

Structural Injustice and Dismantling Racism in Health and Healthcare

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Abstract

Racism in health and healthcare has long been recognised as a structural issue. While there has been growing research and a number of important initiatives that have come from approaching racism as a structural issue, there are a range of implications that yet have to be explored as they relate to health and healthcare. Conceptualising racism in this way provides a means to consider how it shapes and is shaped by a range of global injustices and serves as a foundation for more egregious harms. It also suggests that if we are to dismantle racism, we need to look both within and beyond the traditional domains of health and healthcare and account for a range of broader forces that sustain and re-enforce racism. We first discuss the issue of responsibility, drawing on Young's social connection model to argue that we all have a responsibility to take action in addressing structural racism. We will then deal with a question that naturally follows, namely how we discharge our responsibilities, with a focus on the role of disruptive action in challenging power and ignorance in dismantling racism in health and healthcare.

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Health, Healthcare and Racism

Racism remains a profound issue in health and healthcare. Racism can be defined as a "system of structuring opportunity and assigning value based on race, that unfairly disadvantages some individuals and communities," while unfairly advantaging others (Jones, 2002, p. 10). Racism thus can include interpersonal acts of discrimination but extends far beyond this; it remains ingrained in broader social structures and is maintained through, among other things, prejudice, discrimination, policies, practices, norms and structures which act to reinforce each other, while maintaining the status quo; justifying and perpetuating racial hierarchy.

Racism has a significant role in creating and sustaining pervasive health inequalities (Paradies et al., 2015). It has been shown to have an impact on health through a range of pathways including economic, social, political, environmental and occupational among many others (Bailey et al., 2017). These issues unsurprisingly are found within healthcare systems, not just as they relate to patients, also healthcare workers from ethnic minority backgrounds. For example, experimental evidence from a randomized controlled trial found that black patients

assigned to a racially concordant doctor sought more preventive care than those assigned to a racially discordant one. It was estimated that black doctors could reduce the cardiovascular mortality gap between black and white patients by 19% (Alsan, Garrick, & Graziani, 2019). Addressing health disparities is as much an issue about training and staffing as much as it is about cardiovascular health. Representation of Black, Asian and Minority Ethnic (BAME) clinicians remains a problem in many countries. In the UK for example, compared to their white colleagues, doctors from BAME backgrounds were less likely than white doctors to be considered suitable for specialty training jobs (Iacobucci, 2020) they were also more likely to fail examinations (Linton, 2020) and face disciplinary procedures (Majid, 2020). The recent special edition of the British Medical Journal (BMJ) on racism in health and healthcare lamented the lack of progress that has been made over the last 25 years, despite numerous calls for action, asking “[h]ow can it be that a problem raised in The BMJ more than 25 years ago—that of discrimination in applications for specialty training posts in the NHS—persists” (Adebowale & Rao, 2020).

In the ongoing effort to address these issues, a range of action has been called for. This includes a greater focus on structural factors, such as income inequality and residential segregation and their impact on health. Williams, Lawrence, and Davis (2019) argue that “structural racism is the most important way through which racism affects health”. The purpose of this article is not to echo this sentiment nor is it to call for further research (although both are important and needed) but to discuss some further implications of approaching racism as a structural issue, particularly as it relates to the action we could take to dismantle racism in health and healthcare. To do this we will first draw on the broader literature on structural injustice, using the work of Young (2011) and more recent theorists to show how racism sits alongside other injustices and how it contributes to particularly egregious and catastrophic harms. Importantly, if we are to dismantle structural racism, we cannot ignore other structural injustices. While many of these issues have not gone unrecognised in the literature on structural racism, arguably the most important contribution of Young’s (and others) theorising relates to how we respond to structural injustice. When we talk about structure, we often talk about sweeping harms being the result of cumulative processes and cannot be traced to the actions of any one individual. This poses a challenge for identifying who is responsible. We will introduce Young’s social connection model to argue that we all have a role to play in dismantling racism in health and healthcare. We will then deal with a question that naturally follows, namely how we discharge

our responsibilities, with a focus on the role of disruptive action in challenging power and ignorance in dismantling racism in health and healthcare.

