



Carlin's *Pastoral Aesthetics*: Bioethics, "Do We Want to Be Made Well?"

Terri Laws¹

Accepted: 3 August 2021 / Published online: 29 October 2021

© The Author(s), under exclusive licence to Springer Science+Business Media, LLC, part of Springer Nature 2021

Abstract

As proposed in his book (Carlin in *Pastoral aesthetics*, 2019), Nathan Carlin's methodology provides an opportunity to expand the subject matter of bioethical inquiry and to make the field more demographically and intellectually diverse, equitable, and inclusive. In other words, to offer bioethics a methodological healing not unlike the one offered by the Christ at the pool of Bethesda. However, the proposed benefits can be gained only with a long-term commitment and with great attention to detail, including understanding how content knowledge challenges the effectiveness of the call for *appreciation of the individual*, the balance between autonomy and justice, and who is considered pastoral as well as what is ultimately considered the activity of pastoral aesthetics. This essay combines scholarly and reflective commentary.

Keywords African American religion · Justice · Autonomy · Bioethics · Pastoral

Like the ill man in John 5 who lay at the pool at Bethesda for thirty-eight years, bioethics has arrived at the moment of reckoning in which those of us working in the field must answer the direction question: Does the field of bioethics *want* to be made well? Nathan Carlin proposes a treatment for one type of its ills: a methodology that reintegrates religious approaches to the field as they were present at its modern inception.

In this introduction, I offer commentary on Carlin's *Pastoral Aesthetics: A Theological Perspective on Principlist Bioethics* (2019), appreciating its value and offering critique from the perspective of my social location, including my training and work experiences. The core of my commentary is on the book's methodological contribution. In my critique, I look at three components of the method through a content lens: (1) the pastoral model, (2) the focus on the individual, and (3) the need to include a comparison between the principles of autonomy and justice beyond the individual aesthetics of each principle.

In *Pastoral Aesthetics*, Carlin achieves two important aims relative to bioethics and religion discourse.¹ First, he has contributed a methodology that will be usable in churches

¹ I am using these broad terms intentionally in this commentary.

✉ Terri Laws
terrlaws@umich.edu

¹ University of Michigan-Dearborn, 4901 Evergreen Road, Dearborn, MI 48128, USA

from the pulpit to the pew as well as by academic bioethicists. Second, in offering this methodology, Carlin has written an invitation to a broad conversation. In a field that has become increasingly aware of its severe problems with diversity, equity, and inclusion, I could not be more pleased to offer a few words for consideration in this *long*-needed discussion.

The book is well organized, with a common structure across its chapters. Carlin has dedicated a chapter to each of the four major principles from the “bible” of the field, if you will, now in its eighth edition, authored by Tom Beauchamp and James Childress (2019). This offers a good primer for readers new to the field. Importantly, Carlin does not attempt to dismiss the principlist framework, which is familiar from its decades of use. He notes that he is following Paul Tillich’s mid-twentieth century theo-intellectual innovation. In building upon this familiar territory, Carlin offers a thoughtful correlation framework that argues for a pastoral perspective of principlist bioethics. He writes that his “correlation of theology (i.e., influential images of pastoral care) and culture (i.e., core principles of bioethics), [is intended] to uncover new—and sometimes mundane—issues for moral consideration” (p. 26).

By taking a methodological approach, Carlin seeks to make the principles accessible to pastoral theologians. Similarly, he offers substantial background for the possibilities available from an *aesthetic imagination* (pp. 23–24) to bioethicists and healthcare providers, including what that may look like in engagement with the bioethical principles already familiar to them (p. 31). In general, the idea is that pastoral theologians often serve believers and nonbelievers alike by translating sacred scripture for a difficult situation. Thus, many of these leaders are addressing the spiritual needs of congregants engaged in the health care system during a decision-making moment. As Carlin notes, drawing on Richard Miller, in its standalone formulation, “[B]ioethics tends to be more philosophical than ethnographic” (p. 16). Carlin’s theological perspective is welcome in that it allows for affect within bioethical reasoning. The pastoral aesthetic, Carlin argues, can draw from the context to include more communities in the bioethical conversation. On its face, this method should work well. In this approach, Carlin offers a bridge between principlist practitioners and principlist skeptics.

