To race or not to race: A normative debate in the philosophy of race.[1]

Abstract: *One of the many debates in the philosophy of race is whether we should eliminate or conserve discourse, thought, and practices reliant on racial terms and categories (i.e., race-talk). In this paper, I consider this debate in the context of medicine. The recent resurgence in anti-racist activism and the COVID-19 pandemic have prompted philosophers, medical professionals, and the public to (re)consider race, its role in long-standing health disparities, and the utility of race-based medicine. In what follows, I argue that while utility is insufficient for adjudicating permissible uses of race in medicine, eliminativism is neither necessary nor sufficient for dealing with the sort of ills associated with race-based medicine. I, then, use a virtue-based framework to adjudicate morally permissible uses of race in medicine. In doing so, I demonstrate the limitations of eliminativism, offer a decision procedure for determining morally permissible uses of race, and demonstrate that the debate regarding eliminating or preserving race-talk need not depend on conclusive answers to metaphysical questions regarding race.*

Keywords: *race; racism; medicine; race-talk; virtue*

§1 – Introduction

One of the many debates in the philosophy of race is whether we should eliminate or conserve discourse, thought, and practices reliant on racial terms and categories (i.e., 'race-talk') (Taylor 2013, 27-67). Offshoots of this debate vary in scope and target. For example, should eliminativism be understood as a global or local challenge to uses of race-talk? If local, in what contexts should we seek to eliminate race? What sort of race-talk should be conserved? Are there particular views on race that should be eliminated and others that should be conserved? Of particular importance is how this debate impacts medical research and practice. The recent resurgence in anti-racist activism and the COVID-19 pandemic have prompted philosophers,

medical professionals, and the public to (re)consider race, its role in long-standing health disparities,[2] and the utility of race-based medicine. With increased skepticism around the epistemic and social benefits of race-based medicine (see, e.g., Hochman 2021; Wright et al. 2022; NASEM 2023), how ought bioethicists and medical professionals proceed? More to the point, *when (if ever) is it morally permissible to use race in medicine?* In what follows, I will argue that although utility is insufficient for determining whether it is permissible to use race in medicine, eliminating race-talk is neither necessary nor sufficient for dealing with concerns associated with race-based medicine. This is because eliminativism runs into similar risks related to the use of race-based medicine, and the solutions to address these risks do not require eliminativism (§3). I will, then, use a virtue-based framework to argue that it is morally permissible to use race in medicine *iff* (i) when applicable, social determinants of health are sufficiently engaged prior to or in tandem with the use of race (*social determinants requirement*), (ii) the medical end(s) sought cohere with the aim of medicine and are best acquired using race (*harm minimization requirement*), and (iii) the use of race does not violate the relevant just legal norms constraining medical practice more generally (*legal norms requirement*) (§4). These conditions are necessary, because failure to fulfill any one of them will lead to vicious behavior on the part of the practitioner or institution (§5). And, they are sufficient, because, taken together, they allay the concerns associated with race-based medicine in a manner that coheres with medicine done *well* (§6). I close by presenting a decision tree for the permissible use of race in medicine (§7), highlighting the benefits of my decision tree and offering clarifying remarks regarding the permissible use of race in medicine (§8).

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[2] I will understand health disparities as morally problematic, medically significant differences between human subpopulations (*cf.* Hardimon 2017, 164).

The upshot of this investigation is threefold. First, it demonstrates the limitations of eliminativism in the race-talk debate by placing the debate within the context of medicine. Second, it offers a novel framework for adjudicating morally permissible uses of race-based medicine, by appealing to an un(der)utilized normative framework in the debate – virtue theory. Finally, it demonstrates that the debate regarding the elimination or conservation of race-talk need not depend on conclusive answers to the metaphysical questions surrounding race.

§2 – The biomedical race debate

To understand what's at stake, some framing is in order. *What is race conservationism in medicine? What is race eliminativism in medicine? And, what are the reasons in favor of and against these views?* To begin, race conservationism in medicine – the view that we should preserve race-talk in medical research, treatment, diagnosis, and education – is best understood not as a single view, but a set of (sometimes competing) views. *Biological race conservationists* defend the medical utility of racial classifications that take race to be biological (e.g., Hardimon 2017; Spencer 2018). However, the biological properties constituting races need not (and ought not) imply some form of *racialism.* Appiah refers to *racialism* as the view

> that we could divide human beings into a small number of groups, called 'races,'
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> in such a way that the members of these groups shared certain fundamental,
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> heritable, physical, moral, intellectual, and cultural characteristics with each other
>
> that they did not share with members of any other race (1996, 54).[3]

Historically, *racialist races* have been used to posit *morally significant* inequalities between races and justify racial hierarchies intending to privilege certain racial groups and subordinate others (e.g., Kant 1777; Morton 1839). But such views of human populations are false (Appiah,

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[3] Though *racialism* is intimately related to *racism*, the two concepts are not synonymous with each other.

1985; Feldman & Lewontin 2008; Hardimon 2017) and morally harmful because they violate the dignity and undermine the flourishing of subordinated groups. So, viable biological racial classifications ought to preclude the use of *racialist races* (e.g., Spencer 2014, 1036; Hardimon 2017, 151-153).

Additionally, the races represented in a biological racial classification need not be stagnant or a permanent fixture in the world, but may admit of flux through time (e.g., Andreasen's [1998] cladistic race theory). What's more, a biological racial classification may admit of admixture between races such that an individual is not confined to membership to only a single race (e.g., Spencer's [2014, 2018] OMB race theory). Admittance of admixture is more in line with the empirical data from population genetics (e.g., Rosenberg et al. 2002), and undermines theories of race that rely on antiquated rules, like the one-drop rule.

Note, biological race conservationism will include race theories that understand race as biosocial (e.g., Outlaw 1990; Kitcher 1999), given these theories take race to be partially biologically determined. Additionally, biological race conservationism need not imply biological racial realism.[4] For example, in his defense of biological race conservationism, Maglo posits an instrumentalist conception of race, stating that race is "an efficient, safe, and ethically defensible biomedical problem-solving device" (2010, 364). He writes, "The instrumentalist conception of race I am suggesting is informed in part by the fact that even an utterly flawed scientific concept – one that is invalid in its domain of (presumed) validity – may still prove to be, under certain circumstances, more pragmatically useful than a competing scientifically valid concept" (Maglo 2010, 361).

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[4] On the meaning of 'biological racial realism' see Spencer 2012.

In defense of biological race conservationism, some have argued that the use of biological racial classifications can be beneficial in tracing the etiology of both monogenic diseases and population-specific modifiers implicated in polygenic traits. Examples of race-related, medically relevant genetic differences in monogenic diseases include, but are not limited to, a mutant allele of the *CFTR* gene associated with cystic fibrosis (Hardimon 2017); a mutant allele of the *HEX* gene associated with Tay-Sachs (Hardimon 2017); and, the C282Y mutant allele associated with hemochromatosis (Burchard et al. 2003). Examples of race-related, medically relevant genetic differences in polygenic traits include, but are not limited to, the genetic variant, factor V Leiden, associated with increased risk of venous thromboembolic disease (Burchard et al. 2003; Hardimon 2017); a mutation of the *CCR5* gene that is associated with susceptibility to HIV (Burchard et al. 2003; Hardimon 2017); genetic variants in the *CARD15* gene associated with Crohn's disease (Burchard et al. 2003); and, differences in frequencies of lactose persistence alleles that allow people to digest lactose after weaning (Spencer 2018). Note, in offering these examples, the implication is not that each disease or trait is exclusive to a certain racial group. Nor do the examples imply homogeneity within a racial group. Instead, the data drawn are meant to demonstrate that certain diseases and traits disproportionately burden certain groups, and these burdens can be partially explained as race-related, medically relevant genetic differences.