Racism and Structural Injustice

Structural racism is closely related to structural injustice. Structural injustice exists when the actions of a (often large) group of people, “puts large categories of persons under a systematic threat of domination or deprivation of the means to develop and exercise their capacities” (Young, 2007, p. 170) while at the same time advantaging others, resulting in these groups often standing in “systematically different and unequal social positions” (Young, 2006, p. 143). Structure in this respect refers to the end result of a number of large scale social processes that interact and often re-enforce one another. While these processes are driven by individuals and collectives, the injustices they generate are structural as their cause cannot be isolated or put down to the actions of one agent. As Young (2007, p. 170) notes, structural injustice “occurs as a consequence of many individuals and institutions acting in pursuit of their particular goals and interests, within given institutional rules and accepted norms”. The maintenance of structural injustice therefore is not dependent on individual wrongdoing alone, but is maintained through the ordinary and often well-meaning actions of many via “unquestioned norms, habits, and symbols, in the assumptions underlying institutional rules and the collective consequences of following those rules” (Young, 2014, p. 5) and furthermore in “unconscious assumptions and reactions of well-meaning people in ordinary interactions, media and cultural stereotypes, and structural features of bureaucratic hierarchies and market mechanisms—in short, the normal processes of everyday life” (Young, 2014, p. 6).

There are obvious parallels between structural injustice and structural racism, in both their definition and in how they are maintained. As already noted above, racism is a system of structuring opportunity that advantages some and disadvantages others. In this sense we could think of structural racism alongside a range of other injustices, alongside economic inequality, residential segregation and issues related to migration, just for example. Put another way, racism is maintained through “a set of dynamic, interdependent, components or subsystems that reinforce each other, creating and sustaining reciprocal causality of racial inequities across various sectors of society” (Williams, Lawrence, & Davis, 2019). That is, racism not only sits alongside, but perpetuates a range of injustices (such as income inequality) while equally, these issues act to perpetuate racist attitudes, practices and norms, among other things. Like structural

injustice more generally, structural racism is not necessarily created and maintained through individual wrongdoing. If we are to address structural injustices, like racism, we will need to challenge multiple oppressions that act to re-enforce one another. We will discuss this more below, however let us first consider how structural racism plays out in health and healthcare and how these issues converge to impact health globally and result in far more egregious harms. While the majority of our focus below will be on the UK, parallels could be drawn between almost every country in the global North, as it relates to racism and other injustices.

The COVID-19 pandemic has highlighted the role that structural racism plays in health and healthcare in a number of ways (Schmidt, Roberts, & Eneanya, 2020). Similar to other health inequalities those from ethnic minority backgrounds face significantly higher mortality rates. In England those from BAME backgrounds made up a disproportionate number of ‘key workers’ (those involved in food production, health and key infrastructure for example; The Health Foundation, 2020) They were more likely to be diagnosed with COVID-19 and face an increased risk of mortality between 10 to 50% higher compared to those from White backgrounds (Public Health England, 2020). At the same time COVID-19 has also raised important questions about the distribution of scarce resources. A number of arguments give “priority to maximising the number of patients that survive treatment with a reasonable life expectancy” (Emanuel et al., 2020). Concerns have been raised however that such guidance was racist and “whether members of BAME communities may be perceived as less likely to benefit from scarce life-sustaining treatments, following the revelation that they are more likely to die from COVID-19” (Johal, Prout, & Tinkler, 2020). It was highly unlikely that the above guidance was formulated with any explicit prejudice in mind, the most striking (and important) issue at stake however is how it has highlighted existing inequalities; how COVID-19 has brought structural racism to the surface. While in many respects, work is ongoing to determine why ethnic minorities have been disproportionately impacted by COVID-19, at the time of writing early evidence suggests that those who come from ethnic minority backgrounds are more likely to be economically disadvantaged, are more likely to live in crowded housing and areas with higher population densities, and are more likely to use public transport and face a greater risk of occupational exposure to COVID-19 (Public Health England, 2020). Again, almost identical issues have been identified in the US. In a recent interview, Dr Linda Rae Murray explained how structural factors contribute to increased deaths during COVID-19:

In the Chicago area, the parts of our area that have high numbers of essential workers—on the South Side, the southwest side, the western suburbs—match very well with low-income working-class communities and black and brown communities. So I would argue that all of these structural factors, the things that force people to have hypertension, like racism; the jobs that people are forced to have; the fact that if a member of the family gets sick, they don't have a guest house or a basement for someone to stay in; that you have multigenerational households in relatively small spaces.... All of these structural factors really help account for these horrible differences in case rates and death rates (Abbasi, 2020).

