"Of all the forms of inequality, injustice in health is the most shocking and the most inhuman."—Martin Luther King Jr., Medical Committee for Human Rights Convention (1966)

Just as in education and other areas of social welfare in the United States, the inequalities that Dr. Martin Luther King Jr. was raising in 1966 about health care have continued to persist in today's medically segregated world. In our fast-moving culture and with the increasing virtualization of social relations, the concentration of poverty and its consequences may not always be so apparent to those who live in neighborhoods of greater affluence. Yet, this invisibility must be understood in the context of neoliberalism's dismantling of the safety net, which once offered some semblance of social welfare protection against the excesses of capital. A disgraceful consequence of neoliberalism has been precisely the rising segregation of poor people, particularly people of color, associated with a growing centralization of wealth among the few and deepening structures of economic apartheid within both urban and rural areas across the United States.

The current neoliberal disregard for the impoverishment of large sectors of the population has left millions in extreme poverty around the globe, without access to adequate health care. Just as we can conceptualize education with respect to segregation, so too the history of medicine and health-care abuses must be understood in these terms as well. Similarly, issues of racism in medicine must be engaged within the realities of absurd contradictions of a political economy devoid of a moral compass. Hence, racism or any other form of inequality or social exclusion within medicine, education or the wider society can never be effectively ameliorated without attending to the underlying structural causes.

Comprehending Racism
In a recent national poll sponsored by CNN and the Kaiser Family Foundation, almost half of all the participants stated that racism is a "big problem" in the United States today. This figure constitutes a significant shift from just four years ago, when slightly more than a quarter of Americans described racism in this way. It goes without saying that racism constitutes one of the most violent and insidious forms of human oppression. Yet, racism still seems to be one of the most difficult social phenomena for members of the dominant culture to both see and comprehend.

Often the difficulty with comprehending racism arises from a legacy of faulty perceptions and assumptions that persist in the perceptions of white folks. In addition to ethnocentric values, much of the difficulty is also related to a pervasive and commonsensical ideology of race, coupled with an epistemology that effectively stifles the ability of white physicians to move from an individual perception of bias, prejudice and discrimination to an understanding of racism as a structural phenomenon, which is perpetuated by an institutional apparatus of power and control. This becomes even more complicated when conditions of racism commingle with other forms of oppression to intensify and amplify the lives of patients from subaltern populations. Nevertheless, what is key here is that the ability to comprehend racism, as an institutional phenomenon, is essential to both its amelioration and eradication.

Ethnocentrism in medicine is most often manifested through institutional standards and protocols of behavior by which all in the profession are judged and compared. These standards and protocols are generally based on implicit cultural assumptions that function to preserve and protect the privilege, power and wealth of a ruling class. This phenomenon, for example, is at work in expressed colorblind views, which prevail in medicine and medical schools today. Colorblindness as an ideology tends "to individualize conflicts and shortcomings, rather than examine the larger picture of cultural difference, stereotypes, and values placed in context" (Williams, 2011). In the process, both the normalizing and naturalizing of white superiority and chauvinism function to effectively silence the voices of medical students and patients of color, by ignoring or silencing their concerns or experiences related to racism.

As such, racialized assumptions work to normalize, justify and reproduce biases held by many doctors and medical school professors who fail to perceive the racism inherent in their conditioned inclination to judge and compare the success of poor and working-class medical students of color, for example, against that of affluent white students. Further, it is worth noting here that the notion of a universal ranking of humanity in a hierarchical order that privileges the dominant culture is well integrated across our society, including in the practice of medicine. As such, the Western notion of social Darwinism reflects a prime example of an ideology that wittingly or unwittingly reinforces cultural racism in the sciences, and today sustains the ravenous neoliberal culture of economic Darwinism (Giroux, 2010).

Unfortunately, doctors from the dominant culture, more often than not, tend to misperceive and misinterpret cultural values, beliefs and ways of knowing that are not their own. Numerous studies have shown the presence of such implicit bias among
physicians. According to a study published in the American Journal of Public Health in March 2012, a staggering two-thirds of doctors exhibited racial bias toward patients of color. Moreover, white and Asian physicians overall held more pro-white attitudes on both measures than did African-American physicians, whose scores were largely neutral with respect to racial bias. Another study (Chapman, Kaatz, and Carnes, 2013) concluded, "cultural stereotypes may not be consciously endorsed, but their mere existence influences how information about an individual is processed and leads to unintended biases in decision-making" (p. 1504). With this in mind, John Hoberman (2012), in *Black and Blue: The Origins and Consequences of Medical Racism*, laments that most studies of medical racism do not address the racially motivated thinking and behaviors of physicians practicing today. Within the private sphere of physicians, "racial fantasies and misinformation distort diagnoses and treatments" (p.2).

