COVID 19: Bioethics, the racial line and ethical praxis

Juliana Sassi[1]

Abstract

This article reflects upon the limits and potential of bioethics in a society in which not only people's values are hierarchised along racial lines, but the public and private interests are also structurally antagonised. The author focused on the experience of migrants and asylum seekers in Ireland during the COVID 19 Pandemic. Developing a literature review on bioethics and race, the author locates this case study within the liberal rationality, which is individualist and ultimately values people according to the market needs. Applying the concept of racial capitalism to make sense of racialization processes, the author claims the need to build an ethics that is also practice, what she calls, ethical praxis.

Key Words: Bioethics; Racism; Immigrants; Pandemics.

Resumo

Este artigo reflete sobre os limites e o potencial da bioética em uma sociedade na qual não apenas os valores das pessoas são hierarquizados em termos raciais, mas os interesses públicos e privados também são antagonizados estruturalmente. A autora concentrou-se na experiência de migrantes e requerentes de asilo na Irlanda durante a Pandemia do COVID 19. Desenvolvendo uma revisão de literatura sobre bioética e raça, localizando esse estudo de caso dentro da racionalidade liberal, que é individualista e, em última análise, valoriza as pessoas de acordo com as necessidades do mercado. Aplicando o conceito de capitalismo racial para dar sentido aos processos de racialização, a autora alega a necessidade de construir uma ética que também é prática, o que ela chama de Ética prática.

Palavras-chaves: Bioética; Racismo; Imigrantes; Pandemias

[1] Trinity College Dublin. Sociology specialist in Race, Ethnicity an Conflict.ORCiD: http://orcid.org/0000-0003-0592-0394

Introduction

This article reflects upon the limits and potential of ethics in a society in which not only people's values are hierarchised along racial lines, but the public and the private interests are also structurally antagonised. The author argues that the Pandemic increased long-standing inequalities[1], which are mainly concerned with racialised and class constraints. This article analyses measures the Irish state introduced to manage the spread of the cov-sars-2, and the challenges that migrants and asylum seekers face trying to comply with them due to their precarious situation in the country.

The first section of this article focuses on the bioethics debate about race and racism. The second part places Irish racism within the confines of racial capitalism[2]. And the third section is devoted to an overview of migrants' and asylum seekers' vulnerability during the COVID 19 Pandemic, and their specific situation in Ireland. The arguments made here are twofold: 1) to embody an ethical approach to health care is not possible without reconciling people's interest beyond race and class, but ultimately without making the public interests the common interest of all those living in a society. This common interest is the basis of the ethics of the praxis[3]. 2) The failure of nation-states and transnational organisations in addressing migrant's basic needs and providing them with equal rights is a global problem, not exclusive to some countries. It is a feature of racial capitalism. Therefore, the case study of asylum seekers in Ireland is significant to the point made here. Ireland is a typical liberal state, proud of its vanguard role in human rights legislation[4], it is not a on central route taken by those seeking asylum due to geographical reasons, thus, has a relatively lower number of

asylum seekers applications. Yet, it fails to attend the basic needs of asylum seekers not only due to racism but also due to a market-oriented rationality.

Ethical Praxis

Bioethics has a race problem, had argued the medical historian John Hoberman[5], specialized in the history of medical racism. Hoberman researched the academic production of medicine and bioethics to trace the place of race in the field. Looking at the prestigious Hastings Centre Report publications from 2001 to 2016, he found just one article which covered race and medicine in a broad sense[5] (12), that is, that did not deal with cases considered exceptional or focused on historical periods of overt racism, giving the impression that racism is something from the past. The same absence can be found in the American Journal of Bioethics, which in fifteen years has produced four articles or essays focused on race and medicine[5] (12). Even though a minor theme in the field, the role of witness, race and racism in shaping bioethics theory and practice had been questioned[6]; [7]; [8]; [9]. The need to expand the discussion by looking at power relations reproduced by institutions and practices[10], and the need to respect cultural diversity in bioethics as an ethical imperative[11] have also been addressed. There are few discussions on the need to address racial inequalities by reviewing the bioethics standpoint and making it intersectional[12;13], as well as by questioning the United States' ethical foundations, which draw their values such as individualism from philosophical and religious ethicists, theologians (predominantly Christian), jurists, physicians, and biologists[14] (205). Renee Fox highlights

> The weight that bioethics has placed on individualism has relegated more socially-oriented values and ethical questions to a secondary status. The

concept and the language of rights prevails over those of responsibility, obligation, and duty in bioethical discourse[14] (207).