Additionally, biological race conservationists have also argued that preserving the use of biological racial classifications can protect against the continued oversampling of whites, which leads to the continued underservice of racial minorities, thus perpetuating racial health disparities (Risch et al. 2002; Burchard et al. 2003). This oversampling of whites is particularly blaring in genome-wide association studies (GWAS), where, as of 2009, 96% of participants in GWAS

were of European descent (Popejoy and Fullerton 2016). This disparity in research participants continues. In 2017, 86.03% of participants in the discovery cohorts of GWAS were of European descent, and 76.69% of participants in the replication cohorts were of European descent (Mills and Rahal 2019).

In response, many have argued that biological race conservationism does more harm than good for the health of marginalized racial groups. To begin, biological racial classifications overemphasize genetic differences between racial groups to the neglect of social determinants of health (Roberts 2011; Krieger 1999, 2014). This, in turn, reinforces rather than rectifies racial injustices in healthcare, and worsens racial health disparities. What's more, biological racial classifications fail to capture the medically relevant biological diversity *within* racial groups (e.g., Hanchard 2021), while also dividing human beings in a way that fails to capture medically relevant traits shared *among* racial groups (Hochman 2013, 345; Roberts 2011; Yudell et al. 2016). Finally, many believe the groups demonstrating medically relevant genetic differences are best understood as (genomic) ancestry groups (Yudell et al., 2016; Hochman, 2021), ethnicities (Sirugo et al. 2019; Choudhury et al. 2020), or, simply, populations (Yudell et al. 2016). These alternatives, if better suited for classifying the medically relevant groups, seem to suggest biological races aren't needed in medicine.

These are legitimate concerns, and any viable conservationist position hoping to include the use of biological racial classifications will need to address them. For the time being, I will simply note that current biological conservationist positions have yet to construct a decision procedure that takes seriously all three of the concerns listed above. So, in what follows, I will highlight how my decision tree addresses these concerns without committing me to biological

racial realism or a particular metaphysics of race in general. This non-commitment, I suggest, in turn, allows for a more comprehensive approach to addressing health disparities.

Non-biological race conservationists defend the medical utility of *non-biological* racial classifications, and thus argue in defense of preserving such classifications in medicine (e.g., Root 2001; Roberts 2011, 2020; Msimang 2021; Wright et al. 2022; NASEM 2023). Though there are many conceptions of non-biological races, the ones typically appealed to in the medical context are best understood as *sociopolitical* races. For example, Roberts writes

> race is a political grouping because it has political roots in slavery and
> colonialism, it has served a political function over the four hundred years since its
> inception, and its boundary lines – how many races there are and who belongs to
> each one – have shifted over time and across nations to suit those political
> purposes (Roberts 2011, 5).

And, the National Academies of Sciences, Engineering, and Medicine defines race as

> a sociopolitically constructed system for classifying and ranking human beings
> according to subjective beliefs about shared ancestry based on perceived innate
> biological similarities (NASEM 2023, 4).

While a comprehensive comparison of the various sociopolitical theories of race is beyond the scope of this paper, it is worth nothing that at the heart of these theories is the assumption that race is non-biological and socially constructed for the (political) purpose of subordinating certain racial(ized) groups and privileging others (see also, Mills 1998; Alcoff 2006; Haslanger 2019).

Non-biological race conservationists argue that race should be preserved, because racism is a social determinant of health, and employing a non-biological racial classification helps track the impact of racism on health outcomes (Krieger 1999; Root 2001; Hardimon 2017; Roberts

2020). While it is an empirical question as to how much racial health disparities are modulated by racism, there is substantial data suggesting that racism does impact health (see Krieger 1999; Hardimon 2017; Bailey et al. 2017; Williams et al. 2019). In fact, in the Healthy People 2030 initiative, the US Department of Health and Human Services lists "racism, discrimination, and violence" as one example of a social determinant of health.

Note, for those who adopt a pluralist view of race, non-biological race conservationism is compatible with biological race conservationism. For example, Hardimon argues that 'socialraces' and biological races are compatible in medical research. He argues that the use of 'socialrace' is a "legitimate scientific variable" and suitable for deployment in medical research related to racism's impact on health, because it correlates with differences in health outcomes, is a structural cause of ill health, and can be clearly understood (Hardimon 2017, 160). Additionally, he argues that a biological concept of race is suitable for deployment in research related to race-related, medically relevant genetic differences, because such differences appear to exist and it is thought that more such differences might obtain (Hardimon 2017, 156-61). This is particularly important given the several, distinct pathways leading to racial health disparities. Should race-related, medically relevant genetic differences *and* racism both be determinants in disparities, then the most comprehensive approach to intervening into racial health disparities would need to allow room for both forms of conservationism.

Non-biological race conservationism seems to avoid the potential harms associated with biological race conservationism, because it highlights the role of socioeconomic factors in health outcomes, and offers an alternative classification scheme to biological races. This, in turn, mitigates obscuring the biological diversity within racial groups and the biological similarities among racial groups. Yet, some would argue that non-biological race conservationism, like

biological race conservationism, is susceptible to perpetuating racist attitudes (Hochman 2021, 89-90). For example, Shulman and Glasgow found that those who believed race to be wholly biological, those who believed race to be wholly social, and those who believed race to be a hybrid of social and biological factors did not differ in their levels of racism (2010, 252). Additionally, antirealists about race have argued that defining "race by reference to purely social factors inflates the category of race beyond recognition, with too many different sorts of groups counting as 'races'" (Hochman 2021, 89). Thus, *eliminativists* wish to jettison the use of both biological and non-biological racial classifications from use in medicine. Given the concerns with both biological and non-biological race conservationism, even if preserving race proved medically useful, should we use race-talk in medicine?

§3 – Why not eliminativism?

As previously mentioned, both biological and non-biological race conservationists argue in favor of preserving race-talk in medicine because of the medical utility of racial classifications. But, utility does not imply morally permissibility. In fact, Spencer notes that the use of racial terms regarding human genetic diseases "significantly raises one's probability of developing an 'essentialist' [i.e., *racialist*] conception of race, which is itself correlated with developing racist attitudes" (Spencer 2018, 1034). So, if the use of racial terms in the biomedical sciences risks developing racist attitudes, why not choose eliminativism? Two reasons. First, eliminativism on its own is not sufficient for mitigating the sort of social ills associated with race-based medicine. To see this, consider the alternative classifications offered for investigating population health. As previously mentioned, alternatives typically offered include (genomic) ancestry (Yudell et al., 2016; Hochman, 2021), ethnicity (Sirugo et al. 2019; Choudhury et al. 2020), and populations (Yudell et al. 2016). But, the problem with simply

replacing race with any one of these alternatives is that each alternative runs into similar issues that have historically plagued race. For example, without proper instruction, it isn't clear that the public will make the distinction between these alternatives and race. Sociologists have shown that using population categories in medical genetics that resemble racial categories is associated with a higher probability for developing a racialist view of race, which is positively correlated with developing racist attitudes (Donovan, 2014, 2016, 2017). Thus, even when these alternatives are distinct from race, the harms associated with race appear endemic to these alternatives insofar as their categories are or have been associated with racial terms. Relatedly, the use of ethnicity or some other population classification unassociated with racial terms – e.g., genetically similar populations (NASEM 2023) – may transform the crude racial hierarchy into a finer grained, but wholly unwarranted and deleterious, hierarchy. Ethnocentrism and ethnic discrimination are as morally problematic as racism, as is any population scheme vulnerable to a hierarchical interpretation.