Beyond these examples taking a structural perspective also forces us to look beyond the individual and outside of the traditional domains of health and healthcare, thinking about racism, how it is re-enforced and how it re-enforces other injustices requires us to think beyond borders recognising that increasingly, what happens here, impacts what happens elsewhere and vice versa. That is, we cannot address racism until we look at it as a global problem, until we address the exploitation of labour from poorer countries in the global South or policies of migration which are closely tied to race and ethnicity. Furthermore, we also need to consider how this contributes to far more egregious harms, how catastrophic events and human rights abuses are often not isolated or random, but “rooted in interlocking patterns of structural unfairness” (Powers & Faden, 2019).

Almost all of these issues converge when examining the Grenfell tower disaster in London. Grenfell tower was a twenty four story block of social housing in Kensington London, that is, housing which was traditionally managed by local government (in the UK) and where rent was provided at a lower rate than a private property. In June 2017 a fire broke out in the tower. The fire spread rapidly because of the buildings external cladding which did not comply with building regulations and had been installed primarily to enhance the aesthetics of the building for those living in the surrounding area. Seventy two people died. While Grenfell sat within one of the wealthiest boroughs in London (and the UK), the ward in which Grenfell sat, Notting Dale had significantly higher levels of deprivation and twice the proportion of migrants from the Caribbean and Africa than surrounding areas. While it will remain important to identify those responsible for this disaster, a focus on liability, at least in the traditional legal sense, downplays the broader structural issues that laid the foundation for this disaster. Bulley and Brassett (2020) argue that the Grenfell disaster was not a regrettable national issue or merely a

domestic problem, but something that needed to be considered in light of “global relations steeped in hierarchy [and] violence”. Furthermore, to fully understand Grenfell we need to look to history. El-Enany (2017) argues that Grenfell highlights an ongoing colonial social order, predicated on racism:

Many of the Grenfell residents and their ancestors suffered the dispossessing effects of European colonialism. They lived and fled not only the lasting material consequences of colonisation, but also the economic decline caused by global trade and debt arrangements that ensure the continued impoverishment and dependency of Southern economies on those of the North. The Grenfell residents whose faces now smile back at us from Missing persons posters could not escape their condition of coloniality... The hyper-segregation and differential quality of life of North Kensington residents mirrors practices of the colonial era when British authorities instituted spatial ordering on the basis of ideas and practices of racial hierarchy and white European supremacy.

Structural racism continued to shape the response in the aftermath of the fire. Families of victims and survivors from Iran and Syria were initially blocked from receiving emergency visas to enter the UK (Marsh, 2017), and other survivors opted against seeking medical and legal aid due to concerns over their immigration status (Quinn, 2017). As well as colonialism, racism and global inequality, Grenfell also needs to be seen against the backdrop of UK government’s ‘hostile environment’ policies. Introduced in 2012, the hostile environment refers to a range of policies that aimed to make life as miserable as possible for undocumented migrants. Among other measures, the UK government required landlords, employers, public servants, including police and teachers to check people’s immigration status before they could offer housing or a job; those who failed to do so could face fines or criminal sanction. The hostile environment had far reaching impacts beyond the victims of Grenfell and also had a significant and direct impact on the National Health Service (NHS)¹. Throughout 2017 and building on existing restrictions, identity checks and upfront charging were made obligatory in hospitals and NHS-funded community health services. This meant that unless an individual’s condition was considered urgent or immediately necessary, they were charged the estimated cost of their treatment upfront; treatment could be withheld if they did not pay (Hiam, Steele,

¹ In the UK, healthcare is provided through a publicly funded model, meaning that all in the UK have access to healthcare regardless of their income or employment status. The hostile environment is one example of steps taken in recent years to limit access to this system.