Myser[15] argues that US ethics ethos comes from a White Anglo-Saxon Protestant culture, and, consequently, the ethos that orientates bioethics does not avoid reproducing such values, and prejudices. In the compilation The Ethics of Bioethics: Mapping the Moral Landscape, the history of bioethics in the US is critically analysed, and Myser insists on the need to address and overcome white normativity to advance to more pluralist and democratic standards and policies. She defends that bioethics must discuss whiteness, which is also shared in the work of Anijar[16]. Olivette Burton[17] states that Western science, which is also white, informs ethics, and that social Darwinism and Malthusianism specifically are very influential in shaping ethical discussions on resource conservation, particularly in discussions about organ allocation and healthcare for prisoners, the elderly, blacks and others[17] (8). She defends that bioethics must challenge such premises to look at the specificity of the racialized population and address its concrete needs:

> One can also point to history and say that although the oversight in excluding the cultural Black society seems deliberate, it is also a cause and effect of bioethics' failure to challenge its allies, namely law and medicine, toward effective social change with respect to the Black population. Standards of ethics in healthcare and the behaviour of the medical community towards Blacks and other people of colour are not equally applied. (...) Members of the Black community die at disproportionately higher rates than whites from diseases (i.e. diabetes, heart disease, asthma and HIV) for which management and medical technology have already made significant progress. Yet there is no shortage of descriptive studies being performed on or asked from this population, nor any shortage of models or theories currently in use[17] (10).

Burton diagnoses this reality as racism and prescribes to include and listen to the black people (and communities) when discussing race in bioethics. The fact that she is one of few Black-American in the field is also telling of the need to hear from

those affected by racism, which is not only directed to racialized patients but also to black and other minority members of the medical community[5] (15). When talking about race it is also important to deconstruct myths claiming that black people can endure more pain therefore they are provided with less anaesthesia and denied painkillers, what is reported by Hoberman in the US but has also been reported orally by the Migrants and Ethnic Minorities for Reproductive Justice in Ireland. The particularity of migrants and ethnic minorities is also overlooked by academics in the field. However, to listen to and include the racial issue in the debate does not mean bioethics will end racism in medicine. As bioethics draws its ethos from White Anglo-Saxon Protestant culture, which is market-centred and emphasizes private property rights, it is also central to address the foundations in which such culture emerges from.

Racial capitalism

Arriving in Ireland, the absence of race in medical and bioethics research is notable, with much of the literature imported from the US as can be found in the online library of the Royal College of Surgeons in Ireland. A positive surprise came from the Royal College of Physicians of Ireland, that recently positioned themselves in support of asylum seekers against Direct Provision Centre (DPC). Even though racism and race are invisible in the medical and bioethics literature in Ireland, its existence in the broader society is visible. The treatment asylum seekers receive in DPC is the extreme case of dehumanization non-nationals are exposed within the Irish state. Such case show what a so-called civilized society is capable of when someone's humanity is shaped by the mark of exception such as one's nationality, skin colour, religion, class, genre and/or sexual orientation[18]. On the other hand, racism is not exceptionalism.

Migrants are ultimately valued by the needs of the host country in a racialized international division of labour[19] [20]. While the dominant cultural group simply exists, minorities exist to enrich dominant culture and are defined in terms of how, and to what extent, they benefit the host culture[21] (121). Ireland's relationship with ethnic diversity is marked by racism in political discourse and state practice[22]. Lentin and McVeigh[23] had argued that after the 2004 citizenship referendum, Ireland had turned into an officially racist state. The referendum campaign drew its narrative from the fear of scarcity - or what Balibar[24] calls 'crisis racism' -, accusing the migrant (black) women (preferentially from Nigeria) of coming to Ireland to have babies to get citizenship and, as a consequence, overwhelming the maternity services[23]. This narrative won over 79% of the nation's votes, and the citizenship rights shifted from jus soli to jus sanguinis. Since then, many migrants born children live under the threat of being deported anytime.