In addition to his methodological contributions, Carlin’s primary interest in *Pastoral Aesthetics*, he reminds academic and practical theologians that they have had a place within bioethical discourse since its modern beginnings, which most scholars place in the post-World War II, human rights, and civil rights era (Fox & Swazey, 2008; Jonsen, 1998; Lysaught & Kotva, 2012). Jonsen (1998) provides an especially helpful account by identifying early bioethical thinkers with academic religious training. This is helpful at a moment when there appears to be a reemergence of religion in the field.

This brings up one of the promising features of Carlin’s offering. A method that is open to the mundane clears space for those of us intentionally writing from contextual spaces who have been hesitant to accept the bioethicist label because the topics that are central to the field, too often, are outside the quotidian bioethical issues of our communities of concern and accountability. For example, I have noted that Black and Brown communities connect their views on end-of-life decision-making policies to religious beliefs more often than White communities do (Laws, 2019). In Carlin’s acknowledgment of marginalized, oppressed communities through the use of art theory, there is even space in the public discourse for the religiously based views of these communities. He is to be complimented in that his work is a way to expand the topics as well as the demographics of the scholars.

Because this is a special issue, I pause here to congratulate Carlin on these accomplishments. Full disclosure: he was several years ahead of me in the same doctoral program, although still on site, when I entered. Later, we were both in the Texas Medical Center, albeit at different institutions—he as an early professional and I as a trainee in a bioethics fellowship. During the few collegial conversations we shared during that period, it seemed to me that we were on curiously parallel tracks, shaped in part, I surmise, by differences in our biographies. I came to the work not as a pastoral theologian but as a second-career graduate student who had worked in administrative managerial roles in an academic medical center for a dozen years before seminary. During my work experience, I became aware that a range of issues in healthcare ethics created conflict between members of the care team and families. I learned anecdotally. Sometimes my learning came through my problem-solver role when I faced grieving families. Other times, I learned as a friend and colleague of the patient advocate and one of the medical social workers, both of whom served for a time on the hospital's ethics committee. I learned by listening during the various committees on which I served. In an assignment managing a nascent community-based sub-corporation intended to meet the primary care needs of the urban and rural underserved, I learned about the similarities in their lack of resources. I took these profound experiences with me a few years later when I entered seminary.

In an exegesis class on the healing miracles of Jesus, I began to intellectually work out what I had seen in families' and communities' experiences. In the sacred text, where I saw instances of barriers to access to Jesus's healing powers, such as in the story of the Canaanite woman begging for help for her daughter, some seminary colleagues saw me reading too much into a text where only pastoral care was necessary. In seminary, we were taught to be reflective about the social location we bring to our reading of a text. The reader of *Pastoral Aesthetics* will notice that Carlin provides aspects of his theological location, especially in the epilogue. These early comments in this essay are intended to present the broad shape of my own social location as relevant to my scholarly reflection.

As every author knows, a publication invites commentary. A reviewing author can only hope that discussion of her efforts hews to the best intentions of the original writer. In this light, Carlin's offering is an ideal. I stop short of suggesting that the text is idealistic. Rather, I am suggesting—encouraging, even—that to strive for his ideal that the many should be *seen as complex individuals*, there is much work to be done, not just to be discussed. Nevertheless, to begin the work as a conversation, I propose consideration of three aspects of the content of Carlin's proposal: the pastoral model, the focus on the individual, and the relationship between the principles of autonomy and justice. Lest these be read as merely context specific, I offer a brief explanation regarding their implications for the practice of pastoral aesthetics and for the field of bioethics and religion.

The pastoral model

As I consider Carlin's well-done crosswalk, as is the case with any project that seeks to fill an intellectual and/or praxis gap, I see room for respectful critique and for advancement where there may be agreement. My comments forward are offered in this spirit. As I mentioned earlier, like any scholar, I write from my context, specifically, African American religious studies informing and critiquing bioethics. One of my tasks is to seek to explain

bioethical issues of particular interest and meaning for Black,² primarily African American, communities. One of the criticisms of bioethics from African American communities is its failure to address questions and issues that directly affect Black communities. Carlin writes that “the central claim of this book is that pastoral theologians can bring something distinctive to bioethics. Specifically, pastoral theologians can enrich moral imagination in bioethics by cultivating an aesthetic sensibility that is theologically informed, psychologically sophisticated, therapeutically oriented, and experientially-grounded.” (p. 13) This is welcome in that religion (including theology) is culturally specific.

I have tried to imagine prominent (and widely familiar) voices of Black Christianity using the method Carlin proposes. What aesthetic, for example, might the pastoral (and prophetic) theologian Martin Luther King Jr. of the “Letter from Birmingham City Jail” moment have raised in an application of Carlin’s proposed method? I realize that some will likely argue that King was acting as a public rather than a pastoral theologian and that I am using an example outside bioethics, but I still choose King for the purpose of illustration.

In 1963, King went to Birmingham, Alabama, at the contested invitation of local Black pastors of an affiliate organization of the Southern Christian Leadership Conference that King led. The pastors were seeking to attain civil rights in public places such as the right to not be met by the “humiliating racial signs” (King, 1986, p. 290) in downtown department stores that local merchants had promised to remove (King, 1986, p. 290), the end of “discourtesies” from bus drivers (Patton, 2004, p. 55), and larger issues such as voting rights (Patton, 2004) using nonviolent direct-action tactics. I use this episode as an example to broaden the picture of what qualifies as pastoral or theological activity. These daily demeaning episodes, which today are often termed “microaggressions,” cut to the core of an individual’s personhood, including their psychological wellness (Franklin et al., 2006). So, King’s letter to white moderate pastors was another public episode in the century-long post-Emancipation ordeal rooted in the racial category into which Black citizens were slotted and the daily discrimination they suffered.

Students of Lincoln and Mamiya (1990) *The Black Church in the African American Experience* will be familiar with the unresolved dialectical tensions that Black churches balance in service to congregants and their communities.³ The first of the unranked dialectics is relevant here. The Black Church and its pastoral leadership operate along this tense dialectic, sliding between priestly activities “concerned with worship and maintaining the spiritual life of members” and the “prophetic functions [that] refer to involvement in political concerns and activities in the wider community; classically... pronouncing a radical word of God’s judgment” (Lincoln & Mamiya, 1990, p. 12). I emphasize that King described this daily public treatment of African Americans as *humiliating*. It suggests that his and the other pastors’ public response in Birmingham was pastoral theological activity as well as civil rights political activity. They were *publicly* disclosing pastoral counsel by standing with congregants in the face of psychologically damaging experiences of various kinds. The white pastors’ second letter, to which King was responding, urged Black protestors to be patient and measured and to wait for “gradual” change (Patton, 2004, p. 55). By

² In this sense, Black refers to persons of African descent who may live in any part of the globe. African American refers to Black persons whose ancestral heritage is linked to the history of enslavement in British North America and the land that became the United States.

³ Lincoln and Mamiya define the phrase “the Black Church” as a “sociological and theological shorthand reference to the pluralism of black Christian churches in the United States” (1990, p. 1). There are seven major historic, independent, Black-controlled denominations (Lincoln & Mamiya, 1990, p. 1).

that point, the Birmingham and statewide Alabama struggle had already been years in the making. Efforts had included the year-long Montgomery bus boycott that began in 1955 and had propelled Rosa Parks and Reverend King to prominence (King Institute, n.d.).

I should reiterate here that Carlin expressly envisions contextual issues in the development of his proposed methodology. He writes, “[W]hether focusing on the experiences of individuals... or communities[,]... taking human experience seriously means that we know God, in part, by listening to others. That is to say, knowing God is accomplished not only by prayerfully studying canonical sacred texts but also by judiciously attending to living human documents” (p. 45). Recalling this civil rights history serves two purposes. First, it helps us acknowledge that too often the sorts of routine demeaning episodes King referenced are thought to be long done, that is, *only* historical. Second, sometimes we scholars and practitioners in bioethics and pastoral *theology think we* are listening when we consider the living human document when we become aware of it through the lens of one person’s experience. By raising the matter here, I seek to remind us that to present an effective pastoral aesthetic that will work in bioethics, we must see these contextual experiences from both the individual and the collective perspectives—the individual within their social context *and* their commensurate psychological and sociological references. Incidentally, this is also how we will broaden the range of topics and how bioethicists of color can be welcomed to the conversations in the field on our own terms and can gain allies in the topics relevant to our communities of accountability and concern. These communities often are patients and the underresourced community sites that serve them. Our concerns could also be issues such as private practice policies that encourage patients to be on time for appointments by charging a fee without considering that poor public transportation options that do not run as scheduled may inadvertently cause a mother to cancel an appointment once it becomes evident that she will not be on time. Without doubt, access to quality care for the individual and as a public health issue has health implications and as such should also be fodder for bioethical discourse, but what qualifies as barriers to access are not always as obvious. Again, note this opportunity to improve upon Carlin’s proposal as well as to heal bioethics through the expansion of its topics and communities.