What, then, is left for eliminativists? Hochman recommends referring to (groups of) individuals as *racialized* rather than as belonging to a race. In doing so, Hochman can subscribe to a racial antirealism in which there are no social or biological races, only groups of individuals "misunderstood to be races" (Hochman 2021, 88). An immediate upside to Hochman's antirealism is that it appears well suited to track racism's impact on health, given racism is largely predicated on how (groups of) individuals are perceived by others, rather than biological and social variations underpinning racial differentiation. However, Msimang points out how Hochman's antirealism makes the question regarding what race someone *really is* nonsensical (Msimang 2019, 23). In the context of healthcare, this is an undesirable outcome because it impedes policies and procedures meant to administer corrective justice for racial groups

historically marginalized in medicine. For example, on Hochman's account, reparative legislation becomes increasingly impractical given an individual's membership in a racialized group may not be sufficiently circumscribed to determine whether that person qualifies for reparations.[5] So, despite the potential benefits, Hochman's antirealism also presents potentially adverse consequences. Some additional mechanism is required for determining when to apply Hochman's antirealism and when to avoid its use. And, this reiterates my chief point– that simply eliminating or replacing race in medicine will not do. Other conditions are needed.

This leads to my second point, which is eliminativism is unnecessary to mitigate the social ills associated with race-based medicine. In the sections that follow, I will show that the additional conditions required for the morally permissible use of race in medicine are sufficient for allaying the concerns associated with race-based medicine. That said, I concede that in certain medical contexts, it may be best to eliminate the use of race. For example, medical researchers have developed new eGFR equations to assess kidney function that jettison the use of race, and consequently, allow Black Americans to receive an earlier diagnosis and better treatment for kidney disease (Inker et al. 2021). What's more the race variable is not substituted with some other population-level alternative, but instead with a focus on creatinine and cystatin C levels in patients. So, in some cases, eliminativism may be the most useful and least morally problematic route for improving population health. But, eliminating the use of race in some cases is not wholesale endorsement of eliminativism. Thus, while eliminativism is honorable in its intentions it is neither necessary nor sufficient for its target goal.

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[5] For example, despite being racialized as a black person for a part of her life, many would think it a mistake for Rachel Dolezal to qualify for reparations. For more on normative issues related to the phenomenon of "passing" under Hochman's antirealism, see Msimang 2019.

§4 – When (if ever) is it morally permissible to use race in medicine?

If eliminativism isn't the answer, how might we adjudicate morally permissible uses of race in medicine? In this section, I will lay out the three requirements for morally permissible uses of race-based medicine. In doing so, I will demonstrate how these conditions address the concerns associated with both biological and non-biological race conservationism. But, before I do that, I should say something about medicine, its aims, and its values more generally. First, I will understand the aim of medicine to be to cure, heal, repair, restore, and make whole (Pellegrino and Thomasma, 1993, 46; Beauchamp and Childress, 2013, 202). Though this is primarily associated with physical health and well-being, it also includes psychological and social health. To fulfill this aim *well*, or with excellence, clinicians and health institutions must be informed by certain virtues, or moral excellences. This is because, without certain virtues undergirding medicine, medicine risks becoming a sort of transaction in which the patient is little more than an object for profit or egoistic gains. Physical healing risks becoming confused with the full extent of healing, and risks neglecting the desires, wills, values, and relations of the patient. In sum, the integrity of the patient becomes in danger of compromise.

Though not an exhaustive list, the virtues I am primarily concerned with include *benevolence*, understood as goodwill toward others, or the proper care and concern of another; *justice*, understood as respect for another's moral status and the consequent rights that accompany such a moral status[6]; and, *trustworthiness*, understood as the state of being technically and moral competent in whatever is being entrusted. This is for three reasons. First, these virtues

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[6] This characterization of justice is inspired by Garcia 2020, 474, 475, 484-5.

cohere with a non-racist attitude[7] – an attitude both conservationists and eliminativists seek to promote. Second, these virtues, though their characterizations vary depending on the normative framework, are important to the three most influential normative theories in moral philosophy and biomedical ethics.[8] Finally, these virtues were identified by medical students and physicians as among the most important for good medical practice (Kotzee et al., 2017). Thus, the application of a virtue-based framework (with an emphasis on benevolence, justice, and trustworthiness) coheres with values shared by moral philosophers, biomedical ethicists, and clinicians, and captures well concerns related to racism.

What is disconcerting about conservationism is that the use of race in medicine has, historically, been un/intentionally used to undermine the aims and virtues of medicine. Race-based medicine has been associated with the stigmatization, subordination, exploitation, and underservice of marginalized racial groups. Thus, to promote total well-being, medical professionals and institutions need to exercise caution when using race in medicine. Medical professionals will need not only technical competence – that is, the know-how particular to

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[7] This first reason is inspired by Garcia's *volitional account of racism*, which understands racism as a moral ill because it violates the virtues of benevolence and justice (1996, 9).

[8] Traditionally, the three most influential normative frameworks have been deontology (especially Kantianism), consequentialism (especially utilitarianism), and virtue ethics (especially eudaimonism, or Aristotelian virtue ethics). All three frameworks have something to say about justice, benevolence, and trustworthiness. For discourse on justice, see Aristotle (1999)*,* Book V, Kant (1797/1996), 369-506, and Mill (1861/2003), 216-35. For discourse on benevolence, see Augustine (1994), 97-99, 208, Aquinas (1990), 465-67, 472-73, 477-78, Kant (1797/1996), 569-71, Kant (1788/1996), 206, and Mill (1859/2003), 148. For discourse on trustworthiness, see Aristotle (1999), Book IV, Chapter 7 and Kant (1785/2014), 4:401-403. For general discourse on virtue in Kantianism, see Kant (1797/1996), 533-37. For general discourse on virtue in utilitarianism, see Mill (1861/2003), 211-215.

medicine – but moral competence that demonstrates the virtues necessary for excellent medical practice. Given this, what does morally permissible race-based medicine look like? To begin, consider, the following:

> ***The Multifactorial Inheritance Case***: a health disparity has been observed between two groups, G_1 and G_2. The cause(s) of the disparity are not completely understood, but medical researchers have also observed drastic differences in the living conditions, social interactions, and opportunities afforded each group. Despite the correlation between social and environmental factors and the disparity, medical researchers have reason to believe that genetic factors may also play a role.

Given the finite resources available in medicine, which line of inquiry should be pursued? The social determinants of health? The (potential) genetic factors? Should researchers allocate resources to both? If so, which (if either) should take priority? As previously mentioned, social determinants of health are a chief concern for non-biological race conservationists, and the potential neglect of these determinants is a chief criticism leveled against biological race conservationism. For example, when talking about disparities in asthma, Roberts challenges the wisdom of searching for a "unique genetic signature that predisposes children of certain race[s] to get sick with asthma," when many research studies have identified pests and air pollution as triggers for asthma (2011, 108-11). Without considering how the burdens of pest and pollution are distributed among racial groups, the exclusive search for an asthma gene modulated by race is ill-informed. Therefore, I suggest the following:

>*Social Determinants Requirement:* when applicable, social determinants of
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>health should be sufficiently engaged prior to or in tandem with the use of
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>race.