However, the state does not exist in a vacuum, nor public policies are merely the result of a diabolic plan drafted by white guys legislating from their ivory towers. The state is located in a specific place and time, which in the twenty-first century Ireland assumes the form of a racial capitalist state. The state exists to respond to concrete issues that emerge from the relation among human beings in society, to mediate antagonistic private interests of individuals in civil society[25]. Its rationality and practice follow legal and ethical principles that have in its core the defence of private property rights. When liberalism emerged as a doctrine, black and other racialised people were excluded from property rights and were themselves reduced to a property of the white men. The racialised had no property, no rights, no humanity. Colonisation created the idea of race, with the black and the white person as two extremes[26]. Thus, if coloniality of power[26] can persist without colonisation, it is because the liberal rationality did not

question the private property rights, it departed from it to build its human rights principles. When the erstwhile enslaved person was set "free", they remained disposed, because the properties were already taken and monetised by the white colonisers and those Europeans who had previously enclosed their lands from the peasants. Race has served since then to capital accumulation[2]. Today, according to liberal ideology, everyone is free to compete freely in the free market. Is it ethical?

Migrants, Asylum Seekers and the COVID 19 Pandemic

According to the Central Statistical Office, in April 2019, there was 622,700 non-Irish nationals' resident in Ireland, accounting for 12.7% of the total population. There are many types of migrants living in Ireland differentiated by visa stamps, as well as lack of documentation. There are migrant workers from inside and outside the European Union, which hold distinct visas and have different rights, International and English Language Students that can work part-time, the undocumented, as well as asylum seekers and refugees, which are a specific category of non-nationals. Under the 1951 UN Convention and its 1967 Protocol, an asylum seeker is a person who enters a country seeking recognition as a refugee. Data from the United Nations shows that the number of persons experiencing forced displacement has almost doubled over the last 20 years. The global population of forcibly displaced people increased by 2.3 million people in 2018[27] (2). Around 70.8 million individuals were forcibly displaced worldwide because of persecution, conflict, violence, or human rights violations - 3.5 million were asylum seekers[27] (2). In 2019, 676 300 asylum seekers applied for international protection in the European Union member states[28]. In that year, Ireland ranked 11th out of 27 EU countries in terms of first-time asylum application[28]. In

November 2018, there were 5,928 asylum seekers living in Ireland's Direct Provision Centres waiting for the state's decision on their application[29] (5).

When the COVID 19 Pandemic started, the International Organization for Migration (IMO) released a report stating that international migrants worldwide were more vulnerable than others, with people displaced internally and across borders particularly at higher risk of contamination[30]. According to the study, migrants'

> ability to avoid the infection, receive adequate health care and cope with the economic, social and psychological impacts of the pandemic can be affected by a variety of factors, including their living and working conditions, lack of consideration of their cultural and linguistic diversity in service provision, xenophobia, their limited local knowledge and networks, and their access to rights and level of inclusion in host communities, often related to their migration status[31] (4).

While minorities and low-income persons in general face more challenges in accessing healthcare[1], migrants' specific patterns of vulnerability often lie at the intersection of class, race and visa status[30], but also gender. The IMO study defends that

> migrants are overrepresented in low-income and discriminated minorities, and encounter unique sets of challenges linked with their lack of entitlement to health care, exclusion from welfare programmes, and fear of stigmatization and/or arrest and deportation[30] (5).

In a context of a pandemic and economic crisis such precarity intensifies, once

> migrants are more likely to be excluded from welfare systems protecting workers who lose their jobs and incomes due to lockdown-related closure and failure of businesses, layoffs and reduction in working hours – often despite their disproportionate contribution to welfare systems[32] (8).

The report also addressed the relevance of adequate housing conditions as an element which increases migrants' risk of being contaminated and spreading the virus.