Doctors' attitudes, just like the rest of the population's, are mired in racial stereotypes and folkloric beliefs about racial differences that permeate the general population. Hoberman (2012) further contends that within the world of medicine this racial folklore has shaped perceptions within all medical subdisciplines, from cardiology to gynecology to psychiatry. In the process, doctors have imposed white or Black racial identities upon every organ system of the human body, along with racial interpretations of Black children, Black seniors, the Black athlete, Black musicality, Black pain thresholds, Black lung capacity, and other aspects of Black minds and bodies. This misreading and distortion of bodies of color has extended across other racialized populations, as well.

Despite the long-term persistence of racialization in medicine, the medical establishment seldom engages substantively with either historical or contemporary information about medical racism. For this reason, a deeper understanding of the pervasiveness of racism is unlikely to reach medical schools until the current curriculum is transformed and a new historical and sociopolitical view of medicine is embraced. Until then, university professors in schools of medicine or doctors from the dominant culture are more likely to misread the essence, nuances and inner complexities inherent to living with racism, and thus will tend to invalidate or overly question concerns or the lived experiences of medical students or their patients of color. This is particularly the case with white male doctors or professors who exist in the confines of a mainstream life, where they do not need to be conscious of the profound privilege they enjoy simply because of their skin color, affluence, gender and profession.

**The Legacy of Medical Apartheid**

Structural racism, in the context of capitalism, constitutes one of the most pervasive forces at work in the history of medicine and as such constitutes the wretched cornerstone upon which a medically segregated world has been constructed. The persistent racialization of patients of color throughout history and today reflects enduring and deeply rooted prejudices of the dominant culture that work to justify and sustain political, social and economic inequity. Racial stereotypes and depictions fuel misconceptions of Black people, Latino people, Native Americans, Muslims and other subordinate cultural groups as inferior, stupid, undeserving or violent - portrayals that imprison communities
of color within reified images of the white imagination that often determine the manner in which we are treated, whether in medical schools, doctor's offices or society at large. The persistent difficulty of the dominant society, and by association the medical profession, to accept the lives and struggles of people of color, with dignity and as legitimate, is intensified by repressive contradictions that have persisted throughout the history of medicine in the United States.

Harriet Washington (2006) rightly declares that medical apartheid has been a hidden dimension of medicine, from colonial times to the present. Throughout, it has been customary to employ so-called scientific criteria for classification, as a means to predict and determine the health, mental health and future human value of poor and working-class populations to the project of US capitalist accumulation. In many ways, the same deficit mentality at work in the justification of genocide, slavery and colonization around the world has persisted (albeit camouflaged) throughout our institutions, including in the study and practice of medicine.

During the US Civil War, for example, a major study was launched to quantify the differences in lung capacity of Union soldiers. According to Lundy Braun (2014), the study concluded that white soldiers had a higher lung capacity than those labeled "Full Black" or "Mulatoes." The study relied on the spirometer, an instrument used to measure the capacity of the lungs, which had been formerly used by plantation doctors to make the same assertions; however, with the added caveat that due to poor lung capacity, Black bodies were made for the fields and little else - where their forced labor was said to "revitalize the blood" of a flawed Black physiology. Today, doctors still examine our lungs using spirometers that are "race corrected" and normal values for lung health are reduced for Black patients.

Moreover, as Braun correctly notes, "Not only might this practice mask economic or environmental explanations for lower lung capacity, but the logic of innate, racial difference is built into things like disability estimates, pre-employment physicals, and clinical diagnoses that rely on the spirometer. Race has become a biologically distinct, scientifically valid category despite the unnatural and social process of its creation." Unfortunately, the accumulation of one-dimensional medical research over the years (such as lung capacity in Black patients) makes it very difficult to dislodge racialized assumptions, particularly when the problematic nature and assumptions of quantitative data go unquestioned and the absence of environmental or socioeconomic context go unnoticed.