Here, social determinants of health include exogenous factors, such as diet, residence and neighborhood, exposure to toxic materials, familial and peer relationships, upbringing, and working conditions. Consideration of such factors is applicable when a disease or phenotypic trait (henceforth, trait) is associated with more than one factor or cause, the genetic variations implicated only occasionally produce the trait(s) associated with them, or the genetic variations implicated almost always produce the trait(s) associated with them, but the symptoms are modulated by social or environmental factors. For example, the genetic variations implicated in hypertension (a condition that disproportionately impacts US-born Black Americans) only occasionally produce hypertension (Tanira and Balushi, 2005; Hamid et al., 2009). This is because hypertension is associated with several social determinants of health – e.g., education level, employment, and diet (Tyson et al., 2012; Commodore-Mensah et al., 2021). Thus, the social determinants requirement would demand that social determinants implicated in hypertension be sufficiently engaged prior to or in tandem with the use of race in research, care, and education related to hypertension. Consider, also, phenylketonuria (PKU). The genotypes associated with PKU will almost always manifest as PKU. Nevertheless, the symptoms of PKU are modulated by one's diet. So, despite PKU being an inherited disorder, the social determinants requirement is applicable, because PKU is influenced by factors like food access.

Note, while the social determinants requirement may initially appear to be a safeguard against unwarranted uses of biological racial classifications, it is also meant to influence the use of non-biological racial classifications. Remember, according to non-biological race

conservationists, the primary defense for preserving a non-biological racial classification is to track racism's impact on health. And, while this is certainly appropriate in some contexts, it is unclear that race as a variable is sufficient for adequately understanding and intervening into the relevant social factors implicated in racial health disparities. Using race as a variable may confound or obscure the variety of ways racism impacts health. Consider the following:

> ***Many Faces of Racism in Healthcare:*** races R_3 and R_4 are similarly
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> disproportionately burdened with a disease D_1 because of racism. But, the way
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> racism is implicated in the incidence, prevalence, and outcomes of D_1 for R_3 is
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> different than the way racism is implicated in the incidence, prevalence, and
>
> outcomes of D_1 for R_4. For R_3, the incidence, prevalence, and outcomes of D_1 are
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> predicated on racial residential segregation and housing discrimination that
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> impedes access to hospitals. In contrast, for R_4, the incidence, prevalence, and
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> outcomes of D_1 are predicated on members from R_4 having a lack of access to
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> medical insurance due to strenuous laws that seem to target members from R_4.

Note, then, that both races R_3 and R_4 are disproportionately burdened with a disease due to racist laws and infrastructures. Yet, to simply use race as a variable to track racism would not provide the proper level of specificity to highlight the many pathways to and from racism and how the relevant pathways implicated in both cases are distinct. This problem can be further exacerbated if a *single* race (e.g., R_3) is disproportionately burdened by a disease because of racism, but there are different manifestations of racism targeting different subgroups of R_3. In this case, to simply use race as a variable to track racism would not provide the proper level of specificity to highlight the heterogeneity of racism impacting a single race. This is analogous to a criticism of biological race conservationism, in that it suggests that using race may obscure the social

diversity *within* racial groups. The social determinants requirement seeks to disentangle these variegated social factors prior to or in tandem with race to better target the relevant one(s) for intervention.

Additionally, targeting racism alone as a social determinant of health via the use of race is too narrow an investigation into racial health disparities, given there are likely social determinants not affiliated (or, only distantly associated) with racism that modulate these disparities. For example, diets predicated on religious beliefs may be associated with some racial health disparity (RHD_1), if those religious beliefs are also associated with some racial group(s). But, it is not obvious that RHD_1 is modulated by racism, unless the religious beliefs motivating the diet are predicated on racism. The social determinants requirement promotes investigation into both racist and non-racist social determinants of health implicated in racial health disparities.

The social determinants requirement offers direction as it regards the issue of finite resources in healthcare. In an enterprise where resource allocation is practically unavoidable, the social determinants requirement suggests prioritizing social determinants of health by ensuring that, when applicable, these determinants are not precluded from investigation. Note, however, that the social determinants requirement does not give exclusive (temporal) priority to social determinants of health. Investigation into both race and social determinants of health may prove most effective in intervening into a racial health disparity. So, the social determinants requirement is best understood as prioritizing social determinants of health by precluding, *when applicable*, exclusive investigation into race-related, medically relevant differences via some racial classification. Such prioritizing takes seriously the concern that using race in medicine may lead to the neglect of social determinants of health, but does so in a way that doesn't necessarily preclude the use of race.

Moving on, consider the following:

The Havasupai Tribe Case: In the early 1990s, Arizona State University faculty

members were given permission by the Havasupai tribe to collect blood samples

from tribe members to study the cause(s) of diabetes prevalent in the tribe.

However, at the conclusion of the diabetes study, the samples were further used

for research related to schizophrenia, inbreeding, and human population migration

without the knowledge or consent of the Havasupai tribe. Additionally, these

genetic materials were distributed to the University of Arizona without the

knowledge or consent of the Havasupai tribe. Results from these extracurricular

projects were, in some instances, published for public viewing.

At stake in the above case is a compromise of privacy. Confidentiality, secure and temporary

data retention, and control of genetic material were potentially compromised when Arizona State

University researchers distributed the blood samples without the consent of the Havasupai Tribe.

Additionally, the loss of control over their DNA samples suggested a loss of control over

attributes regarding the identities of the Havasupai participants.[9] All such violations are contrary

to rights to privacy protected under US law[10]; laws that are meant to promote justice by

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[9] In fact, in the tribe's lawsuit against the Arizona Board of Regents, chief among the claims made was a violation of

their right to privacy (Havasupai Tribe of Havasupai Reservation v. Arizona Board of Regents, 2008).

[10] Here, I have in mind the four privacy torts (*the intrusion tort*, *the publication of private facts tort*, *the false light*

tort, and *the appropriation tort*), as well as federal privacy statues related to health records and information (e.g.,

Health Insurance Portability and Accountability Act of 1966 [HIPPA] and the Genetic Information Non-

discrimination Act of 2008 [GINA]) (see Allen and Rotenberg 2016, 52, 125, 160, 179). Note, though I have chosen

to focus on US law and privacy rights, there are also international laws protecting privacy rights (see Allen and

Rotenberg 2016, 12-13, 1297-1578).

protecting the dignity of human individuals and preserving their ability to exercise autonomy and determination over the most fundamental and intimate parts of their lives. Allen and Rotenberg write:

> … opportunities for privacy are said to allow individuals to better express their true personalities, preserve their reputations, relax, create, and reflect. Opportunities for privacy are thought to enable individuals to keep some people at a distance, so that they can enjoy intense intimate relationships with others on their own terms (2016, 8).

So, privacy laws are not arbitrary or without warrant, but aim to promote justice through a demonstration of respect for another's moral status and the consequent rights that accompany such a moral status. In sum, privacy laws are *just* legal norms.