In Ireland, migrants make up ⅓ of the homeless population[33] and 42 % for those sleeping rough[34]. Overcrowding is another issue that affects people in Ireland and disproportionately the migrants. Being migrant herself and working with housing and migrant grassroots groups, the author has followed cases of migrants living in overcrowded dwellings, particularly English Language Students from Latin America. A report from the newspaper Dublin InQuirer at the beginning of the COVID crisis showed a reality well known by migrants: 42 students, mostly from Brazil, were living in a house with one kitchen to be shared among all of them. To rent a bunk-bed in a shared room with four people in this place cost 95 euros per week, almost 400 euros per month[35].

Housing is a particular burden for asylum seekers, given their lack of rights, and the fact they share bedrooms and common areas with many people in the Direct Provision Centers (DPC) where the state allocates them. When asylum seekers arrive in Ireland, they are placed in these centres, which are designed to be only a provisory measure - the duration of the stay is meant to be no longer than six months. In reality, 19.5 per cent remain in the system for over three years, and there have been cases of people in DPC for more than nine years[36]. Thus, when the World Health Organization[37] released guidelines to combat the spread of the sars-cov-2, such as 2 meters physical distancing, they were read among vulnerable and low-income migrants and asylum seekers in Ireland as something that did not correspond to their concrete reality in any way.

Following the World Health Organization[37] guidelines, the Irish Government published on 27th March 2020 Public health measures to combat the spread of COVID 19. Stores, restaurants, sports complexes and churches were closed, and just essential services remained opened[38]. Schools and universities closed, and online classes were offered. People were advised to practice social distance and to work from

home when possible. The United Nations High Commissioner for Refugees Ireland[39] published that all the measures were extended to refugees and asylum seekers. To comply with such rules, the Department of Justice and Equality[40] said it would provide an additional 650 beds for vulnerable residents in DPC. Replying to the Irish Government, the Movement of Asylum Seekers Ireland (MASI) wrote that "social distancing is useless to an asylum seeker sharing a tiny bedroom with a stranger or as many as seven other strangers, having to use communal bathrooms and congregate in a canteen for meals three times a day"[41]. In the first week of May, the Minister for Health Simon Harris confirmed 164 cases of Covid-19 in DPC, with nine clusters around the country and ten people hospitalised with the virus[42]. Figures regarding migrants are not reported separated from the native population.

As said above, the migrant category encompasses a vast amount of people who hold distinct possibilities, opportunities and rights within the host state. Not all asylum seekers or migrants are treated the same way; not all have equal access to work, public services, visa and citizenship rights. It is illustrative of it, the Immigrant Investor Programme[43], which provides citizenship to non-EEA investors. The programme requires a minimum investment of €1milion from the applicant's resources, which must be committed for a minimum of three years. Yet, a child born in Ireland from migrant parents is not entitled to citizenship. In this sense, it is made the argument in this article that the Irish state is not just racist, but also fundamentally liberal. Thus, the situation of migrants and asylum seekers in Ireland cannot be understood without considering class' dynamics. The Critical Skills Employment Permit[44] is designed to attract highly skilled foreign nationals into the Irish labour market with the aim of encouraging them to take up permanent residence. On the other hand, they are not the average case. Even though migrant workers are often overqualified, they are the majority in low paid

job sections of the Irish labour market[45]. The incidence of minimum wage pay among migrants is over twice that of Irish employees according to a research released in 2017[46]. During the Pandemic, it was a scandal that Irish companies were bringing migrant workers to Ireland to work in the fields to pick up fruits[47].

In addition to precarious housing and working conditions, the lack of visa status and rights also worsen the situation of migrants in times of crisis. It specifically affected migrants that had just arrived in Ireland and did not have time to get their documentation, and then could not get a job or access the COVID-19 Pandemic Unemployment Payment or the Exceptional Needs Payment provided by the Irish state. Asylum Seekers who lost their jobs were not entitled to the COVID 19 Pandemic Payment. The possibility to access the labour market and other rights is a long-standing problem for asylum seekers. While asylum seekers are waiting for their appeal to be processed, they cannot enrol in third-level education, they have no full access to work (before the 2018 Supreme Court rule it was a total ban), and they receive a weekly allowance of €29.80 for children and €38.80 for adults[48]. Considering that the national minimum wage is €10.10 per hour, the weekly payment received by asylum seekers is less than half of a working day of anyone working legally in Ireland. Still, even during the pandemic, those who lost their jobs were not entitled to the 350 euros weekly payment which all other workers could access, including the language students' migrants.