The early 1900s initiated the modern era of scientific research, where subjects were seen as objects whose conditions could not only be measured but also manipulated. At that time, measuring and comparing cranium sizes to determine morality and intelligence were commonplace. This form of evaluation was considered to be fully scientific, objective, controlled, reproducible and statistically accurate - in other words "evidence-based." This led (not surprisingly) to a taxonomy that "objectively and scientifically" ranked the racial group of the early psychometrists as superior in human intelligence, with other "races," of course, hierarchically lagging behind.
One of the most notorious studies in medicine was conducted in Tuskegee, Alabama. The 40-year Tuskegee syphilis study, which took place from the 1930s through the 1970s, serves as a profound metaphor for "medical racism, government malfeasance, and physician arrogance" (Reverby, 2009). The study focused on untreated syphilis among African-American men of the region. During the study, US Public Health Service doctors told participants that they were being treated for their disease. Instead, a control group was being inoculated with a placebo, while doctors observed, callously, as the participants suffered through the progression of late-stage syphilis until their painful death.

In the 1930s, the eugenics movement in the United States, with Margaret Sanger as one of its most ardent supporters, began to focus almost exclusively on eliminating what the group termed the negative traits of society. Not surprisingly, the traits considered "undesirable" were to be found predominantly in poor and uneducated populations and populations of color. In an effort to prevent these groups from propagating, the eugenicist movement helped to drive legislation to support forced sterilization (Norrgard 2008). Thirty-one states, including California, enacted sterilization laws. These laws resulted in the forced sterilization of over 64,000 women (Black, 2003).

Initially, sterilization efforts focused on the disabled but later grew to include people whose only "crime" was poverty. These medically executed sterilization programs received legal support from the US Supreme Court. In the ruling of Buck v. Bell (1927), Supreme Court Justice Oliver Wendell Holmes argued, "It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for imbecility, society can prevent those who are manifestly unfit from continuing their kind... Three generations of imbeciles are enough." The court decision legalized sterilization laws in the United States. California's program was so robust that the Nazis turned to California for advice in perfecting their efforts. Hitler proudly admitted to following the laws of California and several other states, which allowed sterilization, without consent, for prevention of the reproduction of the "unfit" (Kühl, 1994).

Women of color in US urban settings and on reservations were specifically targeted for sterilization without consent or under questionable circumstances. In Puerto Rico, under the auspices of Operation Bootstrap, the medical and government establishment targeted poor, working-class women for sterilization, supposedly to reduce the island's population and unemployment rate (Briggs, 2002). In the 1960s, Puerto Rico earned the dubious distinction of having the highest sterilization rate in the world, with women of childbearing age in Puerto Rico 10 times more likely to be sterilized than white women in the United States. By 1965, over 30 percent of Puerto Rican women had been sterilized.

My mother was among these women sterilized, after being asked to sign consent while in the middle of labor with her second child. Puerto Rico was also the site where human trials of the birth control pill were conducted prior to prescribing it to women on the mainland. In the 1970s, Native American women reported being sterilized at Indian Health Service hospitals after going in for routine medical procedures such as appendectomies. In 1975, in Madrigal v. Quilligan, Mexican immigrant mothers sued
doctors, the state and the US government after they were sterilized while giving birth at Los Angeles County General Hospital (Tajima-Peña, 2015).

More recently, in 2013, concerns over sterilization abuse were raised by a study that found that almost 150 women had been illegally subjected to sterilization in California prison medical facilities, from 2006 to 2010 (Johnson, 2013). As this demonstrates, women of color were heavily singled out for sterilizations because the largely white medical establishment believed that lowering birth rates in communities of color would better society - since the cause for the problems people experienced was considered to be located within the people themselves. Moreover, such abuses continue to demonstrate the manner in which sterilization and incarceration have been used effectively as means for social containment of impoverished populations of color, overwhelmingly represented in US prisons.

Most disturbing then is the manner in which the legacy of medical apartheid and its structural causes persist today. This phenomenon manifests itself across the medical-industrial complex through the culture of health care, within doctor's offices, clinics and hospitals alike. Medical researchers too perpetuate racism in medicine when they fail to interrogate commonsensical ideas that racialize bodies of color, whether intentional or not. However, strongly implicated in the perpetuation of this legacy is the traditional formation of medical students, which prepares both medical researchers and clinicians to see the world through the narrow and privileging lens of biomedicine.