The Havasupai Tribe Case highlights how the use of race can violate just legal norms. The potential violation of privacy is the result of using genetic material to partition humanity into subpopulations. Similarly, the use of race in medicine stratifies humanity into subpopulations. Thus, were the use of race to cause an unwarranted violation of privacy rights, or more generally, the violation of just legal norms, it would follow that its use would be impermissible on risk of perpetuating injustice. Thus, I suggest the following:

> ***Legal Norms Requirement:*** if medical professionals are going to use race in medicine, they should do so in a way that does not undermine just legal norms, either through explicit violation of the norms or through the unjust application of those norms.

Medicine is a social enterprise constrained by legal norms to protect medical professionals, their patients, and the medical institutions in which they operate. Because there

are legal norms that constrain medicine, medical professionals need to adhere to those legal

norms. But, it is neither necessary nor sufficient to adhere to all legal norms constraining

medicine to achieve the aim of medicine. *De jure* racism was predicated on *unjust* (race-based)

legal norms. Yet, it would be morally repugnant to endorse adherence to such laws. Instead,

medical professionals should adhere to *just* legal norms. Thus, if medical professionals are going

to use race in medicine, they should do so in a way that does not undermine *just* legal norms,

either through explicit violation of those norms or through the unjust application of those norms.

Unjust laws and policies must be emended or else eschewed. Unjust applications of just laws

and policies require sanctions and reparation to reform insidious practices.

As a final requirement, consider the variegated contexts in which medicine takes place.

One benefit of current conservationist views is that they understand that depending on the

context, alternative classifications may be less morally problematic and more beneficial to the

targeted aims of medicine. For example, according to Maglo, medical researchers should use the

level of classification that best reflects the population(s) observed and that meets the requirement

of improving the status of populations whose health needs are discounted (Maglo 2010, 366-9).

So, if race R_1 consists of members from groups G_1, G_2, and G_3, and I conduct a clinical trial

using *only* participants from G_1, it would be inappropriate for me to generalize to R_1. Instead, I

should use a more fine-grained alternative that better captures G_1 as a distinct group from G_2,

and G_3. Relatedly, if I found a drug to be effective for some race R_5, but I never test the drug

with participants from other races, it would be presumptuous and unwarranted for me to declare

the drug an R_5-specific drug, given I have not even checked its effectiveness in other racial

groups.[11] These concerns, coupled with the promotion of alternative classifications (see§2 and §3) have inspired the following:

> ***Harm Minimization Requirement:*** when the end(s) sought by some medical investigation or practice can be acquired using a classification other than race, and that alternative classification does not generate or multiply harms independent of race considerations, then medical professionals should use the alternative classification.

When faced with two (or more) classifications, if the benefits sought can be obtained with more than one of the available classifications, but one proves less morally problematic, then reason dictates choosing the less morally problematic means to acquire the ends sought. So, if the benefits of using race can be obtained using some alternative classification that is not accompanied by potential risks and harms associated with race, and if that alternative classification does not generate or multiply harms independent of race considerations, medical professionals should use the alternative construct.

In sum, the harm minimization requirement is meant to foreground the ethical and social implications of model choice in biomedicine. In doing so, the harm minimization requirement allows conservationists to take seriously the medically relevant biological diversity *within* racial groups, as well as the medically relevant traits shared *among* racial groups (see §2), because the harm minimization requirement will dictate that the model chosen reflect the diversity *within* and

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[11] This is akin to the charge made against the A-HeFT clinical trial used for the FDA's approval of its first race-based medication, BiDil. Critics suggested that since the A-HeFT trial *only* enrolled Black Americans as participants, its claim to be more effective in Blacks was undermined (see Roberts 2011, 168-89; Maglo 2010, 365-7).

similarities *among* racial groups when relevant to the medical investigation at hand. Relatedly, the harm minimization requirement creates room for alternative classifications and acknowledges that they may be better suited to the targeted aim(s) of the medical endeavor at hand. Assuming these classifications are distinct from races, it may very well be the case that (genomic) ancestry groups, ethnicities, populations, or racialized groups are, at times, better suited than race to accomplish the medical ends sought. For example, Choudhury et al. (2020) conducted whole-genome sequencing analyses consisting of over 50 ethnolinguistic groups on the continent of Africa and found that an ethnolinguistic classification captured medically relevant genetic differences between the groups that would not have been captured if race were used.

One concern with the harm minimization requirement regards cases in which the viable alternative(s) generate (near) equal harms to race. When an alternative construct trades the potential risks and harms associated with race for a new set of risks and harms (race-related or not), how should medical professionals determine which harms and risks to shoulder? Call this the *equivalent harms objection*. Though more of a concern with the *application* of the harm minimization requirement than an outright undermining of the criterion, this is an important question. Medical professionals are not only concerned with eliminating race-related social ills in healthcare, but with eliminating vicious behavior in healthcare more generally. I will focus on cases of incommensurability – that is, cases where there is either no single standard by which to adjudicate between the alternatives or where there is insufficient reason to choose one alternative over another.

The first class of incommensurable cases deal with cases where there is no single standard by which to adjudicate between the alternatives. Take for example, an epistemic harm in comparison to a moral harm. It is unclear that these can be judged by the same standard. Yet,

many will agree that, all else being equal, the moral harm has greater import in deliberation than the epistemic harm. Philip Kitcher offers as an example those scientific investigations that risk inegalitarian conclusions regarding race and sex (2001, 96-108). Prohibition of such investigations might harm epistemically, in that researchers are not given the chance to demonstrate the null hypothesis. But, the moral harms, which include perpetuating racist and sexist attitudes, and the lack of moral benefit, make it so that such investigations should, with rare exception, be avoided. Though Kitcher endorses a consequentialist normative framework, his moral judgment coheres with the virtue-based framework undergirding the harm minimization requirement. The medical professional who cares about the well-being and rights of others will recognize that, at times, certain moral considerations take priority over epistemic ones. As it relates to the harm minimization requirement, this will amount to adjudicating between the *quality* of harms and benefits associated with various constructs to weigh them despite lacking a common measure.

The second class of incommensurable cases deal with cases that appear to pose an irresolvable dilemma. To borrow from Rosalind Hursthouse, an irresolvable dilemma is "a situation in which the agent's moral choice lies between x and y and there are no moral grounds for favouring doing x over doing y" (2001, 63). What's more, in such dilemmas, the moral agent does wrong whatever she chooses. In the current context, the dilemma is that there is no rational reason to choose one construct over another, *and* whatever construct is chosen will violate the norms undergirded by the virtues relevant to medicine. This is a problem. But, such is the nature of irresolvable dilemmas. To assume a decision procedure that adjudicates irresolvable dilemmas is to flatten the complex moral terrain that constitutes the world. It is to treat as simple that which is not. And, it is likely to lead to an unwarranted confidence in one's moral judgment.

That said, even if there are difficulties in adjudicating between constructs, it does not follow that the harm minimization requirement is an unhelpful criterion. It exhorts medical professionals to assess the constructs they use rather than unwittingly adopting potentially harmful frameworks.

The equivalent harms objection is a serious one, and deserves further elaboration. But, for the sake of space, I will limit myself to two concluding remarks. First, when all constructs in consideration present equally damning harms, it may be best to refrain from pursuing the medical ends sought until better constructs are devised. Not every medical endeavor is a worthy one. But, and second, avoidance of certain medical endeavors may not be possible. And, in such cases, when competing constructs have equally damning harms, then perhaps there is no reason to choose one alternative over another. An alternative just needs to be chosen. Anything else would be cowardice or non-benevolence.