Precarity also impacts people's health. The Movement of Asylum Seekers Ireland (MASI) had reported to the Joint Committee on Justice and Equality in 2019 the impact of DPC on people's physical and mental health. Such claims are supported by the Special Rapporteur on Child Protection, the UN's Committee on the Elimination of Racial Discrimination, and the Faculty of Paediatrics at the Royal College of

Physicians of Ireland, which have recently called on the Irish government to end the system of Direct Provision[49]. In 2016, the Royal College of Physicians of Ireland published their position on the matter, highlighting how asylum seekers are disproportionately affected by health issues due to their precarious situation. It states:

> People fleeing war and persecution in traumatic circumstances may have complex mental health needs requiring intervention. For example, rates of post-traumatic stress disorder (PTSD) are up to ten times higher among asylum seekers than in the indigenous population. They are also more likely to suffer from mood disorders. Their mental health needs may be greatly increased by their loss of family structures and social support[50] (10).

While asylum seekers are eligible for medical cards and can register with a General Practitioner (a family doctor) to access health services, the Physicians of Ireland identified several linguistic, cultural and financial barriers that limit their access to proper care[50]. During the Pandemic, these already existing problems became difficult to ignore. According to Susan Dorr Goold from the Center for Bioethics and Social Science in Medicine, "Poverty and illness are mutually reinforcing. Inequities in health that exist already, show signs of worsening due to the Pandemic"[1] [51]. Notwithstanding, during the COVID 19 Pandemic, asylum seekers were expected to comply with the government guidelines to self-isolate. However, while the public had a positive response and a relatively high level of trust on the Irish public institutions to handle the crisis if compared with other European states[52], such measures did not respond to the most vulnerable groups' needs. These groups also included Irish Nationals such as the elderly, single parents, low-income, precarious and front-line workers, many of those migrant nurses from India and the Philippines[23]. People's vulnerability precedes the Pandemic and will remain if no long term, concrete and structural measures are adopted. Emergency measures that aimed to guarantee rights

to all during the crisis must be a right beyond the Pandemic. As people have been saying all around the world, "we do not want a return to normal".

To respond to the COVID 19 crisis, the Irish Government were able to 1) facilitate the emission of Personal Public Service (PPS) Number, a document that allows one to access work, social welfare benefits and public services in Ireland; 2) allow migrants who lost their jobs to access the Pandemic Unemployment Payment, which was more than many migrants get when working; 3)extend migrant students' rights to work full time; 4) ban evictions and provide emergency accommodation in a single room for the homeless; 5) halt deportations; and 6) establish that everyone in need could access private hospitals. The government signed a deal in March with the Private Hospital Association to allow people to access its services for the duration of the Pandemic. Health Minister Simon Harris declared that "there can be no room for public versus private"[53]. Still, the Irish government followed a very liberal approach to the public good if compared with Spain, that nationalized its private hospitals[54]. With the deal, the Irish government is paying each month 150 million euros to these private companies. However, the ministry statement addressed the principles of bioethics, following the principle that the good of the whole party determines each individual's good[55]. Let's exclude for a moment the fact that millionaires own private hospitals and that they were still getting paid with public money that came from workers - including migrants[56]. Looking strictly at the health measures announced by the government, one could say that all were equal to access healthcare in Ireland during the Pandemic and that the common good overcame private interest. As demonstrated in this article, it is just possible to say so if one ignores the limits imposed on people by class, race and visa status to access healthcare. Even if everyone in Ireland were able to access

private hospitals services during the Pandemic, undocumented migrants would not do it due to fear of deportation for example.

Bioethics guides physicians and healthcare worker's conduct, which must be based on principles of universality that ignore one's race and class. However, while there is racism in society, bioethics cannot be colour-blind[57]. The possibility to afford and to access treatment is essential to give people the same chances to receive healthcare. Racism also affects the judgment of the medical staff. Migrants and asylum seekers have been experiencing discrimination in the health system in Ireland[58][59]. If there is no biological distinction on human beings and race is a social construction, such discriminations can only be identified as racism. Thus, to keep discussing ethics without talking about structural and institutional racism and its reproduction in the health system will continue producing the same unequal results on racialized people's lives.

