect of chromophobia and colorblindness is a reduced view of diversity. In Western culture, for three centuries (from the 17th to the 20th century) black and white are considered as noncolors, and black is contrasted to white. However, for most of its history this has not been the case. At least until the Renaissance, in the West three colors are regarded as basic, and black and white are contrasted with red (Pastoureau 2009). Black has been the original color; the oldest pigments were probably black. Already in ancient times there were many blacks, with different degrees and qualities: light and dark, matte and glossy, intense and delicate. The same is true for white which has various shades and nuances.

Experiencing the rich variety of colors in our life-world should prompt us to re-evaluate the notion of diversity. Respect for cultural diversity and pluralism has nowadays been recognized as one of the principles of global bioethics (Ten Have 2017). The awareness that many moral challenges to health and healthcare today have a global dimension implies that they are no longer dependent on the specifics of a particular culture or society. While it remains important to address these challenges at the local, national and regional level, coping with them requires international and global cooperation, as the recent Covid-19 pandemic has illustrated. Such coping presupposes that at least some fundamental values are shared in order to formulate effective policies around the globe. The efforts and difficulties in doing so have been apparent in recent examples of the activities of international organizations, such as the World Health Organisation's response to the coronavirus disease. That there are similar bioethical problems in almost all countries does not imply that the same ethical assessment and approach is used everywhere. The least one can say is that the planetary dimension of health challenges necessitates a rethinking of our usual ethical frameworks. It makes us aware of the "locality" of our moral views, while at the same time encouraging the search for moral views that are shared globally. This implies recognition of the fact that the dominant bioethical approach, based on a limited set of principles, is a product of Western, White culture. If this approach is universalized and applied across the globe it will be an example of ethical imperialism. Nonetheless, this recognition does not imply that it is not possible to reach agreement on principles that can be used universally across borders. This has been the exact mission of UNESCO, adopting in 2005 general principles to guide decisions and practices in global bioethics (in the *Universal Declaration on Bioethics and Human Rights*). Formulating these principles was undertaken at the request of developing countries that wanted similar normative principles to be applied in healthcare and medical research in order to avoid unequal practices and double standards. Such principles should not reiterate and extend the Western individualistic perspective of ethics but take into consideration the value systems of other cultures and countries across the world. That a trans-cultural moral approach is possible has been asserted by non-Western scholars. Jing-Bao (2005) argued the importance of exploring non-Western cultures to uncover their advocacy for universal principles. It is a mistake to assume that such principles (e.g. human dignity) are alien to and incompatible with these cultures. It is *moral protectionism* to assume that ethical principles, even after having emerged and being formulated in Western culture, continue to remain the property of such specific culture, and therefore are not universal but only valid within this specific context. Cultures differ but this does not imply that common standards and universal principles do not exist. It is moreover a mistake to assume that universalism is abstract; values and ideals are derived from particular histories, traditions and places (Malik 2023).

Global bioethics, as it has emerged since the turn of the millennium, does not simply promote universal values or acknowledge moral diversity. It is a dialectical effort to bridge universalism and particularism. Its main challenge is to combine and bridge convergence and divergence of values, and it is therefore not a finished product. How can recognition of differences in moral views and approaches be reconciled with the convergence towards commonly shared values? Criticisms of global bioethics often presuppose simplistic views of globalization. While worldwide interconnectedness bridges the gap between distance and proximity, some scholars assume a radical contrast between moral strangers and friends, while others fear the growth of a bioethical monoculture (Ten Have 2016). But it is not correct that globalization produces either uniformity or multiplicity; it does both. Just as the concept of race is impossible to attribute to individuals, people nowadays are part of multiple cultures. It is not clear where their roots exactly are. They may consider themselves at the same time as Dutch, European and citizen of the world. The same is true for the notion of culture itself. No culture today is monolithic and pure. All cultural traditions are dynamic; they have changed and are changeable; they are necessarily a mélange of different components. Differences do not exclude that there is a common core. The term *interculturalism* is therefore more appropriate than multiculturalism since it acknowledges diversity while at the same time insisting on universal values. The term "interculturality" emphasizes interaction. "Inter" refers to separation but also linkage and communication. The supposition is that we can position ourselves between cultures; we can occupy a place between the universal and the particular. It means that we recognize similarities between self and other that can be the basis for dialogues between cultures, and at the same time that we can maintain differences and sustain boundaries between self and other. In other words, conceptually and practically, we are "in-between," moving beyond dualistic, binary thinking, adopting universalizing as well particularizing practices simultaneously (Lobo, Marotta and Oke 2011).

While multiculturalism emphasizes respect for diversity, individual freedom, justice and equal treatment, interculturalism introduces a moral vocabulary of interaction, dialogue, participation, trust, cooperation and solidarity. It is not sufficient to have multiple co-existent value systems and respect them; rather, the challenge is to produce and cultivate practices that can create community. If there is common ground, it needs to be cultivated through interaction and communication. Convergence is not a given but is rather the result of an ongoing activity of deliberation, consultation and negotiation. It is exactly this "interstitial perspective" that motivates the development of global bioethics.

