Whiteness as a bioethical problem

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In March 2018 the Nursing and Midwifery Board of Australia (NMBA) released new editions of their codes of conduct, standards of practice, and code of ethics. In the glossary section, "cultural safety" was described (among other things) as providing "a de-colonising model of practice based on dialogue, communication, power sharing and negotiation, and the acknowledgment of white privilege". Conservative media commentators reacted by claiming that white nurses were being asked to apologise for being white prior to caring for Aboriginal and Torres Strait Islander patients. Media personality Andrew Bolt called the code a new form of racism and Senator Corey Bernardi characterized the situation as a "new medical Marxism". These responses illustrate what Robin DiAngelo has termed "white fragility" – an immediate defensiveness and sensitivity when a person or institutions whiteness and white privilege are questioned.

As has become reasonably well-known via campaigns such as *Close the Gap,* the life expectancy of Aboriginal and Torres Strait Islander peoples is 10 years less than the non-indigenous population and that chronic disease are over-represented among their communities (Wright and Lewis, 2017). A growing body of research has shown that racism is a determinant of poor health among Aboriginal and Torres Strait Islander peoples (as well as Indigenous and minority populations in comparable settler-colonial countries e.g. Canada, New Zealand, and the United States) (Paradies, 2016). Racism effects health directly in the form of psychological harm, but also indirectly via institutional racism, which can determine the quality of health care provided to Aboriginal and Torres Strait Islander patients. Niyi Awofeso argues that for Aboriginal and Torres Strait Islander Australians, 'racism constitutes a "double burden" …encumbering their health as well as access to effective and timely health care services' (Awofeso, 2011). Although only a small part of the NMBA code, the objective of the "cultural safety" section is to help nurses and midwives address institutional racism in the health system.

Judith Dwyer et al define institutional racism as 'encoded in the policies and funding regimes, healthcare practices and prejudices that affect Aboriginal and Torres Strait Islander people's

[1] In order to keep to time I had to cut or reduce some sections. This is a slightly expanded version of what was presented.

access to good care differentially (Dwyer et al., 2016)'. The identification of institutional racism as undermining Indigenous health is not particularly new and has been noted since at least the 1970s. The Aboriginal Medical Service in Redfern was established in 1971, largely in response to a discriminatory mainstream health system. In 1978, the Doctors' Reform Society had a special issue of the *New Doctor* tackling systemic effects of racism on Aboriginal health.[2] More recently, in 2004, the *Medical Journal of Australia* published an article by Barbara Henry, Shane Houston, and Gavin Mooney titled: 'Institutional racism in Australian healthcare: a plea for decency'. They argued that Australia's health services are institutionally racist and that this racism 'stems from Australia being, or at least having become, an uncaring society' (Henry et al., 2004, 517). Drawing on people as diverse as Frank Brennan, Paul Keating, and Martha Nussbaum they suggest that Australia needs to return to and build 'a more compassionate and decent society' (Henry et al., 2004, 517).

I believe locating the root of institutional racism in an uncaring or indifferent attitude toward Aboriginal and Torres Strait Islander peoples is inadequate. I also think compassion needs to be historicized. What we today consider to be racism was at the time often believed to be an act of care and compassion. Warwick Anderson observes that regardless of their stance on eugenics and race science 'all the experts on Aboriginal Australians in the nineteenth century had deplored the ravages of disease and degeneration among the "poor creatures" they were studying' (Anderson, 2002, 219). They had compassion, albeit refracted through race. Rather focusing on compassion, I believe that to get a better grasp of institutional racism we need to look at how racism has been institutionalized and for whose benefit. I suggest we need to bring whiteness into view.

However, it is not only medicine that has a "whiteness problem". In 2003 Catherine Myser argued in *AJOB* that bioethicists in the United States 'have not paid as much attention as we should have to the origins and standpoints of dominant theories and methods in the field' and as such have left the whiteness of bioethics go unmarked. In doing so, Myser argues that 'we risk repeatedly reinscribing white privilege – white supremacy even – into the very theoretical structures and methods we create as tools to identify and manage ethical issues in biomedicine' (Myser, 2003, 2). A key aspect for marking whiteness of bioethics is recalling the histories of white domination in which many of the leading educational and medical institutions emerged.

A large part of this paper will focus on recalling this history in Australia. This paper explores the historical formation and contemporary implications of whiteness in the provision of health care, health-related research, and bioethics itself. To do this I focused on the historical formation of a social ontology that places whiteness at the centre. Much of liberal moral and

[2] For example, see Bobbi Sykes "White doctors and black women". New Doctor, No8, 1978; and also Arthur Kaufman "Medical Students and Aborigines: Can prejudice be reduced?" New Doctor, Issue 34, Dec 1984

political theory conceives of the individual as without a history and prior to society. However, liberalism as thought and enacted in Australia has a past that is deeply entwined with the production of a social and political reality that has white as the norm with Indigenous peoples and people of color as optional add-ons. This history of whiteness is crucial to understanding how racism has been institutionalized, and thereby crucial to understanding how to respond to it.

This paper has six parts:

I. Brief overview of whiteness studies
II. Charles Mills' critique of racial liberalism
III. Examining racial liberalism in Australia
IV. Medicine and the cultivation of a white nation
V. Effects of whiteness in medicine today
VI. What can bioethics offer?

But first, what is meant by "whiteness"?

Critical race theory and whiteness studies

Whiteness studies has emerged in recent years as a way of examining race relations and the effects of racism by focusing on whiteness and assumptions that "white" occupies a position of normalcy and neutrality. Julie Guthman describes whiteness as a 'messy and controversial concept' that variably refers to 'the phenotype of pale bodies, an attribute of particular (privileged) people, a result of historical and social processes of racialization, a set of structural privileges, a standpoint of normalcy, or particular cultural politics and practices' (Guthman, 2008, 390). It is most of these things, but cannot be reduced to one of them, especially not simply as pigmentation. At different historical junctures racialised groups have moved in and out of the white category. For example, in Australia during the early twentieth century medical scientists debated whether whiteness referred only to Britishness or if it could be expanded to include Nordic-types, or expanded further to include all Europeans (but not Jews), or further still and include Aboriginals. Anderson observes that it 'was never easy to delimit the boundaries of white Australia' (Anderson, 2002, 141). Then, as today, whiteness is not only about raced bodies, but also discourses and practices, about ontology and epistemology.

Sara Ahmed traces the birth of whiteness studies to the work of black feminists such as Audre Lourde, who showed 'how whiteness works as a form of racial privilege, as well as the effects of that privilege on the bodies of those who are recognised as black' (Ahmed, 2004). Lourde and others turn the critical focus from the racialised other to the dominant institutions, beliefs, systems, and practices that do the work of racialising while reinforcing white privilege.

John Gabriel suggests that the political and analytic utility of "whiteness" is that instead of focusing on and producing yet more 'sociological knowledge of the "victim"' of racism, prejudice, and discrimination, whiteness 'problematises the perpetrators and related processes' (Gabriel, 1998, 12). Rather than focusing exclusively on the injustices suffered by Aboriginal and Torres Strait Islander peoples, for example, the whiteness analytic lens allows scholars such as Irene Watson and Aileen Moreton-Robinson to draw attention to the material conditions, histories, ideas, and practices that make such racialised injustices possible (Watson, 2007, Moreton-Robinson, 2015).

Whiteness critique is not the same as calls for diversity and inclusion, it is not an attempt to achieve a post-racial neutrality as such. It is not the "I don't see race" mantra of progressive liberalism. Such "neutrality" is really a normativity. Rather a whiteness critique brings into focus who gets to set the agenda of such diversity programs, and who is at the center of things such that they can determine who needs to be included. The work of whiteness studies is to question the historical forces that have reinforced whiteness as a position of privilege and draw attention to its political and material effects. In CANZUS societies – Canada, Australia, New Zealand, and the United States – which were settled and colonized by the British, whiteness forms the background – the normal order of things – in which *others* appear as a racialized other.

Mills' critique of racial liberalism

While there has been much focus on the idea of "white privilege", the problem of whiteness goes much deeper than privilege to a way of being and knowing. The work of Jamaican-American philosopher, Charles Mills has been particularly useful in critically examining the historical formation of a social ontology of whiteness and an associated epistemology in what he calls racial liberalism.

In regards to a social ontology of whiteness, Mills contends that the social reality is not essentially egalitarian and inclusive, with sexism and racism as anomalies. Rather, they are the norm on which patriarchy and the social structure of whiteness rely (Mills, 2007, 17). This social ontology is also interrelated with a social epistemology whereby a social structure exists that operates in and constitutes the social arrangements that permit and depend on a learned ignorance in relation to the past.

Linda Martín Alcoff describes Mills' 'epistemology of ignorance' as 'a set of substantive epistemic practices designed to protect their belief that society is basically a meritocracy, people of color are responsible for their troubles, and racism is a thing of the past' (Alcoff, 2015, 84). This social epistemology quarantines racism as a relic of an unenlightened past and espouses a new era where racism is a blemish on an otherwise equal and harmonious society.

However, Mills argues that this way of knowing and perceiving the world is borne out of and caused by the social apparatus of whiteness, which is intimately bound to the liberal project.

Mills argues that the common features of liberalism are an 'anti-feudal ideology of individualism, equal rights, and moral egalitarianism' (Mills, 2017, 12), basically a commitment 'to the flourishing of the individual' (Mills, 2017, 5). However, the great liberal political philosophers – Locke, Kant, Smith, Mill, and more recently John Rawls, Robert Nozick, and Michael Sandel – all developed their ideas from a position of 'white racial privilege' and that 'we need to see liberalism as structurally shaped in its development by [this] group privilege' (Mills, 2017, 5). In this move, Mills is self-consciously following second-wave feminism in their identification and critique of patriarchal liberalisms gendered 'conceptualisation of the official polity, its view of the individual, its division of society into public and private spheres, its exclusion of the family from the ambit of justice, and so on' (Mills, 2017, 6). Mills argues that 'liberal political theory is so shaped by the history of white domination, both national and global, that analogously, it tacitly takes as its representative political figure the white (male) subject' (Mills, 2017, 6).

- Locke invests in African slavery and justifies expropriation of Indigenous lands
- Kant is a pioneering theorist of "scientific" racism – see Robert Bernasconi
- Thomas Jefferson proclaims the rights for all men, yet continues to deny freedom to his slaves or move towards abolition of slavery
- I'll talk about JS Mill in a moment

I think Mills arguments regarding racialised liberalism are important for bioethics, as the vast majority of bioethics works within the parameters of liberal pollical and moral theory, and therefore is wittingly or unwittingly implicated in its racial history.

Mills argument is that the history of liberalism has produced a social ontology and epistemology that places whiteness in the centre as the norm. It is for this reason, argues Mills, that liberal philosophers have failed to seriously discuss or address racial injustice, Mills contends that liberalism needs to be 'reconceptualised as ideologically central to the imperial project …(…the boundaries of the polity should be redrawn); liberalism's official ontology needs to officially admit races as social existents…; and above all, in normative political theory…racial justice needs to be placed at centre stage'(Mills, 2017, 6).

Racial liberalism in Australia

While Mills provides an important analysis of racial liberalism in general and racial liberalism in the United States, it is important to note that liberalism emerged in Australia during the 19th C in a distinct manner. For example, the utilitarianism of Bentham and Mill has had much

greater influence than Lockean notions of natural rights in shaping the moral, social, and political realities of Australia.

To do this we need to trace the history of racial liberalism and the ways in which whiteness is centred as the norm. Although there are significant overlaps and cross-fertilisations between Canada, US, NZ, UK, and Australia, each society has its own history. For example, the utilitarianism of Bentham and Mill has had much greater influence than Lockean notions of natural rights in shaping the moral, social, and political realities of Australia.

Like Locke, Kant and Jefferson, J.S. Mill's liberalism also had problematic racial manifestations. Mill not only worked from the British East India Company, but advocated for the colonisation of Australia. In 1836 essay on Civilization Mills talks of clear markers between the civilised and uncivilised. He argues that markers of the uncivilized or 'savage life' are the absence of commerce, agriculture and manufacturing, whereas 'countries rich in the fruits of agriculture . . . we call civilized' – it is the civilised who could rule themselves, the uncivilised needed to be ruled. It would appear Mill's liberalism had little problem with the use of agriculture to dispossess Aboriginal Australians and establish British sovereignty.
Yet, we tend to forget, excuse, or ignore this aspect of Mill, like we do for Aristotle, Locke, Jefferson, Kant etc.

The influence of Mill and the dynamic of forgetting overtly racialized liberalism is also evident in the figure of Alfred Deakin, 2nd Prime Minister. Deakin was a progressive liberal who was central to the federation of the Australian colonies and the drafting of the Australian constitution. Some would say he is our Thomas Jefferson, and like Jefferson his liberal ideals did not extend to non-whites. Deakin was the chief architect of the White Australia policy, and when announcing the policy in 1901 said:

> In another century the probability is that Australia will be a White Continent with not a black or even dark skin among its inhabitants. The Aboriginal race has died out in the South and is dying fast in the North and West even where most gently treated. Other races are to be excluded by legislation if they are tinted to any degree. The yellow, the brown, and the copper-coloured are to be forbidden to land anywhere' Cited in (Anderson, 2002, 90).

As per Charles Mills' diagnosis of white 'epistemology of ignorance', this is a history we actively seek to forget or remember differently (especially those of us working at universities named after him). For example, political scientist, Judith Brett recently wrote an award-winning biography of Deakin. She plays down Deakin's white supremacist speeches and policies, casting them as 'of the time'. Brett suggests,

> We need to exercise our historical imagination to understand why Australians at the beginning of the twentieth century could regard [the White Australia Policy] as an expression of high ideals. Yes, boundaries keep outsiders out, but they also enable those inside to co-operate to achieve common goals. (!!!) (Brett, 2017, 265)

In contextualizing Deakin's statements, such as the 'unity of Australia is nothing if it does not imply a united race', Brett refers to the popularity of J.S. Mill's *On Representative Government* among Australian politicians at the time, especially the chapter on nationality. Here J.S. Mill states: 'Free institutions are next to impossible in a country made up of different nationalities. Among people without fellow-feeling, especially if they read and speak different languages, the united public opinion, necessary to the working of representative government, cannot exist' Cited in (Brett, 2017, 267).

Thus, in J.S. Mill's liberalism and Deakin's implementation of it, a racially, linguistically, and culturally homogenous polity is not only desirable, but it is legislated for in the White Australia Policy. This policy, which requires much greater discussion than can be given here, was not merely political or legal, but medical. The White Australia Policy was intimately tied to medicine in Australia, and Townsville in particular.

Medicine and the cultivation of a white nation

In *The Cultivation of Whiteness*, Warwick Anderson shows that medicine was used and actively engaged in the building of a white nation in Australia. In the 1880s, most Europeans distrusted the tropics as a 'racially dubious territory' (Anderson, 2002, 73). It was not only the environment, but also the dark bodies of "natives" that were thought to be a reservoir of disease that would degenerate and erode the fitness of the white European. A question that persisted at least to the 1920s was: 'Could a working white race ever establish itself in perilous North Queensland and thrive?' (Anderson, 2002, 75) An affirmative answer to this question was central to maintaining the validity of the White Australia Policy and purity of a white nation in the South.

With the support of politicians such Alfred Deakin (then prime minister) and leading medical scientists at Adelaide, Melbourne and Sydney universities, the Australian Institute of Tropical Medicine was established in Townsville with Dr Anton Breinl as initial director. Breinl and his team were charged by the medical fraternity in the southern cities to 'determine whether the white Australia policy made sense scientifically' (Anderson, 2002, 103). It was not just the medical profession interested in the Institute's research, Sir William McGregor, the governor of Queensland stated in 1913 that 'the policy of reserving Tropical Australia as a home for a purely white race is one of the greatest and most interesting problems of modern statesmanship' Cited in (Anderson, 2002, 108). In the terms of R.J.A. Berry the famous (and slowly becoming infamous) eugenicist from Melbourne University, the white Australia policy

'is not a policy at all, but it is in reality a medical problem of the first magnitude' and as such it needed to be put to medical test (Anderson, 2002, 112). According to Anderson, 'National policy had been translated into scientific terms: White Australia was framed as a vast experiment, the results of which only medical scientists could interpret' (Anderson, 2002, 113). For the next half a century or so, medical scientists in Australia were dedicated to 'building a new nation based on purity of race' (Anderson, 2002, 124).

Much more could be said about the influence of Berry,[3] the legacy of eugenics movements in Victoria and NSW, medical experimentation on Aboriginal peoples, and the relationship between politics and social medicine. However, time does not permit. The point here is that medicine provided a scientific ground to racial liberalism in Australia. That is, medicine provided a scientific justification for creating a socio-political reality in which white bodies occupied the centre, where ideals of equality, freedom, and individuality were openly and unashamedly racial coded.

Has this changed today?

Well, in the context of medicine and medical ethics, we like to think that the Nuremberg Code 1947 halted overt scientific racism. Similarly, in the political domain we like to think the 1967 Referendum and Racial Discrimination Act 1975 slowly stripped back the overt racism of political liberalism in Australia. However, I suggest that the social ontology and epistemology that has whiteness as the norm remains largely intact.

Social theorist Aileen Moreton-Robinson, a Goenpul woman of the Quandamooka nation, argues that the Racial Discrimination Act of 1975 'functions discursively, informing white commonsense understandings of Australia's tolerance: "we" have antiracist legislation in place so "we" as a nation cannot be racist; "we" allow nonwhite migrants into the country, therefore "we" are not racist. Despite seventy-five years of an explicit white Australia policy, white subject now rationalize that "race" no longer matters or functions as an exclusionary tool in Australian society' (Moreton-Robinson, 2015).

Similarly, Chelsea Bond, an ARC DECRA Research Fellow at UQ Poche Centre for Indigenous Health and a Munanjahli woman and South Sea Islander Australian, argues that the 1967 Referendum 'may well have made Australia appear less racist, but it did not address the inherently racist nature of the constitution' (Bond). Both Moreton-Robinson and Bond argue that the social and political reality of Australia is constituted by and for whiteness.

[3] Berry's "teaching produced a generation who left their mark on Australian surgery, the foundation of their knowledge being gained in his dissecting-room and museum." K. F. Russell, 'Berry, Richard James (1867–1962)', Australian Dictionary of Biography, National Centre of Biography, Australian National University, http://adb.anu.edu.au/biography/berry-richard-james-5220/text8703, published first in hardcopy 1979, accessed online 11 September 2018.

Bond argues that 'race was the foundation on which this nation was built and it continues to structure our society, its institutions and social life. We cannot build a better nation by simply piling new bricks or new clauses to cement over the reality of race and the way it manifests interpersonally and institutionally' (Bond).

So how does race manifest interpersonally and institutionally in medicine today?

Effects of whiteness in medicine today

This will have to be very brief:

Implications in clinical care

A number of studies across Australia have found that Indigenous patients with the same characteristics as non-Indigenous patients were about a third less likely to receive appropriate medical care across all conditions (Paradies, 2016, Awofeso, 2011, Durey and Thompson Sandra, 2012, Durey et al., 2012, Paradies et al., 2015).

> *This past week an inquiry has begun into the death of Naomi Williams, a 27-year-old Wiradjuri woman. Ms Williams was six months pregnant when she presented to Tumut District Hospital in the early hours of January 1, 2016 with a severe headache.*
>
> *Hospital staff gave her two paracetamol tablets and an iceblock then sent her home. She died 14 hours later as a result of meningococcal and septicemia, according to the autopsy report.*

The inquiry is still going and it is not wise to speculate based on media reports. However, so far it has been revealed that there were systemic failures in accessing Ms Williams medical history, as well as stereotyping of Ms Williams as a drug user.

A second prominent and recent example is the case of *Ms Dhu in Western Australia.*

> *The state coroner Ros Fogliani was highly critical of some actions of police and medical staff, stating that Ms Dhu's medical care in one instance was "deficient" and both police and hospital staff were influenced by preconceived notions about Aboriginal people.*
>
> *Ms Dhu died on 4 August 2014 from staphylococcal septicaemia - a severe bacterial infection - and pneumonia. Released CCTV footage showed Ms Dhu moaning from pain, saying it was ten out of ten.*

> *It was reported an emergency doctor considered her pain real but exaggerated for "behavioural gain". Another doctor also noted Ms Dhu suffered from "behavioural issues" while a constable thought she was "faking" her suffering.*

The downplaying of Ms Dhu's pain is not new. It has long been believed that Aboriginal peoples, and people of colour in general, are less sensitive to pain. Anderson quotes observers at the Coranderrk Aboriginal mission who believed Aboriginal people 'do not suffer pain as acutely as do the higher races, their skin seems not so sensitive' (Anderson, 2002, 157, 219). In 1931 medical scientists from Adelaide University sought to test this hypothesis by placing their Aboriginal research subjects on nailbeds and gauge their responses. Apparently, they did feel pain.

Sadly, as research and media reports demonstrate, such cases of misdiagnosis or denial of appropriate care occur at much higher rate to Aboriginal and Torres Strait Islander peoples.

Research funding and agendas

This also has historical roots. Again, Anderson notes, 'Aboriginal ill health had not often been recognized as a problem even for whites because the original inhabitants were widely dispersed, and it was assumed they would soon disappear' (Anderson, 2002, 157). Similarly, David P Thomas observes in an article in the *Medical Journal of Australia* that 'any research on Aboriginal and Torres Strait Islander peoples before the 1960s was not primarily about improving their health. It was about using Indigenous health research to improve understanding of the health problems of white Australians' (Thomas, 2004, 521). It was only well after the establishment of leading medical research institutes and funding bodies that the health of Aboriginal peoples became a significant concern. Some effects of this include:

- The people and groups researching the health effects of racism tend to be on the margins of medical research establishment.
- The type of research that attracts funding (gov & commercial) tends be directed towards the interests of white population. For example, Chelsea Bond points to the dominance of NHMRC funding towards alcohol-related research in Indigenous communities.[4] Bond acknowledges that alcohol is a significant contributor to the burden of disease experienced by Indigenous Australia (8%), but it is also a significant contributor to the ill health and premature death of the broader population (5%). Yet <1% of NHMRC funding is used for general alcohol related research, while over 6% of identifiable Indigenous health research funding has allocated to research alcohol-related problems.

[4] https://croakey.org/leading-aboriginal-researcher-raises-some-critical-questions-for-the-nhmrc/

- Bond contends that it not so much the amount invested in deficit research agendas, but they need to build capacity among Indigenous health researchers to conduct their own research.
    - This is what Lester-Irabinna Rigney has written about in terms of Indigenous intellectual sovereignty, arguing that Indigenous peoples interests, experience s and knowledges are [or should be] at the centre of research methodologies and the construction of knowledge about us, which he says is necessary to counter the 'racialised research industry [which] still prevails in Australia. see (Rigney, 2001).

Implications for ATSI & POC health professionals

See Leesa's Story in Aileen Moreton-Robinson's *White Possessive.*

These are issues that have bioethical significance

What about Bioethics?

Ok, so medicine is the bad guy here. We all know that. That's why we're bioethicists. Bioethics is new. 30-50 years old. It isn't implicated with this history. Right? It emerged out of racialized medical violence, Nuremburg Codes and Tuskegee. It is anti-racist, right?

I could just leave it at whiteness is an issue that requires bioethical attention. Yes, that is important, but it needs to be noted that whiteness hasn't received significant bioethical attention and I contend that is because bioethics is deeply entwined with this history such that it cannot or will not see whiteness or racial injustice. How has this happened?

Simply:

- Bioethics is attached to biomedicine
- Bioethics is attached to liberalism (Dawson, 2010).
- Liberalism is blind to its own whiteness and racism (see Charles Mills).
- Thus, bioethics is blind to its own whiteness and racism.
- As such, bioethics is theoretically and practically implicated. That is, whiteness does not only contribute to bioethical problems such as discriminatory patient care, but it shapes the way we think ethically about these.

In the Introduction I mentioned Catherine Myser's paper from 2003. Little has been said about whiteness and bioethics since. Almost 15 years later, Camisha Russell argues that questions of race and whiteness in bioethics have not been significantly addressed, yet critical race philosophy may help. Russell argues that 'the experiences of people of color be shifted from margin to center, engendering shifts in bioethics from rights to justice, from consent to collaboration, and from competence to humility' (Russell, 2016, 44). In making this shift,

Russell suggests that it is 'not simply a matter of applying bioethical analysis to the problems of marginalized people (to 'help them out' or 'be more fair')' (Russell, 2016, 49). Rather what Myser and Russell (and by extension Mills) are suggesting is a re-constitution of the social ontology that has whiteness as the norm – norm in the sense of normative and standard. Russell argues that 'we must look from the margins of bioethics toward the center in order to critique and ultimately displace that center in favor of something more expansive, more responsible, more respons*ive*, and much more flexible in terms of its world view' (Russell, 2016, 49). I recommend Russell's work on the biopolitics of race and reproduction as an area where she has sort to develop a bioethics that is expansive and flexible in its pursuit of justice.

So, what can be done?

Whiteness of settler-colonial Australia cannot be addressed simply by inclusion and diversity into already existing institutions, ontologies, epistemologies – there needs to be greater focus on the structural factors – the terms and the conditions.

Gregory Phillips,[5] a Waanyi and Jaru man from North West Queensland and medical anthropologist cautions against 'inclusion and equity discourse' and instead calls for 'new terms of reference in Indigenous health which centre Indigenous sovereignty'. Chelsea Bond expands on Phillips to argue that such an approach will 'demand a relationship between Indigenous and non-indigenous Australia that is premised upon justice instead of benevolence'(Bond).

Justice[6] instead of benevolence

To return to the suggestion that to do deal with institutional racism Australia needs to become more caring and compassionate, I follow Phillips, Bond and others, to suggest that it less about empathy, benevolence, or compassion, but justice and substantial change to the terms and references of our institutions as well as the constitution of this nation.

What does that look like?

- **Stepping out of the center** and starting the "hard work" of seeking out, listening and promoting the voices of Aboriginal and Torres Strait Islander thinkers and researchers. Also, decolonising methodologies (eg Linda Tuhiwai Smith).

[5] https://theconversation.com/ms-dhu-coronial-findings-show-importance-of-teaching-doctors-and-nurses-about-unconscious-bias-60319

[6] Importantly, the concept of justice used needs to be decolonizing. At the Australasian Society for Continental Philosophy conference in 2017 Lewis Gordon observed that decolonising knowledge is often characterised as a form of justice. However, he suggests that we do not only need to decolonise knowledge, but also decolonise justice.

- **Changing the narrative that we tell about ourselves and disciplines e.g. Silence of bioethics curricula:** It is very common for bioethics curricula in Australia to examine the Tuskegee syphilis case, but it is less common to examine experimentations on Aboriginal peoples and the eugenics movements of the 19th and 20th C that continue to have legacies in existing institutions.

- **Indigenous Sovereignty.** Uluru Statement from the Heart, for example, can provide some clues for thinking about a postcolonial bioethics Megan Davis, a Cobble Cobble woman from Queensland and professor of law at UNSW, argues that the call for sovereignty and treaty in the Uluru Statement is a 'moral challenge to all Australians: hear our voices, and pause to listen and understand' (Davis, 2017, 142). While the Statement seeks to change the Australia constitution, the declaration of Indigenous sovereignty and claim of distinct rights has implications for thinking about bioethics and racial justice in Australia.

Listening to these voices may help to decenter whiteness in a way that ultimately produces a bioethics that is expansive and flexible in the pursuit of justice.

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