Using these three requirements, I will argue that it is morally permissible to use race in medicine *iff*

> (i) when applicable, social determinants of health are sufficiently engaged prior to
>
> or in tandem with the use of race (*social determinants requirement*),
>
> (ii) the medical end(s) sought cohere with the aim of medicine and are best
>
> acquired using race (*harm minimization requirement*), and
>
> (iii) the use of race does not violate the relevant just legal norms constraining
>
> medical practice more generally (*legal norms requirement*).

In what follows I defend the necessity and sufficiency of these criteria for adjudicating morally permissible uses of race in medicine.

§5 – On the necessity of (i) – (iii)

My argument for the *necessity* of (i) – (iii) is as follows:

1. If failure to fulfill (i) – (iii) while using race in medicine is vicious, then it is necessary to fulfill (i) – (iii) for the permissible use of race in medicine.

2. Failure to fulfill (i) – (iii) while using race in medicine is vicious.

3. Therefore, it is necessary to fulfill (i) – (iii) for the permissible use of race in medicine.

Regarding (1), though virtue-based frameworks are not typically seen as theories of right action, virtues can be used to generate obligations and prohibitions (Hursthouse, 2001; Garcia, 2020). For example, except in the case of irresolvable dilemmas, perpetuating vice is prohibited for the sake of human well-being and flourishing. Thus, when omitting (an) action(s) ϕ in some context C results in viciousness, it follows that ϕ-ing is necessary in C to avoid viciousness. Consider the following argument from analogy: if not ensuring your toddler has a competent babysitter before you leave for the theater is vicious, then it is necessary that you ensure your toddler has a competent babysitter before you leave for the theater. Though leaving for the theater is not inherently vicious, it is vicious to leave for the theater when you have failed to first ensure the safety and security of your toddler by finding a competent sitter. Notice, too, that which sitter you choose will vary depending on context (e.g., who's available). All that is required is that the sitter can competently care for your toddler. Similarly, the use of race in medicine is not inherently vicious. And, how (i) – (iii) are fulfilled will vary depending on context. What is required is that (i) – (iii) are fulfilled, and that their fulfillment is done in a manner that coheres with medicine done *well*. Why?

In the case of each requirement, failure to fulfill any one of them will demonstrate technical or moral incompetence tantamount to viciousness. This viciousness will ultimately compromise the aim of medicine. Regarding the social determinants requirement, failure to

fulfill this criterion will result in bad science and poor medical practice. There is a plethora of data demonstrating the impact of social determinants on both mental and physical health. To use race without fulfilling the social determinants requirement is to inadequately address these confounders. Consider, again, racial health disparities related to asthma. Without considering how the burdens of pest and pollution are distributed among racial groups, the exclusive search for an asthma gene modulated by race is ill-informed, and diminishes the trustworthiness of the medical practitioner/institution.

What's more, failure to fulfill the social determinants requirement demonstrates an unjust and non-benevolent attitude, because it does not take seriously enough how race-based medicine may further stigmatize the health of certain racial groups. Ironically, using race to improve the health outcomes of marginalized racial groups without considering the relevant social determinants is likely to worsen the health of those groups, because the exclusive (ab)use of race has in the past contributed to racism, and racism – both interpersonal and institutional, both directly and indirectly – impacts physical and mental health (Krieger, 2014; Bailey et al., 2017; Williams et al., 2019). So, failure to fulfill the social determinants requirement undermines trustworthiness by promoting bad science and poor medical practice. And, failure to fulfill the social determinants requirement also undermines justice and benevolence by risking unnecessary stigmatization of certain racial groups and confounding social factors implicated in health disparities.

Some might object that the social determinants requirement places too heavy a burden on researchers and clinicians by demanding them to engage in interventions beyond the scope of their expertise. For example, why should a medical geneticist be engaged in the work of a social epidemiologist (especially if she isn't trained for such work)? And, what does it mean for a

clinician to engage social determinants of health when treating patients? Call this the *overburdening objection*. As previously stated, how the social determinants requirement is fulfilled will vary depending on context and competency. For example, in the case of the medical geneticist, collaboration with a social epidemiologist, or acknowledging alternative explanations in social epidemiology, may be sufficient. And, in the case of the clinician, it may simply amount to how she prioritizes treatment recommendations. Ultimately, the social determinants requirement is meant to highlight the indispensable role of medical professionals in the remedy of social determinants of health. But, it need not amount to adopting research methodologies or practices beyond their expertise.

Regarding the harm minimization requirement, failure to fulfill this criterion also results in bad science and poor medical practice, but for different reasons. To begin, it fails to acknowledge that different research programs and medical practices require different classification schemes to fulfill the many ends sought in medicine. For example, as previously mentioned, hypertension disproportionately impacts Black Americans. But, the rate at which hypertension impacts Black Americans is not stable across all ethnic groups typically subsumed under the racial group, 'Black.' Thus, in medical research related to hypertension, a more fined-grained classification (e.g., ethnicity) is better suited. To ignore this in favor of using race is to demonstrate a lack of technical expertise.

What explains this lack of technical expertise? I suggest it is ignorance of the relevant classification or moral incompetence. Initial ignorance of the relevant classification is excusable for the medical neophyte, though such ignorance would undermine her trustworthiness. It is less excusable for the expert whose expertise suggests some acquaintance with alternative classifications and whose expertise is meant to confer some authority on the subject matter. To

favor racial classifications (with their attendant risks and harms) at the neglect of better-suited classifications is to be negligent. So, at best, failing to fulfill the harm minimization requirement demonstrates technical incompetence. Or, worse, it demonstrates a technical incompetence founded on negligence, and thus moral incompetence. In either case, violation of the harm minimization requirement acts against the aim of medicine and the virtues undergirding it.

Some might object that the harm minimization requirement is too restrictive, in that there are very few scientific classifications that are indispensable to a research program. Consider, for example, the varied ways that taxonomists divide organisms into species, sometimes in a single research program! So, the objection goes, there will always be some alternative to race that can be used to achieve the ends sought. Call this the *underdetermination objection*. In response, consider again, my response to current alternatives , in which I argued that simply replacing race with some alternative is insufficient to stave off the relevant concerns, because many of these alternatives have similar potential harms to race (see §3).

What's more, depending on the trait(s) being investigated, the use of alternatives, such as ethnicity, ancestry, or population may be impractical or imprecise. The appropriate level of classification is contingent on the context. For example, Spencer (2018) highlights a study on maternal age-specific rates for Down syndrome based on maternal race/ethnicity, in which researchers found that Pacific Islanders, age 40 years and older, had significantly lower rates for children born with Down syndrome than other racial/ethnic groups investigated in that same age range. And, as Spencer notes, "This pattern is robust across Polynesian and Micronesian women, which strongly suggests that the Pacific Islander race is not too heterogeneous to be useful in health research" (Spencer 2018, 1033-34). This result is important, because "maternal age-specific Down syndrome rates are used to... estimate a woman's risk of having an infant with

Down syndrome given her age" (Forester and Merz 2003, 625), and could impact family planning for some individuals. Thus, any use of a finer-grained classification would have unnecessarily multiplied categories, and obscured the study's ability to generalize across multiple populations cared about.