6.10 Conclusion

It could not have been a real surprise that the Covid-19 pandemic disproportionately affected people of color. Health and healthcare disparities for these populations have already existed for a long a time. But the pandemic, in conjunction with the Black Lives Matter movement, was a wakeup call that placed issues such as racism, structural injustice, discrimination and vulnerability more center stage in bioethics. Since then, the pervasiveness of the moral associations of white and black (and to a lesser extent, other colors) as well as their deleterious effects on health and healthcare have become major topics of concern in ethical debate.

In previous chapters it is shown that in the history of medicine and healthcare, colors have played a significant, and generally positive role. They are regarded as diagnostic and prognostic clues about what is going on inside the human body; they are indicators of physiological and pathological processes; they suggest particular medicinal effects. Colors themselves are often interpreted as relaxing or exciting, and have long been used as remedies. The synthetic production of colors in the nineteenth century laid the foundations for the modern pharmaceutical industry. This symbiotic relationship between color and health collapsed as soon as color was connected to the idea of race. The discriminatory and classificatory functions of color are projected on human beings rather than on the surrounding world, and give rise to normative judgments of superiority or inferiority. In order to avoid these negative impacts, the prevailing view in policy and science nowadays is that color should not be noticed as a relevant issue. In the context of bioethics, the result of colorblindness is that issues such as race and racism are insufficiently addressed in bioethical discourse.

This chapter elaborates how bioethics should deal with color. It emphasizes that race should be taken seriously as an ethical problem. Given its negative implications, the concept of race should preferably be eliminated in healthcare and medical science. The challenge for bioethical analysis is to critically focus on settings in which the notion continues to be used: language, disease conditions, clinical practice, research and medical education. The second, and related challenge concerns racism. Bioethics cannot be silent about racism because racism evidently violates crucial ethical concerns and principles such as justice and human dignity. Racism is also a significant source of medical harm since it is a barrier to health and healthcare for people of color. Bioethics should furthermore acknowledge that racism is still pervasive in contemporary societies. Cultural changes, policies and legislation have not eradicated racism but have made it less openly and explicitly practiced. Racist attitudes, beliefs and behaviors are now generally regarded as aberrations and exceptions, manifested at the level of implicit prejudices and biases. While it is important to counter such biases, especially in the context of healthcare, and to "de-program" the often unintended normative associations of colors, racism also persists because it is incorporated in institutional and organizational practices. Such systemic racism is invisible. Examples mentioned in this chapter are clinical guidelines and algorithms, research findings, and the use of so-called "normal" values which almost automatically put people of color at a disadvantage, since most of the data is related to White subjects. The implication of persistent racism is that bioethical analysis must not only focus on the perspective of individual patients and healthcare providers but should address the contextual and structural dimensions of health and disease, and of the systems and services that are supposed to care for all people.

Confronting and interrogating race and racism demand a reorientation of bioethics. The core argument of this chapter is that bioethics should be "chromophilic"—not blind to colors or affiliated with only one color, white or black. This calls for a review of the methods as well as contents of bioethical discourse. Ethics used to be regarded as a rational undertaking of argumentation and deliberation. Recently, however, the role of emotions and feelings in moral judgments has been reassessed. Most moral judgments are not the outcome of reasoning but primarily made as soon as a situation, condition or act is perceived as morally relevant, and based on emotions triggering an intuitive response. Only then is moral reasoning applied to justify the judgment to other people. In this view, bioethics is like aesthetics, and should not only focus on rational arguments but also on the intuitive stage in which moral judgments are immediately and automatically delivered. In regard to notions of race and racism, this opens up the way for bioethics to go beyond the rational level of ethical principles that evidently condemn these notions, and to direct its critical attention to the emotional level, where color associations and normative evaluations arise in inconspicuous ways.. Bioethical analysis can help to identify why and how such associations emerge, and are reinforced in language and imagery. Most of all, bioethical analysis can use moral imagination to make individuals aware of the perspective of other people, and to better understand the experiences of others.

Besides employing other methods, a race-conscious bioethics should also redefine its contents. Ongoing experiences with racism illustrate the shortcomings of the ideology of individualism which permeates bioethics as well as healthcare, social and economic policies. People of color are discriminated against and stigmatized because they belong to racialized groups or categories that are systematically disadvantaged. Whereas the effects are harmful and disrespectful for individuals, the roots of the problem are at a different level: the dehumanizing system of unjust social relations which is the result of historic legacies of oppression and exploitation. If bioethical discourse wants to address issues of race and racism it therefore needs to concentrate its critical attention at this systemic level. This chapter argues that two concepts in particular are important: power and diversity. Additionally, the chapter highlighted how an inclusive and enlarged conception of bioethics has emerged that provides more intellectual and moral tools to scrutinize power differences and diversity concerns. This so-called global bioethics applies a range of ethical principles, which not only articulate individualistic values (such as personal autonomy) but also communal and social values (such as vulnerability, justice and solidarity) as well as environmental ones (e.g. respect for biodiversity, and future generations). Operating with a range of principles, global bioethics shows that it acknowledges diversity and, at the same time, aspires to determine the values human beings and various cultures share and have in common. It confirms that the world is full of colors, enjoyable, beautiful and valuable.

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