**Racialization and Medical School Formation**

Schools of medicine have, unfortunately, been slow or reticent to reorient the field, beyond cosmetic curricular initiatives or well-intentioned efforts to bring more students of color into the fold. The traditional, one-dimensional, curative focus and vertical structure of medicine can be linked to ideological beliefs and institutional practices that have, as Braun argues, perpetuated plantation structures of racialization within impoverished communities. In many Black, Latino and Native American communities, the hospital essentially became "the big white house" where racism and other forms of societal inequalities were enacted through a racializing and paternalistic health-care culture that exclusively privileged a Western scientific epistemology of disease that rejected as mere superstition the health epistemologies of curanderos, santeras, sobadores, medicine people, naturalists and Chinese medicine.

At times, rejection of such alternative modalities has been made on the premise that alternative health-care approaches are either not scientifically proven or that practitioners do not practice in sterile conditions. Yet, it is interesting to note that these claims seldom go beyond the anecdotal and that the medical establishment is resistant to acknowledge that millions of people over the years have experienced success with alternative health approaches, when conventional medicine failed. Hence, underneath such debates exist deep epistemological tensions and ideological questions related to power, authority and conquest that seldom are addressed (Saks, 2005).
Consequently, poor and working-class communities of color have been subjected to health disparities tied to medical issues of authority and control, and afforded none or little voice or authority in their own health-care decision-making, whether at the national or local level. In many instances, low-income patients of color only receive palliative care, due to either lack of access to state of the art medical treatment or the fact that they do not come in for treatment until the late stages of an illness. My aunt who died of breast cancer is sadly an example of this latter phenomenon. The distrust of doctors and hospitals she had developed over her lifetime fueled a stubborn reticence that led to her demise at only 66 years old.

The Western epistemological propensity of "scientifically" reducing, fragmenting and disembodying knowledge has also led to a health-care system, particularly in communities of color, which has focused on one set of symptoms or disease at a time, ignoring the interactions among diseases, overall cultural and social dimensions of health, and an integral approach to medicine that could access the strengths and wisdom that patients possess with respect to their own participation in their health care. Similarly, the medical field and the formation of physicians are still plagued by the legacy of scientific racism and ethnocentric beliefs in the superiority of Western medicine, medical school formation and health care. The neoliberal era has only solidified and intensified these beliefs, despite the rhetoric of inclusion and occasional cultural competency modules that might be added to the medical school curriculum. In some cases, views of culture, ethnicity or race only reinforce dominant social constructions of particular races, normalizing economic and political hierarchies by conserving stereotypes and myths of superiority that justify inequalities.

Moreover, in the contemporary neoliberal quest for measurable data and "evidence-based" legitimacy, medical assessment and standardized protocols are constructed under a rubric of objective knowledge, where medicine is treated as an objective and external body of information, as if produced independent of human beings and independent of culture, time and place. Meanwhile, little attention or relevance is given to the fact that a stubborn logic of innate racial differences continues to drive research, health protocols, assessment criteria and the treatment provided within communities of color today. In 2011, a John Hopkins study suggested that medical students may "learn" to treat non-white patients differently than white patients, which impacts health disparities. It goes without saying that these dynamics can have negative impacts on the education and experience of medical students; but, in particular, for the patients of color they will eventually treat, care may be compromised by such views.

Brian McKenna (2011), a medical anthropologist, contends that professors in medical schools by in large uphold a carte blanche adherence to the educational practice of meritocracy - a practice that functions as one of the primary socialization and sorting mechanisms, implicated in the difficulties many working-class students of color face in medical school. Through everyday practices of meritocracy, an unjust distribution of wealth and power, both in the field and society, is justified. First, this is done by establishing the merit of the medical elite as legitimate heirs to power, privilege and wealth. And second, meritocratic logic persists in blaming those who cannot "pull
themselves up by their bootstraps," by implying they don't have the necessary intelligence, motivation or drive to partake of the health care offered them by the medical establishment.

**Money as the Driving Force**

In today's world, money is the overarching driver of biomedicine, as the commercial and market interests of medicalization expand their jurisdiction. Medical officials, government agencies and Big Pharma corporate leaders perpetuate a voracious appetite for (ever-changing) accountability measures in exchange for federal funding and corporate contributions to medical research, tax initiatives in support of medical education and research, and state budget increases for public health initiatives. In addition, major medical research institutions rake in billions of dollars in expenditures for medical research that often simply perpetuates the distorted and racialized notions of patients of color from working-class communities.