& McKee, 2018). In addition to this, the government also pushed a number of data-sharing arrangements, within the NHS and with other public services, using patient data from the NHS for immigration enforcement purposes. The hostile environment has caused destitution, ill-health, and exploitation. Beyond the victims of Grenfell, urgent and immediately necessary care has been wrongly delayed and withheld from vulnerable patients, primarily because of confusion related to what constitutes urgent and immediately necessary treatment. This has also resulted in people being deterred from seeking services (Gentleman, 2017; Kang, Tomkow, & Farrington, 2019; Potter, 2017), with many fearful of seeking treatment because of possible deportations (Equality and Human Rights Commission, 2018). Thousands more have been wrongly turned away from services (Bulman, 2017). For healthcare professionals, these policies raise a range of clinical and ethical issues, at the heart of these is the risk of being co-opted to act with policies that clearly undermine health and wellbeing; as a de-facto border guard. A recent survey found that numerous doctors had faced pressure from administrative staff regarding patients need for care, up front charging also increased workload and time away from patient care (BMA, 2019a). This observation, that upfront charging is less efficient and even generates economic losses has been supported by others (Shahvisi, 2019), suggesting that the hostile environment is not about austerity, but rather about weaponizing public services such as the NHS (Uthayakumar-Cumarasamy, 2020) to appeal to some broader sense of xenophobia (Shahvisi, 2019). While one could argue that Grenfell had little to do with racism; that the poverty had to do with residents being new migrants or due to government austerity as multiple other towers had similar cladding, this would oversimplify the issue. As we said above, racism needs to be considered in light of other injustices; racism will not be addressed until other injustices are addressed. While racism is not the only issue, almost all of the issues as they relate to the Grenfell disaster come back to race. Those from BAME backgrounds were one of the hardest hit by austerity measures, while the UK's migration policies actively discriminate against those who are mainly non-white (Owen, 2020). In this sense, such arguments are reductionist and only serve as a distraction to the larger problem, racism, a problem that remains the 'elephant in the room' (BBC News, 2020).

Above, we have shown how structural injustice relates to structural racism in health and healthcare. Structural racism sits alongside, and shapes and is shaped by a range of other structural injustices. The implications of this is that to understand the extent of these issues, we need to look both within and beyond the traditional domains of healthcare to broader, global issues and historical issues, such as income inequality, colonialism and our treatment of

migrants. Structural racism interacts with health and healthcare in a number of ways, from health inequalities, to how we formulate clinical guidance (i.e. see the guidance related to COVID-19 discussed above), to the broader social determinants of health. Like the hostile environment, occasionally structural injustice has a direct impact on healthcare systems, often however, it remains a pervasive force obscured by everyday practices, policies and norms. We used the example of the Grenfell Tower disaster to show how such issues are interconnected and not only serve to reinforce one another, but how structural racism can act as a foundation for far more tragic events. While some of the above insights may not be new for those who have already questioned these issues, one of the major advantages of drawing from the literature on structural injustice relates to its insights about how we could respond to such issues. Below we will discuss a question that naturally follows, who is responsible for structural problems.

Responsibility for Structural Racism

One of the problems in taking a structural approach is that we begin to lose our grip on responsibility, that is, who is responsible for such sweeping harms that cannot be traced to one individual, but are the result of cumulative processes. Traditional theorising about responsibility has generally held that an individual is responsible for wrongdoing if their actions directly caused or contributed to harm and that action was under their control. While there is room to stretch this idea and argue for a more expansive form of individual responsibility, at the end of the day, such a form of responsibility is inadequate to begin to think about how we should respond to structural injustice. That is, while a number of examples given above will have individuals who are more responsible than others, they also have structural causes, beyond the control of any one individual. Similar critiques have been advanced elsewhere, criticising this focus at the expense of broader structural factors, Hoover (2012, p. 234) argues:

...emerging understandings of responsibility in world politics have been too focused on the actions of individuals, leading to the neglect of structural causes of mass violence and more indirect lines of responsibility revealed by attending to the wider social context. Related to this limited focus on individual actors, academic accounts of moral agency have tended to downplay the political aspects of this focus on the individual's failure to uphold their obligations, which obscures the power inequalities and particular

interests that are served by focusing on individual actors over enabling conditions and social structures.