The underdetermination objection does not imply the discontinuation of race, given current available alternatives, like ethnicity, ancestry, and populations. That said, if the context required a more well-defined alternative, and that alternative was morally superior, it would follow from the harm minimization requirement that clinicians and researchers should use the alternative to race *in that context*. Or, if an alternative were more well defined, morally superior, and could be used in *every instance* race is used, it would follow from the harm minimization requirement that clinicians and researchers would have no need for race. I am completely comfortable with those conclusions. Yet, it would still stand that additional criteria are required to adequately address the potential harms seemingly endemic to any classificatory scheme dividing humans into subpopulations.

Finally, any use of race that fails to conform to the legal norms requirement risks corroding medicine through the promotion of injustice. Thus, failure to fulfill conditions (i) – (iii) while using race in medicine demonstrates viciousness through technical or moral incompetence. Such incompetence compromises the aim of medicine and violates the virtues necessary for promoting medicine done well. Thus, if medical professionals and institutions are going to use race in a way that does not impede the aim of medicine and does not promote viciousness, they will need to fulfill each condition. That each condition is necessary implies that any condition taken on its own, or any combination of two conditions to the exclusion of a

third, will be insufficient for the permissible use of race in medicine. But, why think that the three criteria taken together are sufficient for the permissible use of race in medicine?

§6 – On the sufficiency of (i) – (iii)

My argument for the *sufficiency* of (i) – (iii) is as follows:

4. If fulfillment of (i) – (iii) allays the relevant concerns with race-based medicine in a manner that coheres with medicine done *well*, then fulfillment of (i) – (iii) is sufficient for the permissible use of race in medicine.

5. Fulfillment of (i) – (iii) allays the relevant concerns with race-based medicine in a manner that coheres with medicine done *well*.

6. Therefore, fulfillment of (i) – (iii) is sufficient for the permissible use of race in medicine.

Regarding (4), if medical professionals can assuage (or, resolve) the relevant concerns with race-based medicine in a manner that coheres with medicine done *well*, then these concerns no longer serve as justification for eliminating race in medicine. Admittedly, as advances are made in medicine, and as social structures continue to change, new harms, risks, and benefits may emerge that demand amending or expanding the conditions for the permissible use of race in medicine. But, given the time-sensitivity of medicine and health, and given the potential utility of race in medicine, excessive restriction of the use of race in medicine errs on the side of non-benevolence. There should be space for some risk if the benefits include closing racial health disparities and caring for racial groups typically marginalized and underserved. Thus, addressing the relevant concerns, which include mitigating racism, properly addressing all confounding (social) variables implicated in disease, and acknowledging the diversity *within* and similarity *between* groups is sufficient for defending against the most deleterious risks.

The question, now, is whether fulfillment of (i) – (iii) in fact allays these concerns in a manner that coheres with medicine done *well*. To begin, the social determinants requirement helps foreground the concern that emphasis on supposed genetic differences to the neglect of social determinants of health both misses a major culprit in health disparities and reinforces rather than rectifies racial injustices in healthcare. Additionally, fulfillment of the social determinants requirement comports with a just disposition, especially as it relates to corrective justice. Addressing social determinants of health, many of which are modulated by systemic injustices, would not only mitigate negative health outcomes, but begin the process of repairing structures that have historically disadvantaged certain racial groups. For example, creating environments in which fewer pests are present and less pollution is pumped into the air will not only improve the quality of health of those confined to these spaces, but also begin redressing the residential segregation that has informed how the disproportionate burden of pests and pollution is distributed among racial groups. By seeking to remedy disparities in the environment, healthcare aids in the larger project of *restoring* the rights and wills of people historically oppressed and ignored in such environments. In doing this, (groups of) individuals being served have a greater potential to integrate the whole of their lives.

Furthermore, consideration of social determinants of health demonstrates a good faith effort to mitigate the sort of racialist thinking that is commonly associated with race by shifting (some of) the focus on structural injustices instead of erroneously attributing racial health disparities to issues inherent in a race's biology or culture. Sincere and sustained engagement with social determinants of health will highlight not only the habits of the communities in question, but the catalysts for the development of such habits, as well as the non-cultural, non-biological exogenous factors at play. For example, Williams and Collins (2001) note that racial

residential segregation can (partially) account for issues of comorbidities and substance use, where a lack of access to quality grocery items, a lack of access to recreational facilities, and heavy advertisement from tobacco and alcohol industries is disproportionately shouldered by black neighborhoods. Without this information, inferring racialist explanations is low hanging and spoiled fruit. Worse, it unwarrantedly blames the sick and vulnerable for their sickness! But, when sufficient consideration is given to social and environmental influences apart from or in tandem with race, it becomes more difficult to make such careless inferences. This demonstrates both benevolence and trustworthiness. It demonstrates benevolence by giving proper care and concern to mitigate racial health stigmas. It demonstrates trustworthiness by complimenting the benevolent and just disposition previously mentioned with technical competence. Fulfilling the social determinants requirement demonstrates an understanding of the (fundamental) causes of diseases and ailments. It provides medical professionals with the relevant information to make informed decisions about how to intervene in a manner consistent with the aim of medicine. Thus, the social determinants requirement is sympathetic to eliminativists' concerns about social determinants of health in a manner that coheres with medicine done well.

Moving on, the harm minimization requirement takes seriously the alternative classifications offered, and encourages the use of these alternatives when appropriate. In some contexts, alternatives do work better than race. For example, Williams & Williams-Morris highlight how the *racialization* of the Hispanic population is associated with psychological distress, material inequalities, and negative health outcomes (2000, 246, 247, 249, 252). But, under certain racial classifications (e.g., the Office of Management and Budget's racial scheme), the Hispanic population would not be considered a race/racialized group, but instead an

ethnicity. Yet, it is the racialization of this community, and the consequent racism, that is driving the negative health outcomes. So, the harm minimization requirement acknowledges that context matters when choosing a classification, and in some contexts, certain racial classifications are inappropriate. But, the harm minimization requirement doesn't presuppose that race will never be the best classification in other contexts.

What's more, adherence to the harm minimization requirement demonstrates both technical and moral competence. It demonstrates technical competence in that proper application of classifications in medicine requires technical expertise. Additionally, it demonstrates technical competence in that a more expansive set of classifications will allow medical professionals, when necessary, to better highlight the (genetic) diversity *within* and (genetic) similarity *among* groups when necessary. It demonstrates moral competence in that careful consideration of a classification's moral import demonstrates commitment to promoting and preserving the integrity and respect of those persons most impacted. This combination of technical and moral competence warrants the sort of trust necessary for healthcare and medical research to function as it should. In sum, the harm minimization requirement reflects well the cognitive and dispositional states necessary to practice medicine well.

Finally, the legal norms requirement allays concerns about the use of race undermining the dignity and rights of racial groups. The legal norms requirement takes as a central component to the permissible use of race the protection of human rights and the promotion of those laws that acknowledge the equal moral status of all human persons. Ultimately, the legal norms requirement acknowledges the sociopolitical dimensions of using race in medicine, and seeks to protect (groups of) individuals from structures that have historically used *de jure* racism

to justify the subordination and neglect of some in healthcare, without assuming all uses of race in medicine will, in some way, violate the dignity and rights of these racial groups.