Consistent with the neoliberal education agenda, schools of medicine also have become part of the corporate system of education. At the administrative level, medical schools are expected to function with the breadth and efficiency of large corporations, where medical students are more like consumers than cultural citizens who must grapple ethically with their world; knowledge is more like a commodity for the marketplace; and teaching, clinical in focus and technical in orientation, is more obsessed than ever with data collection, performativity and accountability. As such, medical education is rigidly hierarchized and instrumentalized to better serve the interests of the medical-industrial complex and its segregated world. The consequence is that teaching cultural diversity in medical schools not only remains fragmented, with uncertainty about what it means to be "culturally competent" (Siraj, 2011), but there is a glaring scarcity in the number of lectures and courses offered to medical students (Horowitz, 2005).

Scholarships to medical school - albeit helpful to individuals and in making a small dent in the dearth of Black and Latino medical school enrollments across the US - unfortunately, do little to undo or cast away the legacy of 500 years of segregated medicine in this country. More to the point, such efforts alone do not attend to the structural root of a medically segregated world, which can only be understood by connecting social and material conditions of oppression to the commonsensical manner in which power and privilege is reinforced, reproduced and distributed among a tiny elite. Hence, to transform medicine and the culture of medical school requires full reinsertion into the very social fabric of society, the place where the genuine transformation of oppressive values and beliefs can be identified, challenged and reinvented, in the interest of a truly democratic system of medicine and society - where the lives of everyday people are inextricably linked to an emancipatory understanding of medicine.

In the current context, it is not surprising to find professors of medicine who exhibit dehumanizing acts of power in their responses to medical students, most particularly those from working-class communities of color. Such relationships bear severe consequences upon the lives of medical students, who are not yet fully indoctrinated into
the hierarchical sanctum, so they are still able to call into question the racializing injustices and authoritarian nature of this pedagogical domestication and elitist formation. Studies, however, have shown that as medical students don their white coats, along with the veil of silence and subordination expected of them, they soon find themselves only too well disciplined in both accepting Western science as God and the authority of a homogenizing medical world as superior (McKenna, 2011).

This process of formation, unfortunately, often leaves young doctors impoverished by a contrived professional arrogance that deliberately alienates them from their own capacity to know the world as integral human beings - where heart, body and spirit complement the mind in a multidimensional and emancipatory dance of healing. The larger implications of this professional formation, of course, is that once students leave medical school the tendency is to reproduce what they experienced and were taught - not only with respect to content, but also the manner in which doctors perceive their entitlement and privilege, in comparison to those outside the medical field.

More and more, doctors are converted from actively engaged healers to passive medical technicians who toe the line. As an affluent and compliant workforce of the medical-industrial complex, doctors often become involuntary agents of an immoral free-market economy that has transformed medicine into a commodity for profit, to be bought and sold to the highest bidder. Health management organizations on steroids are the new phenomenon, as smaller practices and hospitals are swallowed up, and doctors try to stem the tide of the receding humanistic vision that once beckoned them to embrace medicine as a vocation.

Protests and Mobilization

It is worth noting here that during the 1960s and 1970s, many medical students across the country did mobilize to support the antiwar and civil rights movements and to denounce, for example, the repression of the Black Panthers - who considered the fight against medical discrimination as central to their politics (Nelson, 2013). Medical student demands centered on culturally relevant curriculum and responsive medical school governance policies, along with efforts to gain an equal voice in decisions of admissions, promotions and graduation standards. As a direct outcome of progressive efforts by medical students in that era, some important changes were accomplished.

In *White Coat, Clenched Fist*, Fitzhugh Mullan (2006) speaks to his own politicization and that of many other medical students and residents during the 1960s. He explains how their work became the starting point for many discussions among the medical left during the era of the Vietnam War, a period which coincided with the introduction of the modern concept of family medicine into health-care policy and medical education. Regrettably, the contemporary neoliberal medical establishment has unabashedly picked apart many of the community practices associated with that era, in the quest to squeeze out greater profits from the illnesses and health problems of the population, as well as the labor of physicians working with the most needy patients.
More recently, Jennifer Tsai (2015), a medical student at Brown University's Warren Alpert Medical School, noted, "in the White Coat Die-In demonstrations orchestrated by medical students across the nation, aspiring physicians displayed solidarity with the message that racial injustice is a public health concern that merits the attention and efforts of health care professionals. It is clear from the mobilization and investment of our medical community that there is a desire to engage in clearer articulation and understanding of the health disparities landscape." Unfortunately, in the midst of these expressions of solidarity among medical students today, many are entering into clinical practice at the very moment when past advances associated with civil rights, in both education and medicine, have been eroded or abandoned in the absence of a robust emancipatory ethics to guide the way.