In an attempt to address these shortcomings, Young (2006) proposed the *social connection model of responsibility*. Most fundamentally and simply, this model suggests that those who contribute to the structures that create and sustain injustice have a responsibility to address them. This is because of the benefits they derive from these structural processes, that is, responsibility, “derives from belonging together with others in a system of interdependent processes of cooperation and competition through which we seek benefits and aim to realize projects” (Young, 2006, p. 119). There are several important distinctions between the social connection model and traditional theorising about responsibility. First, the social connection model doesn’t attempt to isolate responsibility for wrongdoing or guilt. Second, it foregrounds the background conditions that create and sustain injustice. Third, this approach is forward looking (to solutions) as opposed to backward looking (to blame). Fourth, as this model doesn’t seek to isolate wrongdoing, it follows that responsibility to address injustice is shared. Finally, and following all of these points, if we are to address structural injustice, our responsibility can only be discharged through collective action, that is, a concerted effort by everyone.

Importantly for us and in drawing some of the above points together, turning to structure yields two major advantages. First, it expands the scope of who or what might be responsible for injustice. That is, rather than identifying malicious individuals or problematic institutions or policy, we can instead look toward the background structures and processes which reproduce injustice. As noted above, while structural racism is pervasive, there are a range of other structures that shape and are shaped by racism. We also cannot begin to deal with these issues without critically examining the past, and confronting issues such as colonisation. Second, it also expands the possible agents who bear responsibility. Instead of looking toward individuals for example, as a structural problem multiple agents are almost always implicated, many of whom have contributed unknowingly or with good intentions. That is, those who go about their day to day life, who otherwise mean well also have responsibility, because in small and indirect ways, they too contribute to these injustices.

While much more could be said about who is responsible one further point is worth making before moving on. That is, not all of us are equally responsible, those with relative privilege, powerful collectives or those who have the power to change structures all arguably bear greater

responsibility for addressing structural racism. Further discussion is warranted on this point, which is unfortunately beyond the scope of this paper. Below we will deal with a question that naturally follows after identifying who is responsible, namely how we discharge our responsibilities, with a focus on the role of disruptive action in dismantling racism in health and healthcare.

Dismantling Racism in Health and Healthcare

There are a number of things that could be said about how we could address structural racism and there are a number of initiatives that already exist. We could start with ourselves, making an effort to educate ourselves, and take steps to call out racism behaviour and be aware of racist structures, norms and systems. Healthcare professionals could do this within and outside of their roles. More broadly, we could lobby for broader change, in wards, in hospitals or throughout the entire healthcare system; we could also lobby the government for change. Education of course has an important role to play here, as a means to divorce “institutions from the racial discrimination system” (Bailey et al., 2017; Bell, 2021). Many of these issues have not gone unrecognised. A number of authors have already challenged professional bodies and leadership organisations to do more (Geia, L. et. al., 2020). To complement this we could turn our attention to more focused health initiatives. Informed by a structural perspective above, any intervention if it is to be effective, would need to challenge multiple injustices; racism, residential segregation, economic inequality. While thinking about a place to start or deciding where our action could be particularly effective, we could look to challenge “leverage points within a sector that might have ripple effects in the system (e.g., reforming drug policy and reducing excessive incarceration)” (Bailey et al., 2017). It should go without saying that further research in this area is long overdue.

