

# Public Health and Precarity

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**Abstract:** One branch of bioethics assumes that mainly agents of the state are responsible for public health. Following Susan Sherwin's relational ethics, we suggest moving away from a "state-centered" approach toward a more thoroughly relational approach. Indeed, certain agents must be reconstituted in and through shifting relations with others, complicating discussions of responsibility for public health. Drawing on two case studies—the health politics and activism of the Black Panther Party and the work of the Common Ground Collective in post-Katrina New Orleans—we argue for the need to attend more carefully to the limitations of states and state-driven public health programs.

**Keywords:** feminist ethics, public health, racism, relational theory, social justice

## 1. Introduction

Who should be responsible for protecting and promoting public health? Philosophers have recently debated the questions of whether state agents and agencies ought to bear sole responsibility or whether we might sometimes need to look beyond the state to focus on community groups, families, and other agents as necessary. Subtle differences aside, we find in these conversations a common focus on the centrality of the state in safeguarding public health. We might think of this broad tendency as embodying a "state-centered" approach to public health: agents and agencies of the state are regarded as the instigators of decisions about what should be the priorities of research and practice, as well as the central conductors of public health research, the initiators of public health campaigns, and the enactors of public health policy.

Susan Sherwin's relational approach to public health ethics cautions us against overly simplistic answers to questions of responsibility, including those that would have us rely solely or primarily on the state, as well as those that point beyond the state to other actors. Sherwin reminds us that every agent's opportunities for acting are shaped and constrained by the actions of agents and agencies of many different types, including those operating at different levels of human

organization. For this reason, she emphasizes the need to conceive of the responsibilities of individuals, organizations, and institutions *in relation to one another*. Building upon Sherwin's work, in this paper, we introduce additional considerations in favor of moving away from a state-centered approach to public health and toward a thoroughly relational approach. Instead of asking the question "Who should be responsible for safeguarding public health?" which suggests that agents could be singled out as responsible apart from their relations with many other agents, we recommend starting with the questions of who is actually involved, whose relationships would need to shift in what ways, and who would need to do what and for whom in order to accomplish specific health-related goals. Drawing on two case studies—the first featuring the health politics and activism of the Black Panther Party, the second focusing on the work of the Common Ground Collective in post-Katrina New Orleans—we argue for the need to attend more carefully to the role of the state in creating and maintaining public health crises, to the inherent limitations of state-driven public health programs, and to an array of factors that contribute to reproducing those limitations over time. While Sherwin's work emphasizes what state agents and agencies are unable to do without the cooperative and enabling actions of others, our case studies focus on what the state—at least as currently constituted—simply cannot do, and on the role of state-based and philanthropic organizations in distributing life chances unevenly across populations. To Sherwin's efforts to reconceptualize responsibility relationally, we add that certain agents may be called upon to undergo changes in and through shifting relations with others, not only because they could be contributing more or differently, but also because they would need to be constituted otherwise to cease neglecting or actively compromising the health of specific populations.

Our case studies focus on communities living in states of heightened vulnerability to violence, harm, and suffering produced by current social and economic conditions. Members of such communities are also forced to cope with a reduced likelihood of receiving adequate attention, conferrals of credibility, or ameliorative responses from others when publicly expressing their needs. To exist under such conditions is to live in a state of *precarity*. To understand the meaning of "precarity" in the context of public health, we draw on the work of Judith Butler (2009), who distinguishes "precariousness" and "precarity" as follows:

Lives are by definition *precarious*: they can be expunged at will or by accident; their persistence is in no sense guaranteed . . . . *Precairity* designates that politically induced condition in which certain populations suffer from failing social and economic networks of support and become differentially exposed to injury, violence, and death. Such populations are at heightened risk of disease, poverty, starvation, displacement, and of exposure to violence without protection. (25–26, emphasis added)

We believe precarity is the most pertinent notion to describe the contexts in light of which we might better grapple with questions of responsibility for public health. Precarity encompasses "vulnerability," which is also closely bound up

with the universal condition of precariousness. Unlike vulnerability and precarity, though, precarity focuses our attention on “non-ideal conditions,” reminding us that actual economic, social, and political institutions are far from just and reining in overly rosy assumptions about the capabilities and motives of governmental and nongovernmental actors alike. Since it is a politically induced condition, precarity also reminds us of the ways that populations are not only vulnerable simply in virtue of being alive, but are also *made vulnerable* by the environments in which they live and by how those environments are shaped by the decisions and actions of agents of various types, typically in ways that serve the interests of dominant groups.