An Ethics for Liberation

The erosion of a humanizing ethics in medicine is profoundly responsible for the growing inequities in health care today - inequities perpetuated most often through a false dichotomy that separates clinical competency from the capacity of doctors to also become self-reflective in their practice (McDermott, 2012). Hence, prior to positing questions of health-care allocation, we should be considering fundamental questions about how we define health, and how health should be inextricably linked to our personal and communal liberation. This to say that we need ethical standards of medicine in the United States that begin with a deep sense of faith in others and a solid commitment to political solidarity. In addition, there is a need for a critical ethics of medicine, one capable of infusing criticality into medical research, formation, practice and community health practices - a criticality that holds medicine's moral obligation to the people at the very center of discourses on health care.

In today's world, physicians have a responsibility to both ask and answer difficult questions about racism and its impact on medicine and society. Yet ongoing public opportunities for tackling hard questions generally remain in the hands of a tiny elite, while, as McKenna (2011) reminds us, the hidden curriculum of medical school socializes students to be quiet in the face of unethical behavior, as they undergo cultural indoctrination. In the process, medical students move from being reluctant to speak out against injustices in their first year to not even hearing the injustice in the third. This dynamic is further intensified by the fact that medical students must eventually compete for internships and residencies, requiring strong recommendations from professors. The consequence here is that there is an interlocking system of hierarchical expectations that reinforce and perpetuate the strict hegemony of biomedicine. So even when questions of bioethics are raised, for example, seldom are the issues framed around the pernicious impact of material inequality, the historical legacy of racism in medicine or the longstanding consequence of these on the lives of the most vulnerable.

Nevertheless, even in the midst of this hidden curriculum, medical students are introduced to four ethical precepts during their medical formation: beneficence (do the right thing); non-maleficence (do no harm); respect for autonomy; and the exercise of justice. But given the stubborn persistence of racism in medicine, these have proven to be
miserably insufficient. Hence, if medicine is to genuinely support just and democratic life, there are at least three additional ethical principles that must be at the forefront of medical school formation and medical practice. The first is to honor all life; the second is community care; and the third is speak truth to power.

To honor all life is to fundamentally enter into a relationship with living beings with a sense of respect, faith and kinship. Emerging from African wisdom, the principle of Ubuntu, "I am because we are"; and the Maya adage, "In Lak'ech: Tu eres mi otro yo: You are my other me," reminds us of our fundamental connection to all life. Both these non-Western notions constitute the heart from which all interactions between living beings must proceed, so that no person or living being is left outside the circle of life. This speaks to a sensibility that goes beyond the Western epistemological notions of "Do onto others as you would have them do onto you." Or "I think, therefore I am." Both In Lak'ech and Ubuntu begin with the essence of honoring the shared life and connection between us. It is only through beginning with such an ethical sensibility, that we can move to an ethics of community care.

The ethics of community care points to an underlying recognition that medicine began and must return to its communal origins of caring for one another, if it is to serve as an emancipatory force in our society. And as such, medical care is not an object to be reformed, but rather a relationship between human beings for the benefit of both the patient and the physician. With this thought in mind, John McKnight (1995) argued, "Service systems can never be reformed so they will 'produce' care. Care is the consenting commitment of citizens to one another. Care cannot be produced, provided, managed, organized, administered, or commodified. Care is the only thing a system cannot produce. Every institutional effort to replace the real thing is a counterfeit. Care is, indeed, the manifestation of community ... And it is at this site that the primary work of a caring society [and a caring medical community] must occur" (p. x). Furthermore, an ethics of community care also values, supports and promotes patient participation and decision-making in the process of a liberatory health care - an ethos of health care that unfolds with communities.

Lastly is the ethical principle of speaking truth to power. Speaking truth to power is not about moral superiority. It is about the willingness to move beyond disabling attitudes of denial, neutrality and silence. It is about the courage and strength (both personal and political, individual and communal) to stand up in opposition to policies and practices within medicine, the university and the larger society that continue to reproduce pernicious structures of racism and inequalities in medicine today.

To speak truth to power requires that we live our lives with the same truth we expect, and, most importantly, that we cultivate coherence so that the gap between the words we speak and the actions we take become less and less each day. It is through such coherence that we might finally begin to undo not only the silences of the past, but also the silences of today. Over 50 years ago, James Baldwin wrote, "We live in an age in which silence is not only criminal but suicidal." Nowhere are these words more applicable than in the medically segregated world that continues to exist today.
References


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