Focus on the individual

In his method intended to include more psychology in bioethics, Carlin clarifies that in terms of technique, he is not asking providers to learn psychoanalysis; rather, he urges them to develop a “curiosity” (p. 57) about their patients. He proposes a technique grounded in art theory to advance this patient-centered curiosity that will bridge bioethics principles with pastoral theology. A basic theory is to analyze a work of art by examining what the artist has done to draw attention to the center (centric) of a piece. The artist also will have created a relationship with what is outside the center (eccentric). In Carlin’s proposal, the bioethics principles are centric and pastoral theology points to the eccentric. In the technique, Carlin’s aim is “to demonstrate that pastoral theology can draw attention to a variety of margins” (p. 31). As Carlin notes, he is not the first theologian to use these methods to achieve a similar goal of diversity. One theologian he does not reference in the book is Anthony Pinn, who used related methods in theorizing the nature of Black religion (2003). Pinn and Carlin both employ art criticism in their attempts to reach the center of their subject matter, which Pinn termed the “core” (Pinn, 2003, pp. 180–200). Both are striving to reach newness in space or in being and the opportunity to achieve complexity. They both

also see the opportunity in a force that is the result of this notion of the center. Importantly, Pinn notes that it is a sort of conversion experience that frees African Americans to drive toward the impulse to seek their complexity, free from the gaze that constrains them to sociological “dehumanization” (p. 181). In other words, being gazed upon too often simplifies.

Both Carlin and Pinn end similarly, with the individual. Pinn (2003) stresses that this is not a rugged individualism but a “fruitful agency... made real because the feeling or aching for more humanity is no longer superseded by the terror of dehumanization” (p. 181). In using art criticism, Pinn writes, the process is relevant in “content and form, [and it brings relevance to] identity and aesthetics” (p. 194). In Pinn’s understanding, the hermeneutical process—which emerges from one’s context—raises consciousness yet retains a social aspect (pp. 193–94). Pinn further notes that his theory of the process of striving for one’s complexity, though developed within the context of Black religion, can be applicable to individuals outside this context. As a matter of spirituality and as a matter of healthcare decision making, Carlin’s version of moving toward complexity is reasonable enough. But Pinn’s construct hews to the experience of the marginalized as both individuals and group members, and this dual interaction needs to be understood to develop the complexity that Carlin wants us to achieve in bioethics.

Considering Carlin’s proposed method in the African American context, the focus on the individual is limiting. In bioethics, the fact that health disparity and inequity exist as a field of inquiry inherently requires a group-to-group comparative analysis. Health disparity is a differential experience and/or outcome resulting from the same disease process; health equity aims to reduce or eliminate health disparity and its causes and effects (Braveman, 2014). The causes of health disparity and inequity are many. However, whatever the causes of the different experiences of groups, the differences suggest that individuals in certain groups experience the benefits of U.S. healthcare disproportionately as a result of being in a particular group in addition to or before they are individuals. In other words, individuals come with a narrative(s) about their group that may conceal their individual circumstances.

Health literature is replete with research that examines the differential experience of Black patients (as well as other people of color and persons of low wealth and low income). This research makes clergy, scholars, and the public aware of issues such as the experiences and implications of differential diagnoses, misdiagnoses, and/or undertreatment that spring from the long history of race-based presumptions, narratives, and stereotypes. A recent study that gained widespread general press coverage offers a clear example regarding the belief that Blacks have a greater threshold for pain (Hoffman et al., 2016). The study found that persons with no medical training as well as medical students falsely believed there was a race-based biological difference in pain tolerance. This belief is doubly pernicious within the context of meta-analytical research that demonstrates that Blacks’/African Americans’ pain often goes undertreated (Meghani et al., 2012). Relatedly, in another example of not being heard or believed, illness and death during pregnancy, during labor, and after delivery are disproportionately high among Black women compared to their white counterparts. The experience of tennis champion Serena Williams after the birth of her daughter in 2017 (Salam, 2018) provides an illustration. The day after her daughter was born, her care team lost precious time looking for other causes even as Williams told them they needed to check her for a pulmonary embolism, a condition she had previously experienced. After ruling out other possibilities, they eventually acceded to her request and found that multiple blood clots in her lungs were causing her breathing difficulties (Salam, 2018).

Americans are increasingly aware of the sociocultural rite known as “the talk” that parents of Black children must have with their children. Psychologist Boyd-Franklin (2003)

calls attention to versions of this developmental task in which the parents of Black children must instruct their offspring on the realities of the racism they will inevitably face when they are viewed as representative of narratives of blackness—a thug, a thief, a threat—often by a societal authority figure or even by a random white adult (Boyd-Franklin, 2003). “The talk” seeks to prepare children to aim to survive the episode with the greatest level of physical, legal, and/or psychical safety possible. Boyd-Franklin grounds her text in therapy with families. She describes versions of “the talk” as part of racial identity development, a lifelong dynamic (Boyd-Franklin, 2003).

To use Carlin’s proposed method in religion and bioethics to learn to be curious about one’s patients is to deeply empathize with the inseparability of people from their social context in addition to the responses from the individual he proposes will benefit from being read as a living human document. Understanding the world of patients, especially those who are in an identifiable out-group, is to acknowledge that African American patients, for example, may have experiences that cause them to wonder whether they were denied pain medication because the doctor believes that, as African Americans, they were drug seeking rather than seeking relief for a clinical condition. Naturally, we patients prefer to focus only on the compassion that we want to believe drove healthcare professionals to enter their fields of expertise. However, history and cumulative life experience may dictate deferral to an undesired wisdom.

Those of us in religion and bioethics research too often have failed to address these occurrences as matters of medical racism. Instead, some find it more palatable to discuss these issues in terms of systems as though humans are not making decisions within the systems. It is commendable that the Institute of Medicine of the National Academies (2002) commissioned and published *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*. The authors discuss how disparities develop in systems and institutions but largely decline to discuss in detail the ways that individual care providers, as moral agents, contribute to discriminatory practices. More recent research has begun to acknowledge implicit bias (Hall et al., 2015). However, as I was putting the finishing touches on this essay, an editor of one of the world’s leading academic medical publications, the *Journal of the American Medical Association (JAMA)*, caused a Twitter stir when he tweeted, and later deleted, “No physician is racist, so how can there be structural racism in healthcare?” (Crist & Kalter, 2021).

For patients affected by these attitudes, the sociological conceals the psychological, so the pastoral aesthetic of working toward the curiosity of persons in those groups (I have used examples from African Americans’ experiences) should also include developing the willingness to expand the activities deemed to be squarely within the scope of academic bioethics proper. Carlin’s work provides a methodology for a pastoral aesthetic and Pinn’s model provides for a conversion of the self, but an effective convergence of psychology of religion and bioethics will address the sort of content that perpetuates limits to autonomy and an unjust healthcare system.

Autonomy and justice

The relationship between autonomy and justice is the last area of my comments on the methodology that Carlin has constructed to correlate a pastoral perspective with bioethics. Here, too, there is an emphasis on underrepresented communities. I agree with Carlin (2019) in his critique of the misuse of the autonomy principle in bioethics. In fact, it is

widely agreed that autonomy is treated as though it is first among the principles. Carlin offers this view: “For Beauchamp and Childress, respect for autonomy is about choice. Applying this principle in clinical, research, and public health settings often entails thinking through situations where it may not be obvious who should decide” (p. 55). Carlin continues, “As a centric force in bioethics, principlist applications of respect for autonomy tend to focus on... issues such as informed consent, truth-telling, privacy and confidentiality, and capacity and competency issues” (p. 55). As a pastoral expansion, Carlin proposes to “*shift the focus away from a respect of choice to an appreciation of individuals*” (p. 55). Through the vignette that Carlin offers to illustrate the value of psychoanalytic interpretation, the reader gains a full view of how this can boost the mental health of the subject. In the section above on focus on the individual, I alluded to the idea that before choice autonomy for an individual can be realized, some patients experience being seen through the lens of a group narrative or through a presumption of who they are. In any healthcare encounter, a patient chooses to provide as much helpful information as possible to a provider to gain quality treatment; this is the point of the model of appreciative autonomy that Carlin seeks to revise through the pastoral aesthetic. The ease of the shift from choice autonomy to appreciative autonomy presumes that choices are presented to patients with equality. This becomes a chicken-and-egg problem. An anecdote is helpful here.

During my bioethics fellowship, I had the opportunity to shadow physicians at various levels of training as they engaged patients in diverse clinical settings within cancer care. During an observation day at a healthcare site for indigent people, I shadowed a physician who met with a 51-year-old Black male patient with a cancer of his digestive tract. The doctor talked with the patient and then with her preceptor. She laid out a treatment recommendation with the preceptor that included the prescription of an expensive medication. She determined that the patient’s “unstable social situation” (he had a record of sometimes unexplained missed appointments) would make his maintenance on such a drug difficult to manage, so the limited resource—the expensive medication—should be given to someone who would be able to take the drug as prescribed on a regular schedule. The preceptor accepted her recommendation without questions. She informed the patient and his spouse that moving forward the clinic staff would help to make him comfortable. (Discussion about the various methods through which we ration healthcare in this country is common fodder in bioethics.) Was this patient being appreciated while he was being presented with this limited choice? Will an autonomy grounded in an appreciation for individuals lead to equitable choice?

Conclusion

In the year after the publication of *Pastoral Aesthetics*, the United States faced a once-in-a-century pandemic and what some have termed a(nother) racial reckoning. The combination presents a test case for Carlin’s methodology and how the nature of the content can challenge its effectiveness. The 2020 racial awareness moment began with the 2013 social media emergence of #Blacklivesmatter through the Twitter platform (Freelon et al., 2016) and was fueled by killings of unarmed Black teens who had been deemed threatening. But it was the cavalier mundaneness of the murder of the prone and handcuffed 46-year-old George Floyd that drove diverse groups of Americans to protest in the streets during a deadly pandemic. An officer of the law knelt on Floyd’s neck for 9 min and 29 s until the life was snuffed out of him, and we watched the cell-phone video that was replayed

countless times on media across the globe. As the pandemic continued to rage, Black and Brown Americans were hospitalized and died of complications from COVID-19 at rates two to three times that of white Americans. Even so, the tweet quoted above by the *JAMA* physician-editor responsible for clinical study reviews and education was from a sixteen-minute podcast during which he described himself as a structural racism skeptic (*JAMA Network Learning*, 2021). Before that, Southern Baptist seminary presidents had reaffirmed the essence of a 2019 resolution that dismissed critical race theory, intersectionality, and other scholarship used to interconnect systemic discriminatory practices even as they condemned racism (Schroeder, 2020; Shimron, 2020).

This is the context into which we are being called. Using Carlin's method will not be for the faint of heart. It is not to be entered into lightly. Without a long-term, prospective commitment, the method will cause more harm than good and will raise awareness but not lead to action, but that would not be the fault of the method offered. It would be because the person(s) engaging in the proposed pastoral aesthetics did not realize how much was at stake and squandered another opportunity to simultaneously create equitable healthcare and move the nation forward in deepening our understanding of each other as humans.

Funding The author has no relevant financial or non-financial interests to disclose.

Declarations

Ethics Approval Where I have cited any of my prior published work, I have included it in the reference list and have excluded any in-text pronoun references that point to my identity before review.

Consent to Participate Does not apply.

Consent for Publication Not applicable.

Disclaimer The author certifies that there are no affiliations with or involvement in any organization or entity with any financial interest or non-financial interest in the subject matter or materials discussed in this manuscript. The author has no financial or proprietary interests in any material discussed in this article.

Conflict of Interest The author has no conflicts of interest to declare that are relevant to the content of this article.

References

- Beauchamp, T. L. & Childress, J. F. (2019) *Principles of biomedical ethics* (8th ed.). Oxford University Press.
- Boyd-Franklin, N. (2003). *Black families in therapy: Understanding the African American experience* (2nd ed.). Guilford.
- Braveman, P. (2014). *Public Health Reports*, 129(Suppl 2), 5–8. <https://doi.org/10.1177/00333549141291S203>
- Carlin, N. (2019). *Pastoral aesthetics: A theological perspective on principlist bioethics*. Oxford University Press.
- Crist, C., & Kalter, L. (2021). *JAMA podcast on racism in medicine faces backlash*. WebMD. <https://www.webmd.com/sex-relationships/news/20210304/jama-podcast-on-racism-in-medicine-faces-backlash>
- Fox, R. C., & Swazey, J. P. (2008). *Observing bioethics*. Oxford University Press.
- Franklin, A. J., Boyd-Franklin, N., & Kelly, S. (2006). Racism and invisibility: Race-related stress, emotional abuse and psychological trauma for people of color. *Journal of Emotional Abuse*, 6(2–3), 9–30.

- Freelon, D., McIlwain, C. D., & Clark, M. D. (2016). *Beyond the hashtags: #Ferguson, #Blacklivesmatter, and the online struggle for offline justice*. Center for Media & Social Impact. http://archive.cmsimpact.org/sites/default/files/beyond_the_hashtags_2016.pdf
- Hall, W. J., Chapman, M. V., Lee, K. M., Merino, Y. M., Thomas, T. W., Payne, B. K., Eng, E., Day, S. H., & Coyne-Beasley, T. (2015). Implicit racial/ethnic bias among health care professionals and its influence on health care outcomes: A systematic review. *American Journal of Public Health, 105*(12), e60–e76. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4638275/pdf/AJPH.2015.302903.pdf>
- Hoffman, K. M., Trawalter, S., Axt, J. R., & Oliver, M. N. (2016). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proceedings of the National Academy of Sciences of the United States of America, 113*(16), 4296–4301. <https://doi.org/10.1073/pnas.1516047113>
- Institute of Medicine of the National Academies. (2002). *Unequal treatment: Confronting racial and ethnic disparities in healthcare*. National Academies Press.
- JAMA Network Learning. (2021). Structural racism for doctors: What is it? https://edhub.ama-assn.org/jn-learning/audio-player/18587774?utm_source=twitter&utm_medium=social_jama&utm_term=4514464209&utm_campaign=article_alert&linkId=111964313
- Jonsen, A. R. (1998). *The birth of bioethics*. Oxford University Press.
- King Institute. (n.d.). Alabama Christian Movement for Human Rights. <https://kinginstitute.stanford.edu/encyclopedia/alabama-christian-movement-human-rights-acmhr>
- King, M. L. Jr. (1986). Letter from Birmingham City Jail. In J. M. Washington (Ed.), *A testament of hope: The essential writings and speeches of Martin Luther King, Jr.* (pp. 289–302). HarperCollins.
- Laws, T. (2019). How race matters in the physician-assisted suicide debate. *Religion and Politics*. <https://religionandpolitics.org/2019/09/03/how-race-matters-in-the-physician-assisted-suicide-debate/>
- Lincoln, C. E., & Mamiya, L. H. (1990). *The Black Church in the African American experience*. Duke University Press.
- Lysaught, M. T., & Kotva, J. J. (Eds.). (2012). *On moral medicine: Theological perspectives in medical ethics* (3rd ed.). Eerdmans.
- Meghani, S. H., Byun, E., & Gallagher, R. M. (2012). Time to take stock: A meta-analysis and systematic review of analgesic treatment disparities for pain in the United States. *Pain Medicine, 13*, 150–174.
- Patton, J. H. (2004). A transforming response: Martin Luther King's "Letter from Birmingham Jail." *Rhetoric & Public Affairs, 7*(1), 53–66.
- Pinn, A. B. (2003). *Terror and triumph: The nature of black religion*. Fortress Press.
- Salam, M. (2018). *For Serena Williams, childbirth was a harrowing ordeal. She's not alone*. New York Times. <https://www.nytimes.com/2018/01/11/sports/tennis/serena-williams-baby-vogue.html>
- Schroeder, G. (2020). *Seminary presidents reaffirm BFM, declare CRT incompatible*. Baptist Press. <https://www.baptistpress.com/resource-library/news/seminary-presidents-reaffirm-bfm-declare-crt-incompatible/>
- Shimron, Y. (2020). *Southern Baptist seminary presidents nix critical race theory*. Religion News Service. <https://religionnews.com/2020/12/01/southern-baptist-seminary-presidents-nix-critical-race-theory/>

Publisher's Note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.