The upshot of the sufficiency of (i) – (iii) in adjudicating morally permissible uses of race in medicine is that it makes eliminativism unnecessary. The risks and harms associated with the use of race in medicine are sufficiently assuaged under (i) – (iii), and done so without wholesale eliminativism.

§7 – Putting it all together

Having argued for necessary and sufficient conditions for the permissible use of race in medicine, it's now time to put it together:

3. It is necessary to fulfill (i) – (iii) for the permissible use of race in medicine (§5).

6. Fulfillment of (i) – (iii) is sufficient for the permissible use of race in medicine (§6).

7. If (3) and (6), then it is permissible to use race in medicine *iff* (i) when applicable, social determinants of health are sufficiently engaged prior to or in tandem with the use of race, (ii) the medical end(s) sought cohere with the aim of medicine and are best acquired using race, and (iii) the use of race does not violate the relevant just legal norms constraining medical practice more generally.

8. Therefore, it is permissible to use race in medicine *iff* (i) when applicable, social determinants of health are sufficiently engaged prior to or in tandem with the use of race, (ii) the medical end(s) sought cohere with the aim of medicine and are best acquired using race, and (iii) the use of race does

not violate the relevant just legal norms constraining medical practice more generally.

Since the combination of (3) and (6) are logically equivalent to the consequent in (7), it follows that fulfillment of (i) – (iii) are necessary and sufficient for the permissible use of race in medicine.

Using these conditions, I can generate a decision tree for determining the permissible use of race in medicine (see Fig. 1). Call this the *race in medicine decision tree, or RIM*.
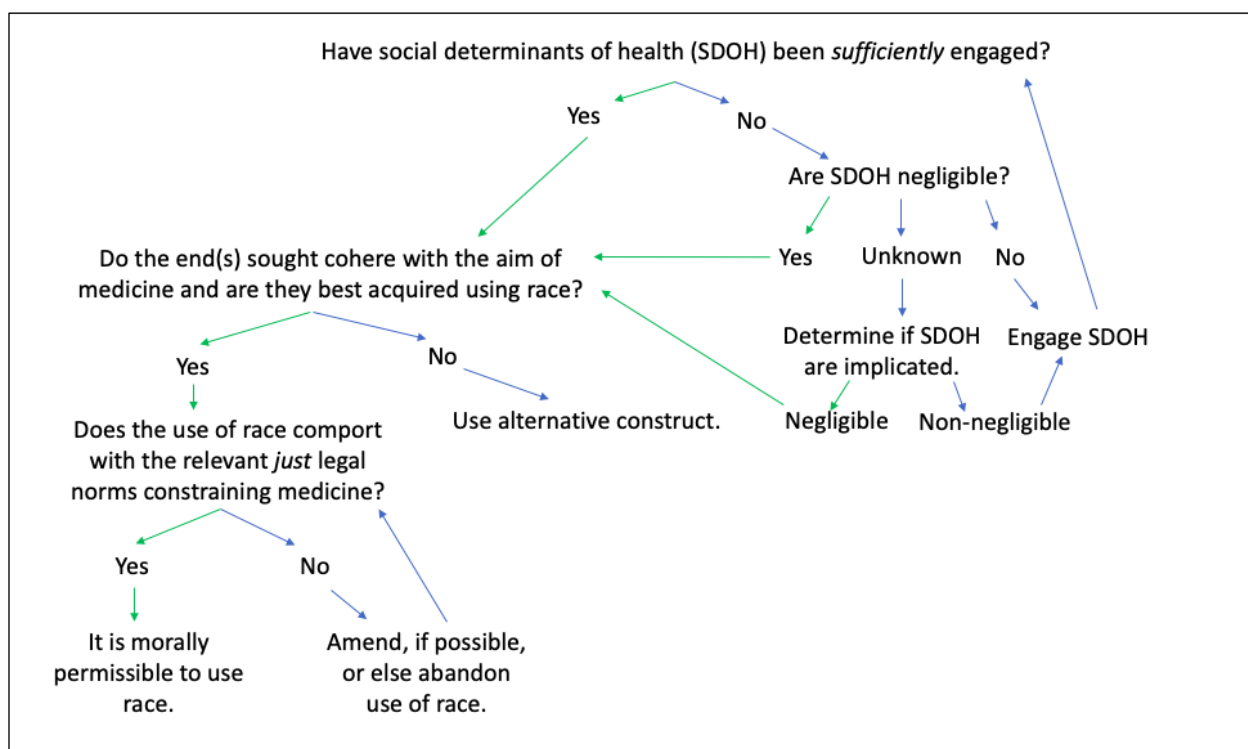

Fig. 1 – RIM

These conditions are generated by virtues associated with medicine done well and are meant to direct toward the sort of actions precipitated by these virtues. Note, the order in which the conditions are placed is not meant to suggest some sort of (temporal) priority of certain conditions over others. In fact, the conditions can be rearranged to generate an equivalent

decision tree. What is important is that these conditions are fulfilled for the permissible use of race in medicine.

Also note that though RIM is presented as a decision tree, it does not follow that it can be applied in any mechanical manner, as fulfillment of each criterion will vary depending on context. But, such is the nature of moral deliberation. Following Hursthouse, "A normative ethics should not aim to provide a decision procedure that any reasonably clever adolescent could apply" (2001, 18). A decision tree that requires mechanical adherence to the exclusion of practical reasoning flattens the moral terrain in a way contrary to the aims of medicine and human flourishing. Nevertheless, RIM foregrounds norms and values central in the debate about the use of race in medicine and promotes the virtues necessary for practicing medicine well.

Finally, with advances in medicine, and as social structures continue to change, new harms, risks, and benefits may emerge that demand expansion of RIM. Thus, while RIM is suitable for our *current* sociohistorical context, new conditions may be necessary to accommodate significant changes in medicine and society.

§8 – Conclusion

The conservationists and eliminativists highlighted in this paper want the same thing – more equitable healthcare for all. RIM provides that by drawing a bridge between the relevant parties of this debate. It assuages the concerns associated with race-based medicine without disregarding the potential benefits highlighted by conservationists.

In closing, I want to make four remarks. First, in defending conservationism in medicine, it does not follow that eliminativism may not be suitable in other contexts. Given the context-sensitivity surrounding race and racism, any global eliminativism or global conservationism is unlikely to resolve the normative debates in the philosophy of race. Second, as is the case with

nearly all metaphysical debates, the nature and existence status of race is still a live debate in the philosophy of race. But, medical professionals, researchers, and their patients cannot wait for the debate to be settled before engaging health disparities. RIM demonstrates that we can engage in moral deliberation about some of the most pressing normative issues in race and medicine without resolving or committing ourselves to a particular metaphysics of race. Third, RIM ought not be seen as an attempt to let race in the back door of medicine. Given the conditions presented, it very well may be the case that most race-based medicine practiced today is done so in an impermissible manner. RIM is meant to keep us accountable to and consonant with virtuous medical practice. Finally, in defending conservationism in medicine, it does not follow that I, or other conservationists, believe there are morally significant differences to be found between racial groups. For example, using race in medicine will never demonstrate a difference in moral status between racial groups, because *moral status is not determined by one's biology, culture, or social circumstances.* RIM is meant to promote the closure of racial health disparities, not (re)assert bankrupt racial hierarchies. RIM encourages medical professionals and institutions, *as well as philosophers*, to grapple with their reasons for using (or, excluding) race-talk in their research, practice, and discourse.

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