One form of action that is often overlooked in addressing structural racism (at least in the literature related to health and healthcare) is disruptive action. While different terminology has been used (e.g., non-violent resistance, civil resistance; see Essex, 2021), and while action has occurred in response to a range of issues, the idea of disruption and seeking change outside of established (and less contentious) institutional channels has been commonplace in health and healthcare. Resistance from the healthcare community in Apartheid South Africa has been well documented (Digby, 2013). More recently, in response to climate change, doctors have engaged in civil disobedience alongside extinction rebellion. A number were arrested as a result

(Stott, 2019). In Chile, amid violent riots “healthcare for the streets” provided on the spot medical assistance (Sherwood & Cambero, 2019). In Sudan, doctors have been instrumental in organising pro-democracy protests (Goldstein, 2019). It is not only healthcare professionals who have engaged in protest. Such action is not only isolated to healthcare professionals, social movements have long organised in response to a range of health issues, including access to care, improvements in sanitation, health inequality and how we approach disease and disability (Allsop, Jones, & Baggott, 2004; Berridge, 2007; Labonté, 2013). This has occurred for centuries, with some of the earliest dating back to occupational health during the industrial revolution (Brown et al., 2004). Many of the issues we discussed above have also been met with action that could be considered disruptive. In response to the hostile environment, a number of services exist to cover the gaps that now exist. Guidance has been produced for clinicians attempting to navigate these regulations (BMA, 2019b; Torjesen, 2019) and assertively advocate for patients who may be subject to these policies (#patientsnotpassports, n.d.). Efforts to lobby for change have been made, some taking their complaints directly to Westminster, protesting for reform (Kmietowicz, 2018). In response to COVID-19, in the UK, doctors have protested in relation to inadequate protections, including PPE and the lack of a strategy for its impact on the BAME community (Merrifield, 2020). Across the globe the death of George Floyd in the US has sparked protests against systemic racism, again a number of healthcare professionals have taken part (Miller & Landsverk, 2020).

Disruptive action provides a means to challenge power and pursue justice, often where few other opportunities exist. This of course is not to say that disruptive action alone is likely to lead to a just society, it has the potential however to be an important remedial form of action that moves us a step closer to realising broad collective action and structural change. Ferrell (2019) offer this defence for such action:

A painted-over swastika or a factory picket line may do little in the moment to overturn arrangements of power, but they may do much in the long run to organize and encourage those who continue to confront that power, and may inaugurate a process of imagining and living more progressive alternatives. The potency of even immediate acts of resistance also provokes a deeper set of questions regarding the better world for which resisters strive.

While we agree with Ferrell (2019) and see disruptive action (or resistance to use his term) as critically important in opposing power, if we are to take steps to truly challenge structural racism, we will need more than just you and me and anybody who may read this article to take action (Gould, 2018). We as individuals act under constraints, many (if not most of us if you are reading this) will continue to benefit in some ways from structures that disadvantage others. Practically, we can and should take steps to be aware of how we benefit from racist structures, how we re-enforce racist stereotypes or norms; we as individuals can only do so much and the structures in which we act are likely to remain. Looking more broadly, we could instead lobby for change in hospitals or healthcare systems and we may achieve a change in practice or policy; we may reach a number of staff who were ignorant to the issues. Such action however fails to challenge broader issues such as residential segregation and criminal justice reform. Even beyond this however, even with large scale initiatives, larger structural constraints will remain, within and across borders, weighted down by historical injustices. Furthermore, if we challenge one oppression others are likely to remain, for example while racism exists throughout every country, racism and oppression also exists between and within minority ethnic communities and across borders. We could also lobby the government, however the government too acts under constraints. As we have seen above many have acted to introduce policy to appease xenophobic and racist fears. While this all seems quite daunting and fairly pessimistic, it is not to say that change does not or cannot happen. If we are to dismantle racist structures, we need to think big.

Recognising that structural change often requires large scale collective action, Young felt that such action was far more likely to occur if we change how people understand their responsibilities in relation to justice, that is, raising awareness about how they contribute to structural injustice. One problem with this idea however is that structural problems are maintained by otherwise benign practices that are built into the unquestioned norms and practices of day to day life, making them hard to spot. What about those people above who contribute, not maliciously and unknowingly to structural racism? This is not to say that the majority of people are unaware that racism exists, they may however be ignorant of how they contribute to its maintenance, how it manifests in everyday norms and practices; they might be unaware of their contribution to the background conditions that allow racism to perpetuate. This is a fairly critical assumption, which has been overlooked. In attempting to address this problem Hayward (2017) draws on the concept of white “epistemic ignorance” developed by Mills (2007). Epistemic ignorance is fundamentally political and can involve both “not

knowing something that is true” or “believing something to be false that is true or something true that is false” (Hayward, 2017, p. 404). Such ignorance becomes a particular problem when it is attached to social dominance. Epistemic ignorance can be maintained in a number of ways, like structural injustice above, through social norms, assumptions, practices and beliefs. For those in dominant groups, this serves to allow them see themselves as ethical, “even as they enjoy systematic unearned advantage” (Hayward, 2017, p. 404). While we may be more likely to do the right thing for a number of reasons a necessary condition for action is that people first need to recognise, or have conscious awareness, that there is a problem. One way to challenge such ignorance is to present people with new information, to confront them, to disrupt this ignorance. To this effect Hayward (2017) identifies disruption as a means to this end. As well as challenging power, disruptive action could therefore serve as a means to challenge ignorance. Unlike non-disruptive forms of political action, its focus is not to persuade but to confront; to highlight oppression and demand change. In this sense, disruptive action is also about making the structures that perpetuate injustice unsustainable, politically, financially, socially. In Hayward’s (2017) words:

...when structural change is enacted, it is not only, and it is not principally, because privileged people are made to understand their responsibilities in ways that align with the ethical principles they endorse. Instead, in significant part, it is because those whom injustice harms engage in political disruption, one important product of which is the interruption of motivated ignorance.

This call for disruptive action however, raises a range of further questions, with the notion of justifiability also pressing. Again, like the above question on responsibility, there is significant scope for further discussion here on a range of questions, however, we will briefly offer some thoughts on the issue of justifiability. Disruptive action can carry risks for those undertaking such action. There is a significant literature here that explores the justification for specific forms of disruptive action such as whistleblowing, strikes and civil disobedience. It is again beyond the scope of this article to go into each of these in any detail, however in highlighting the diversity of disruptive action it is worth noting that a number of frameworks exist that help us begin to evaluate whether such action could be justified. Powers & Faden (2019) suggest that the moral significance of such action could be seen across five dimensions. First, the degree to which it coerces others to act. Second, the extent to which such action disrupts established social expectations and norms. Third, the potential for adverse effects and harm to others,

including a failure to address the injustice in question. Fourth, the degree to which it may damage democratic processes and public deliberation. Finally, the risks that such action poses to the breakdown of civil order and the rule of law. Quite obviously when we talk about disruptive action, we are talking about a spectrum of action. Disruptive action could involve anything from distributing pamphlets, vigils, strikes, non-cooperation, whistleblowing, boycotts and civil disobedience. Action could be undertaken in view of the public or secretively, those engaging in the action could be anonymous or identifiable. Action could be collective or individual, it could also be legal or illegal. Action could also be direct or indirect, that is, it could directly target the institutions, people or practices where change is being sought or have other indirect targets. Action could also be civil, polite and uncontroversial or it could be deliberately controversial, contentious or uncivil. Beyond the framework above, there remains a need to assess each itself and whether it is proportional to the harms which it is attempting to disrupt. Again, however this is a discussion for another time.

Conclusion

We have a great deal ahead of us if we are to dismantle structural racism in health and healthcare. Structural racism sits alongside, and shapes and is shaped by a range of other structural injustices. To understand the extent of these issues, we need to look both within and beyond the traditional domains of healthcare to broader, global issues and historical legacies, such as income inequality, colonialism and our treatment of migrants. We used the example of the Grenfell tower disaster to show how such issues are interconnected and not only serve to reinforce one another, but how structural racism could lead to disastrous consequences. If we are to address structural racism, large scale collective action is required. In moving toward this, disruptive action could serve a number of purposes, in challenging power, but also in playing a role in challenging existing ignorance toward such injustice. Beyond what we have discussed here there is substantial scope to expand on these discussions, namely around who is responsible, and the type of action that may be effective in dismantling structural racism. In short, if we accept that the world is unjust and that we have some responsibility in remedying these harms, there is fertile ground to discuss how we should go about it.

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