## 2. Who should be responsible for public health?

In the mainstream bioethics literature, who is typically assumed to be responsible for protecting and promoting public health? Foundational texts suggest a variety of possible agents as being chiefly responsible. These agents are positioned as responsible for various dimensions of public health, from defining what constitutes “health” and what belongs within the purview of “public health” provision, to making decisions and setting priorities among public health initiatives, funding and conducting public health research, initiating public health campaigns, directly providing health services, and evaluating the success of public health initiatives. In their 1988 report, the Institute of Medicine’s Committee for the Study of the Future of Public Health in Washington, D.C., noted the primacy of *the state* in public health efforts: “The mission of public health is addressed by private organizations and individuals as well as by public agencies. But the governmental public health agency has a unique function: to see to it that vital elements are in place and that the mission is adequately addressed” (19).

Bioethicists have articulated a variety of approaches to understanding the state’s role as the primary agent responsible for protecting and promoting public health. In “Rethinking the Meaning of Public Health,” Mark Rothstein (2002) establishes his own perspective on the types of agents that ought to be chiefly responsible for public health. He resists any approach that mixes state and private sector agents, due in part to his concern that this will result in lack of coordination and accountability and a lack of capacity for employing coercive measures when necessary (146). Rothstein calls his narrower approach to understanding the responsibilities and agents of public health a “government intervention as public health” conception. On this conception,

public officials [take] appropriate measures pursuant to specific legal authority, after balancing private rights and public interests, to protect the health of the public. These measures may be coercive. The existence of a public threat demands a public response, and in a representative political system it is the government that is authorized to act on behalf of the public. (146)

What gives the state this authority is its “police power,” which is the power to enact such laws as will protect public health and promote public safety (146;

quoting *Jacobson v. Massachusetts* 197 U.S. 11, 25, 26 [1905]). Rothstein argues that government entities are entitled to mandate public health actions when at least one of the following conditions obtains: (1) a population's health is threatened (e.g., by infectious disease); (2) the government has unique powers and expertise related to a health issue (e.g., disease surveillance and reporting); and/or (3) the government is more efficient or likely to produce an effective intervention (e.g., newborn screening programs). While Rothstein sometimes seems to leave open the possibility of other agents being involved in the design and implementation of various kinds of health campaigns (e.g., population health and broader social programs to address homelessness), he insists that public health is the proper occupation of states alone.

Dan [Beauchamp \(1976\)](#) argues for the need for a “social justice” approach to public health, where health protections must be ensured by state agents and agencies, rather than left up to market mechanisms and individual health consumers’ choices. Although Beauchamp’s view is less pointed than Rothstein’s, he agrees that it ought to be the role of the state to ensure that citizens have access to health services, as well as protections from dangerous products (e.g., substances), practices (e.g., inadequate preventive care), and conditions (e.g., workplaces). As he writes, “the control of hazards cannot be achieved through voluntary mechanisms but must be undertaken by governmental or non-governmental agencies through planned, organized and collective action that is obligatory or non-voluntary in nature” (107).

In the Institute of Medicine Report, Rothstein’s “government intervention as public health” approach, and Beauchamp’s “social justice” approach we see a common focus on the centrality of the state in protecting and promoting public health. We might think of all three as representing a “state-centered” approach to public health—agents and agencies of the state are cast as the main instigators of decisions about what should be the priorities of research and practice, as well as the central conductors of public health research, the initiators of public health campaigns, and the enactors of public health policy.

The state-centered approach has been challenged on several fronts. For example, Angus [Dawson and Marcel Verweij \(2015\)](#) argue for an expanded understanding of which agents and agencies should be responsible for safeguarding public health, pointing beyond government entities. They claim that “the state in the form of national or local government, is only one possible . . . collective actor, where activity occurs on ‘behalf’ of the population” (1). Elsewhere, [Verweij and Dawson \(2007\)](#) write, “To improve average health, to reduce health inequalities, or to improve those conditions that are relevant for the health of anyone, will normally require joint and coordinated action by many people and institutions. Governments will often play an important role in facilitating or coordinating these efforts, although this might not always be necessary” (26). [Dawson and Verweij \(2015\)](#) offer examples of public health interventions that require the participation of individual citizens (e.g., vaccination programs), that require actions on the part of individuals to care for their own health

(e.g., cancer screenings), and that require *joint* participation to improve overall health conditions (e.g., collective efforts to reduce smoking can help ensure fewer people start smoking) (26). On their view, public health is and ought to be promoted by means of various local activities (e.g., campaigning for healthier food in schools or promoting cycling), some of which do not depend on the supervision or support of state agents. Certain activities may be supported by government agencies, but require social change carried out by a multitude of agents at the local level. As Dawson and Verweij (2015) point out, “Many forms of health-promoting activities require a change of social norms—the case of smoking is an excellent example—a process that can partly be facilitated by but cannot really be implemented by government action” (1).

Feminists have also issued a number of challenges to the state-centered approach. For example, Wendy Rogers (2006) argues that, although government entities have important roles to play in the funding and organization of public health, they should not be the only leaders, since they cannot fully meet the needs of communities and are not capable of some of the political self-criticism required (353). Madison Powers and Ruth Faden (2006) offer an extensive analysis of questions of social justice in relation to public health, and they, too, push back on the notion that states ought to be the sole or primary agents of public health. As they write,

Ours is an account of justice that denies that there are separate spheres of justice, within health policy or within social policy more generally . . . . We reject simple formulaic claims, such as . . . the claim that no justifiable health care system can make substantial use of the market as a means of allocating health care . . . . Our interest lies in the design of basic social institutions, including but not limited to government and the market, and the impact of those institutions on these socially situated groups. (xi)

Rosemarie Tong (2009) considers the specific needs of the elderly in public health planning, emphasizing the importance of governments, communities, and families working together to meet the long-term healthcare needs of elderly individuals. And echoing these remarks, Ryan Melnychuk and Nuala Kenny (2006) make a convincing case for the value of solidarity in developing public health policy, noting that “we are all in this together, and protecting the public and hence ourselves will require society-wide collaborations” (1393).

Instead of a state-centered approach, each of the above-mentioned authors advocates for what might be called a “mixed” approach to public health. While the state would still play a variety of important roles (e.g., governments would provide the legislative framework for public health, distribute resources to non-governmental health service providers, and facilitate and coordinate public health campaigns carried out by schools, communities, and families), a mixed approach recognizes that involving government entities in specific programs may not always be necessary, let alone helpful or desirable. A state-centered approach may seem most compelling when we are faced with problems that seem completely

insoluble absent the coercive powers of government. However, a mixed approach shows sensitivity to a broader range of public health issues, many of which can be and are routinely addressed through the voluntary participation of organizations, groups, and individuals, in some cases without enabling legislation, funding, centralized coordination, or other government support. Whereas a state-centered approach offers a simple, singular answer to the question “Who should be responsible for safeguarding public health?” a mixed approach offers something more like a pie chart: taking agents of many different types as they are, each owns a determinate share of the responsibilities for accomplishing a given health-related goal, leaving open the possibility that governments might end up shouldering burdens of various sizes—and on occasion, none at all.

In her most recent work, Susan Sherwin (Sherwin and Stockdale 2017) argues for a *relational* (rather than a state-centered or mixed) approach to public health ethics. A relational approach is distinguished by its scope, orientation, and core values. Unlike approaches that focus narrowly on pandemic planning, for example, a relational approach embraces “the full spectrum of public health responsibilities from poverty, to sanitation, to pollution, to infectious disease, to epidemics and pandemic threats, to global warming, to bioterrorism” (Baylis et al. 2008, 196). We agree with and are adopting Sherwin’s expansive understanding of “public health responsibilities” for the purposes of this paper. Thus, in posing the question “Who should be responsible for public health?” we mean to hold in view the full range of public health problems enumerated here. Moreover, we are concerned not only with the subset of tasks associated with carrying out select interventions, but with all of the tasks associated with Sherwin’s more expansive understanding of public health (including, for example, legislation, decision-making and prioritization, research, and so forth).

Sherwin argues that a relational approach is needed because public health ethics should be grounded in the nature and scope of public health and should begin from “a recognition of the values at the core of public health, not a modification of values used to guide other kinds of health care interactions” (Baylis et al. 2008, 199). Since the main concern of public health extends beyond the well-being of individuals to that of communities and populations, and since the scope of public health extends to what society does collectively to assure the conditions for people to be healthy, Sherwin joins the Public Health Agency of Canada in calling for “a social starting point for public health ethics that recognizes community as foundational” (Kenny et al. 2010, 9). Unlike individualistic approaches that focus on perceived tensions between the goods of individuals and of communities, or between individual liberty and communal security, a relational approach strives to clarify “the complex ways in which individuals are inseparable from communities and build on the fact that the interests of both are interrelated” (Baylis et al. 2008, 200).

While most approaches associated with autonomy-driven mainstream bioethics adopt a highly individualistic, rights-based orientation imported from

research and clinical ethics, a relational approach to public health ethics works from an orientation that is thoroughly relational in character (Baylis et al. 2008, 196). For those adopting such an orientation, relational theory becomes a “shaping sensibility” through which core ethical concepts can be fruitfully reinterpreted (Sherwin and Stockdale 2017, 14; Doan and Sherwin 2016, 84). The three core values undergirding Sherwin’s proposed approach are *relational autonomy*, *relational social justice*, and *relational solidarity*. The “relational” qualifiers signal that each value is to be understood as a conception of persons as relational, which emphasizes that all persons are, to a significant extent, socially constructed, though not as equals. Sherwin claims that public health ethics requires a relational conception of persons because this type of ethic “deals with the health needs of communities and populations through actions that are taken at a social or political level” and needs to operate with an understanding of persons that “recognizes and responds to their fundamental social and politically and economically situated nature” (Baylis et al. 2008, 201). