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## Medical Oppression: The Structural Mistreatments of African Americans in the Health Care System

### **Signs of Injustice:**

When scrutinizing any US institution heavily enough, one finds many potential attributes of discrimination and prejudice<sup>1</sup>. These characteristics may present themselves most obviously in the origins of the institute<sup>2</sup>, as well as, with increasing complexity, its evolution. It is no surprise then that when analyzing the progression of the healthcare system in the US, we see that it too is not immune to this trend. The historic existence of blatant, unapologetic, racist oppression and injustice has soaked deeply into the fiber of healthcare and deteriorated the medical treatment of black people in America. These biases, along with the assistance of materialistic disparities, form a node in healthcare where the effects of oppression and injustice can be seen on both the flesh and dignity of black Americans.

The disparities in health outcomes between black people and their fellow Americans function as the most obvious canary to the problems in healthcare. African Americans have the lowest life expectancy out of the four major racial groups (White, Hispanic, Black, Asian) in the US, with the gap in life expectancy between white and black Americans in 2020 being 5.8 years (Arias 2021). This increased mortality also extends to black children, who have a death rate of

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<sup>1</sup> Examples of which include policing (ACLU, 2020), the housing market (Williams 2020), and Education (Chatterji, 2020)) in the U.S.

<sup>2</sup> Potentially in relation to slavery, as is the case with education (Williams 2005).

approximately twice the death rate of white children (Marabito 2021). Furthermore, in 2019, black mothers had more than twice the mortality rate of white mothers (Hoyert 2019), and black people ages 18-49 were two times as likely to die from heart disease than whites. Although the health of African Americans over the years has continued to improve, evidenced by a steadily decreasing death rate, there persist abnormal trends in the health and life prospects of black people in America. These outcomes may not be the sole consequences of medical injustice. Nevertheless, trends like 'younger African Americans are living with or dying of diseases commonly found in older white Americans,' do suggest that the sources of these issues may be related to disparities in health care (CDC 2017).

Research looking into health care has found evidence of potentially racially motivated discrepancies in the quality of care some people receive. The “NAM [National Academy of Medicine] reported that minority persons are less likely than white persons to be given appropriate cardiac care, to receive kidney dialysis or transplants, and to receive the best treatments for stroke, cancer, or AIDS” (Bridges 2018). The study also found that black people were discharged earlier from hospitals and (regarding COVID hospitalizations) were less likely to receive a medical follow-up (Robinson-Lane 2021). Research has also found that black people are less likely to be referred to a specialist (which has been shown to result in improved medical outcomes (Masters et al. 2016))(Schulman et al., 1999). Furthermore, black Medicare beneficiaries received seventeen of the most commonly performed medical procedures in hospitals less often than white Medicare beneficiaries (Anderson 2004). Yet, black Medicare beneficiaries did receive four non-elective procedures more often, “Such as the amputation of a lower limb...that reflect delayed diagnosis or initial failure in the management of chronic disease”(Anderson 2004). Lastly, it has been shown that black people are significantly less likely

than white people to receive pain treatment, and in the cases when they did, their dosages were lower (Trawalter 2020).

These examples represent only some of the forms that 'lower standard of care' entitles for African Americans. These disparities indicate, as Nussbaum may argue, an overall limit of the capabilities of African Americans as well their dignity. Using capabilities approach to analyze this issue allows us to discuss and address people who have had injustices done to them without oppressing their dignity. It allows us to ask not what someone should do, but rather what they can do (should they want to do it), which in turn allows us to strike the balance between concern for their well-being, as well as their autonomy. From this approach, having one's life shortened or having one's bodily health jeopardized because of both preventable materialistic factors and prejudicial variables is a limit to their capabilities, and is an obstacle in ensuring everyone is treated with dignity. It is an attack on two of, what Nussbaum considers core capabilities for living a life with dignity, and due to their fundamental nature (life and health), other capabilities on her list. More so, acknowledging the subjectivity of pain, one cannot help but wonder if black patients are victims of epistemic violence, if they, as advocates for their complications, are not being believed (Dotson 2011). Epistemic violence is the silencing of an individual or group due to a listener's unwillingness to listen or engage in what the speaker has to say, questioning the individual's knowledge (Dotson 2011). There is a significant subjective aspect to reporting one's level of pain, discomfort, or illness that requires a level of trust in the listeners. The under prescription of pain medication and lower quality of treatment may potentially stem from a physician's unwillingness to engage with African American patients. Making them victims of epistemic injustice with their health and pain being the collateral.

The disadvantage/privilege dichotomy throughout healthcare, for blacks and whites over the years, has shifted into increasing complexity. The direct exchange that used to occur (conducting new experiments on black people, perfecting medical techniques on black people for the benefit of other patients (Villarosa 2019)) has diluted and changed. The privileges of today's age encompass being able to interact with and be understood by the medical staff you interact with (the majority of which are white) (AAMC 2018). Doctors who seem to be able to understand, diagnose and address your medical issues with more precision and impact. On the other hand, there exists a portion of our community whose outcomes are in part a consequence of their race (infrequent specialist referrals, improper pain medication, and overall improper care not falling on the population evenly).

Healthcare oppression is unique in that its consequences are as much physical as they are psychological. The dignity of the person, as well as their health, is threatened by factors that are inherently prejudiced as well as materialistic. As will be argued shortly, they originate from evolving historic context and systemic forces, and addressing these issues will require mapping out the social factors that have produced them. Social factors that both directly and indirectly, contribute to these disparities. Albeit difficult, that will be the next step in alleviating the medical injustice felt by black people in America.

### **The Birdcage:**

Injustice and oppression in the modern age are becoming increasingly complex. The simple vectors that used to connect force A to effect A (such as the consequences of slavery) no longer exist and have instead been replaced by (as Marilyn Frye argues) a birdcage. Scrutinizing any single wire of a birdcage would only confound us as to why the bird is confined. It is only when we take in the collective structure of the cage that we realize how the bird, or in our case,

black people in America, exists in a system that limits its outcomes. Understanding the structural social forces behind the disparities in health care experienced by African Americans, as argued by Jonathan Eastwood and Claire Smith, will require an analysis of the elemental social structures of representation, relations, and rules that make up the healthcare system.

What makes a social structure is its existence over a prolonged period, its effects on and between individuals, and its ability to constrain capabilities (enabling and limiting action) (Eastwood 2021). The simplest elemental form of social structure to describe in these terms is representation (e.g., stereotypes, controlling images). The trajectory of medical representation and disparities in US healthcare originated during slavery when perceived differences between black and white people were frequent avenues of research. Physicians set out to prove (through inhumane experiments) that, to name some of the more popular and persistent misconceptions, black people felt less pain and had thicker skin. These fallacies made their way into medical journals and were exploited as justification for slavery as well as fuel for further racist ideologies (Villarosa 2019). Black people became the medium through which many painful experiments were conducted before the development of anesthesia (Villarosa 2019). These inaccurate representations of African Americans represent a long-term social structure that has constrained and deteriorated the current medical treatment of black people. A survey found that “40% of first- and second-year medical students endorsed the belief that “black people’s skin is thicker than white people” (Sabin 2020). Furthermore, the same study found that medical residents and students who held beliefs about the biological differences between black and white people were less likely to suggest proper pain treatment. (Hoffman 2016).

Fallacies such as these represent only the visible tip of the bias iceberg infecting medical decisions in the US. They hint at the existence of more inherent, unconscious perceptions

(unknown to the agent themselves) that could act as scaffolding in the interactions between doctor and patient in place of more accurate and relevant information. One patient described an interaction with a doctor where they were told, *“I need to write this prescription for these pills, but you'll never take them and you'll come back and tell me you're still eating pig's feet and everything... Then why do I still need to write this prescription”* (Institute of Medicine 2003)? While all doctor-patient interactions may not be this extreme, it is difficult to imagine that troubling representations could not shape the medical trajectory (less frequent follow-ups, fewer specialist referrals, etc.) of black patients, leading to worse health outcomes, and thus attack the dignity of black people in the US.

Although slavery was abolished, and such obvious abuse is no longer permissible, the fallacies mentioned above had already soiled the general medical perception of black people, and medical research continued to see them as potential test subjects. This issue was brought to the forefront of public perception during the infamous Tuskegee experiment<sup>3</sup>. African American men who had syphilis were lied to and told they were receiving treatment, only for them to never receive any medication, and be barred from treatment in their community (McVean 2019). While experiments like this were not unique (Royles 2020), the Tuskegee experiment represented the most public and blatant disregard (occurring over a period of 40 years and going through both public and private organizations) for the welfare of African Americans (McVean 2019).

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<sup>3</sup> The Tuskegee experiment was an experiment looking into the development of the syphilis virus in humans. The experiment recruited black men from Macon County and assessed them for the disease (while not telling them exactly what they were being tested for). The experimenters then kept the positive syphilis status of these men a secret from them and told them they were being treated for 'bad blood'. The men were enticed to remain in the study with food, transportation, and funeral expenses. As the experiment progressed, the test subjects were blocked from receiving any treatment. "In 1934 they provided doctors in Macon County with lists of their subjects and asked them not to treat them. In 1940 they did the same with the Alabama Health Department"(McVean 2019). The experiment was eventually overtaken by the Center for Disease Control, which opted to continue it.

Such a history is potentially one of the reasons why current relations between doctors and black patients are tenuous. First and foremost, of all the active physicians (in 2018) only 5.8% were black, meaning that many black patients interact with and receive treatment from white doctors. While a racially heterogeneous combination of patient/doctor is not inherently an issue, differences in culture and representation may make cooperation for the attainment of the maximum health outcome of the patient an issue. A study found that black patients were more than twice as likely to have a negative descriptor used in their electronic health record, descriptors like ‘not compliant’ or ‘agitated’ (Sun et al. 2022). Furthermore, "African Americans...have been found to receive poorer interpersonal communication, including lower levels of affective behaviors such as rapport-building and overall affective tone, and greater physician verbal dominance, less patient-centeredness, and shorter visits, compared with white patients" (Martin et al. 2013). This disconnect in communication and cooperation is only exasperated by higher levels of mistrust among black patients. A study sponsored by the American Journal of Public Health found high (relative to other races) levels of mistrust towards physicians (Armstrong 2007), which has been reaffirmed by other research reports (Martin et al. 2013). The study also found, however, that levels of mistrust were dependent on other variables besides race including socioeconomic background and geography.

Besides impacting the relations between doctors and patients, socioeconomic circumstances act to lay down the rules for which healthcare abides. For example, to gain access to proper health care, insurance is in many ways critical. However, as of 2019, 15% of African Americans were uninsured, making their access to preventative health or treatment (especially for those without the means) financially improbable (ASPE 2020). Furthermore, even with insurance, out-of-pocket costs can be prohibitive to proper treatment. As of 2019, African

Americans had the second-highest poverty rate (behind Native Americans) (KFF 2019), and as of 2020 the lowest average household income of the major racial and ethnic groups (Wilson 2020). Consistently higher percentages of black people report worries about medical bills, delays in refilling their prescriptions to save money, and problems paying medical bills (ASPE 2020). One patient explained, *“I know there have been a couple of times the doctor wanted to prescribe a certain medication but because of how much it was, he prescribed something else. Not what was best, but what I could afford”* (Institute of Medicine 2003).

To argue that outcomes are solely dependent on individual decisions or interactions between individuals is to be ignorant of the context within which these outcomes are produced. An individualist’s approach to the sufferings of individuals “obscures oppression” inflicted on a group (Young 1994). It hides larger patterns of injustices by zooming us onto a particular tree and shielding away the forest. This practice encourages us to participate in victim-blaming, which by virtue of the transfer of culpability wipes our hands clean of any responsibility, leaving those harmed individuals to “wrestle with their bootstraps” (Young 1994). This approach to analyzing societal problems is antithetical to making evidence-based interventions. From what we have seen outcomes are not born from an infinite selection of possibilities. Inaccurate representations and historic context taint the relationship between black patients and doctors, and rules about who can receive quality health care limit long-term health outcomes. Furthermore, the impacts of these forces in funneling individuals of the same group into similar outcomes become even more obvious when these limiting factors are removed<sup>4</sup>. Any attempts to combat these issues must take these external forces into account and recognize the history and context fueling these outcomes.

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<sup>4</sup> Research has shown that “Black patients have better health outcomes and routinely agree to more—and more invasive— health tests and interventions when they’re seen by Black physicians” (Brooks 2021)



## **Research Oriented Interventions:**

Calling something unjust or oppressive, as a facet of the essence of the words, is to call something morally wrong. Such a declaration should instill in those who hear (and comprehend) it, a sense of duty. A negative duty to refrain from perpetuating the harm and a positive duty to act in ways that reduce or eliminate the harm (Ashford). The first two parts of this research, by looking into the harms and causes of medical injustice among African Americans in the United States, sought to lay the groundwork to make that declaration. The first section elucidated the harms suffered by the group, making us aware of the canary whose song we could not hear. Nevertheless, the existence of suffering does not automatically imply oppression or injustice, for although the two may be connected, there are instances where they are thoroughly unrelated. The second section of this paper aspired to connect these two dots (suffering and injustice). It sought to construct a reasonable link between the harms discussed and their sources. From that section, we saw that, in many ways, the harms inflicted on African Americans were unearned. Larger societal forces, economic factors, biases, and historical mistreatment were some of the main reservoirs from which these harms were irrigated over black people in the US. With that background in mind, it does not feel far-fetched to call the unearned discrepancies in health care quality unjust or, using Iris Marion Young's definition of the word, oppressive<sup>5</sup>. As rational people who wish to live in a morally conscious and just society, the infliction of unjustifiable harms should be a major source of concern and an active point of intervention.

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<sup>5</sup> Young defines oppression as consisting of five faces, and any group who faces one of those faces can be considered oppressed (Young 1990). African Americans through history have seen many of these faces, from the exploitation and powerlessness of slavery to the marginalization of the post-slavery era (Alvarez 2017). Medical injustice can potentially fall under powerlessness and violence, which come in the physical pain felt by black people in the US from the health care, and the power dichotomy between patients and the system. The inability of black people to change this system that is leading to a decrease in their capabilities at life and health is particular to their group.

For as many unique forces there are at play in the perpetuation of the reduced quality of health care provided to black Americans, there are as many, if not more, potential solutions. Such a multitude of avenues to pursue can pose a real challenge for even the most well-intentioned individuals, who may agree that a problem exists, but may disagree on the steps to take in response. Nevertheless, such a bottleneck should not leave us so paralyzed as to not at least make attempts to act with what we know. Even if our interventions may not be flawless. With that in mind, from what I have gathered, the first step that we should take to mitigate or correct the unequal distribution of quality health care in America is to adjust our health insurance system. It is difficult for us to discuss how we should tackle the lower quality of health care provided to African Americans if we do not first address access to health care.

As was mentioned previously, healthcare coverage and cost are major contributors to health care disparities in the US, and can thus potentially be major points of intervention. Previous governmental organizations have sought to address these issues through numerous programs and interventions, the most significantly successful of which was the passage of the Affordable Care Act (ACA) and the expansion of Medicaid. The passage of the ACA was intended to make health insurance more affordable for Americans. It raised the eligibility for an individual to qualify for health insurance to 138% of the federal poverty level while at the same time partially subsidizing the cost of insurance for individuals who earned above a certain income and did not qualify for Medicaid (NCSL 2011). Support for this bill was politically tenuous and after much litigation, a Supreme Court decision ruled the expansion of Medicaid to be optional for states (Rossenbaum 2012). While the federal government offered to subsidize Medicaid expansion (funding 100% of the program for 3 years, and 90% from then on) for states who opted into the program, twelve states chose to not expand their coverage. This dispute was

in part borne from bipartisan beliefs and ideologies centering around a disagreement over the role of government; is it the government's job to act as a welfare state and ensure services like health care insurance.

For the states that did welcome the ACA, the effect that the expansion of Medicaid had on individual coverage was tangible. Following the enactment of the ACA, the percentage of nonelderly Black Americans who were uninsured (from 2011-to 2019) dropped by 8%, with the largest percent decrease in coverage occurring between 2013 and 2016 after the expansion of Medicaid (ASPE 2022). While not necessarily racially targeted, this legislation reduced unequal access to health care and minimized the coverage gap between black and white Americans (ASPE 2022). Nevertheless, as mentioned above, the ACA has fallen short in improving coverage for African Americans in certain geographical locations in the US. Thirty-seven percent of uninsured black Americans live in Florida, Georgia, and Texas, three of the states who chose not to expand their Medicaid program (Johnson 2022). Many other southern states possessing a high percentage of both black and uninsured members of their population, would see a significant reduction in their uninsured rates if these measures were adopted, with nearly 1 million Black American adults becoming eligible for insurance if the holdout states expanded their coverage (Johnson 2022). Another aspect of increasing Medicaid expansion should also be closing the coverage gap (consisting of people who do not qualify for Medicaid or government subsidies) and ensuring that those people also have coverage. The effects of proper insurance coverage are tangible, with one study finding that by covering the cost of colonoscopy screenings and treatment for colon cancer for uninsured individuals in Delaware, the state saw an increase in colonoscopy screenings for black people (54%) with the mortality gap from colorectal cancer between blacks and whites nearly being eliminated (Williams 2019).

Nevertheless, while increasing coverage can increase the utilization of health care, many other factors determine if someone is able to visit their doctor. As mentioned in the first section, much of the health problems that black Americans face can be mitigated with early preventative measures and quality continuity of care. For many black Americans, a racial group that has the lowest median household income in the US (Wilson 2020), finding the time, will, and means to visit a doctor may not be feasible. Working to increase health care coverage would be meaningless if we did not also seek to reduce the barriers that prevent many from accessing health care.

This type of intervention can come in many different forms. Programs have been implemented in many hospitals that take into consideration the social, economic, and legal problems that may prevent an individual from going to the hospital.<sup>6</sup> These programs acknowledge the complex relationship between the socio-economic context of the individual and their health and attempt to address these issues at their source. One such program, Integration of Community Health<sup>7</sup>, has been proven to be effective in “Improving the control of high blood pressure and reducing cardiovascular risk, enhancing diabetes control, managing HIV infection, and increasing the uptake of cancer screening tests” (Williams 2019). Lastly, employment in and of itself, especially the demanding time requirements of low-wage employment, can be one more barrier to the improved quality of health care for low-income individuals. Research predicts that the implementation of paid sick days would allow individuals to utilize preventative health

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<sup>6</sup> Some of these programs include Medical Legal Partnership (MLP), which connects patients to attorneys if there is a legal issue that can “affect quality of life, and their management of their disease” (Williams 2019). Health Leads, attempts to help patients who struggle to meet food, housing, and employment needs (Williams 2019). Nurse-Family Partnership improves post-pregnancy care by sending nurses to the homes of low-income first-time mothers for periodic checkups (Williams 2019).

<sup>7</sup> The program recruit’s health workers to improve the health of the community outside the hospital setting (Williams 2019).

measures more, for both themselves and their children, and would reduce the cost consequences that come from delayed treatments (NPWF 2021)

Increasing coverage and reducing social barriers act to increase the capabilities of black Americans to visit doctors. It respects their autonomy, providing them with the option to visit a doctor should they so choose. Their desire to visit the doctor, participate in preventative screening, and continue their quality of care, however, are also dependent on feelings of trust and inclusion. Research has shown that patients' trust has been “Associated with patient satisfaction, treatment adherence, continuity of care and improved health” (Martin et al. 2013). In the face of inaccurate representation and weak relations between patient and doctor, increasing trust becomes an important part of shrinking the gap in health care quality and overall health outcomes. This can come in the form of dispelling myths about the biological differences between races, as well as working to improve interpersonal communication between physicians and patients. Educating physicians to be conscious of the power imbalance between themselves and their patients (the biases they may have, and the epistemic injustice they may be perpetuating) and bringing their patients into a discussion about their health can have a tangible impact. Validating the patient's illness experience and encouraging their participation in their health plan has been associated with greater patient trust overall (Martin et al. 2013).

While hopeful, these suggestions do not claim to be perfect or comprehensive. They seek to make ethical recommendations, based on research, which respects the dignity of every person who may be affected. However, as was previously mentioned, even the most well-intentioned individuals, while agreeing on the existence of a problem, may disagree on the interventions we should take. Two popular moral theories that can be used to gauge whether these recommendations are morally permissible are utilitarianism and contractarianism. A utilitarian

approach to these proposals seeks to calculate a cost-benefit analysis of the suggestions. A utilitarian would look at how many people will benefit from these interventions and by how much v. how many are harmed and by how much. One pitfall of this doctrine is that it leaves open the possibility for the severe suffering of some to be morally permitted if their suffering promotes the happiness of a large enough majority. Another prominent moral theory, and the theory which we will use to gauge the recommendations we have laid out, is contractualism. Rather than looking at aggregate happiness, contractualism asks, "Could any individual involved in the contract (or recommendation) be able to make an argument for the rejection (or promotion) of the contract in good faith"? This approach rejects the possibility that the intense suffering of some could be outweighed by the aggregate joy of the majority, comparing individual arguments instead. For many of the suggestions above, there is an associated economic cost. The funds for the expansion of Medicaid coverage, and the implementation of social programs that attempt to take a holistic approach to health care (addressing health concerns and socioeconomic concerns), must come from somewhere.

Before, we take a contractualist approach and weigh the strongest individual argument for and against the implementation of these programs, understanding the true cost of these programs is important. Programs that attempt to improve health outcomes and increase preventative health do not necessarily increase the net expenditure of the entity implementing it. For example, the CRC program that was implemented in Delaware saw approximately \$1.5 million in saving due to the reduced incidence of CRC (Williams 2019). It is not automatically obvious how the implementation of such programs will translate to cost, especially in programs that attempt to focus on preventative measures. Nevertheless, even if these programs required increased taxation, from a contractualist point of view, I do not think that any individual who

would be taxed more under any of these provisions would be able to make a reasonable argument against their implementation. The improved health outcomes (reduced mortality and morbidity) for a person of a historically marginalized group of people are not equivalent to the increased taxation associated with the implementation of these programs. The distribution of the cost of these programs makes it so that the actual cost to each individual would not be substantial, a small fraction of their income. A value that no reasonable individual would claim is not worth the outcomes these programs produce.

This same thought process can be applied to the suggestion of paid sick leave for preventative health care checks, as well as educating physicians on gaining patient trust. While it is more difficult to argue for such paid sick leave for small businesses<sup>8</sup> that may not have the funds to pay for sick leave, I do not believe that large corporations would be able to claim that paying their employees for sick days is morally unjust. Their arguments of lost wages do not hold the same ethical weight as the improved health of their employees (and their employee's children). Preventative measures may lead to less time spent out of work for medical issues that have become more serious, and therefore a more reliable workforce. If it is the case that it may be shown that paid sick leave would significantly harm the welfare of large corporations (as to threaten the job security and welfare of the person) then it may be the case that the implementation of the program and its costs would need to be diluted further. This can be done by spreading the cost, once again, through taxation with the goal that no single individual or entity would be so burdened to the point that the cost upon them is ethically equivalent to the mortality and morbidity of at-risk individuals.

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<sup>8</sup> A small business owner may be able to argue that they do not have the means to pay their employees for sick leave and would instead have to reduce hours or lay off certain individuals. In this case, even the individuals whose health may benefit from paid sick leave (from a contractual point of view) would argue against the implementation of such a program.

Furthermore, an individual physician may argue that training on how to gain the trust of their patients would detract time away from their schedule and possibly treatment of other patients. Nevertheless, I do not feel that this issue is sufficient to justify the lack of trust-building training. Trust among patients and doctors, as we have seen, has been linked to better continuity of care. A reasonable physician, who wishes to do no harm, and work to improve the health of a non-zero fraction of his patients would not be able to contest training that would allow him to do just that.

It can be argued that by virtue of living in a society where medical injustice exists, we are complicit in its persistence. That although we may not be, as Gregory Mellema explains, taking an active role in the reduction of the quality of health care for African Americans. Our silence and lack of vocalization against the processes that bring about those outcomes can, by our proximity to the situation, place us in the metaphorical splash zone of the ethical consequences of the issue, tainting our integrity (Mellema 2008). This simply tangential connection most of us feel we have to medical healthcare disparities may compel some to feel that they are not culpable for these harms and are therefore not responsible for addressing them. This paper has not sought to reject that claim of faultless, nor implicate privileged individuals in the perpetration of these harms. Instead, the goal has been to make an argument for the political responsibility of each and every one of us in at least acknowledging and denouncing these harms. This political responsibility comes from the virtue of being a participant in our society. As participation in a society that strives to be morally just, we must take an active role in the reduction of oppression and suffering wherever it may be.



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