Conclusion

The case study of this article is a textbook of a European liberal state. Migrants' rights to live in the country are judged from a market-oriented rationality. This rationality ultimately protects private gains rather than human beings' health and safety. The case study of Ireland is significant to point out though to the potentiality - but more than that - the need for an ethical practice during and beyond the pandemic. Ethics that is practice, and that to be universal must overcome racial capitalism.

The literature on Bioethics the author engaged in the article is mainly from the American Journal of Bioethics, which deals with racism and inequality in healthcare in such a context. Inequalities that in great extension, draw from the generalized

privatization of services and structural racism. However, to say it is not a novelty within academia nor for the broader society. In 2002, Hollywood released John Q, the drama of a black father that could not afford a heart transplant to his son. The movie shows that if you cannot pay, you cannot have. However, liberal ideology will always defend that individuals have a choice. It reminds another movie released recently called Rather, in which choice is what makes people live or die in the game. The protagonist of the film accepts to play to afford the transplant and the treatment of her brother. If she wins, her brother's name would be the first on the donation list. As art is a product of a space and time, these two examples are very telling about the US values, which due to its political and economic influence are exported worldwide. Due to US influence, racism, oppression, and the narrative of suffering became also naturalised.

Thus, it is not enough to criticise the limits of liberal ethics intellectually. It is imperative to question the world from which this ethic emerges and to build an ethical practice to oppose such a world structurally. The point made in this article is that it is imperative to reflect about the limits inherent to an ethics in which the public and private interest are materially antagonised by private property, that is by individuals rights to protect its private property. The private property is the basis of the liberal legal framework, which draws from an Anglo Saxon Protestant culture that emerges to protect private ownership that has been accumulated in the hands of few due to primitive accumulation, turning women into housewifes, and colonisation. The liberal ideology sees man a wolf to man (Hobbes, 2003). The hegemonic culture is founded under the self, the other is seen as a threat to the individual, and the racialised has always been the other.

It is imperative to position the self as part of a whole to which our lives all depend, including all other species on this planet. That is why the problem of bioethics

to deal with racism and class constraints is an ethical problem that goes beyond this field of knowledge. Thus, as important as it is to include other fields of knowledge to the discussion on bioethics, as suggested by Fox[14], the problem of bioethics will not be solved solely due to it. Nor the problem of racism will end by including the others' perspectives. Racism did not evaporate with the Barack Obama government, once he kept working within liberal rationality, oppressing people and disproportionately Latinos and blacks[61]. That is why Burton's call to engage with racialized communities is urgent. The ethical concerns faced by bioethical theorists and healthcare workers are not just epistemological ones, or a matter to be administered by politics, specialists, or technocrats.

So how can bioethics help in such a complex project? In Ireland, the author suggests medical organizations starting supporting those affected by racism and pressure the state to implement long-standing demands from migrants and asylum seekers grassroots groups in Ireland such those from the Movement of Asylum seekers, Anti-Racism Network, Anti-Deportation Ireland, United Against Racism and Migrants and Ethnic Minorities for Reproductive Justice. They are the right to work, the abolishment of the Direct Provision system, citizenship for all those who live in the country, and reproductive justice rights. It is also primordial the investment in the public health services and support for those low-paid workers within the health system, such as nurses. When reflecting on the lessons to be learnt from the Pandemic, Goold pointed out to the

> need for greater investment in public health personnel, research and infrastructure, the need to lessen pre-existing health inequities, and both cherish and strengthen our capacity as families, communities, nations and the human race to place the public interest and the common good over our own[1].

To be able to put the common good before the private is not possible without universal healthcare that would serve not only those excluded by race or class dynamics but to all those made vulnerable due to exclusionary values. If ethics must be practice and practice is movement, it is necessary to combine intellectual reflection with concrete action to build an Ethical Praxis. Ethics cannot find fertile soil to grow in a land that is fracked in its structure.

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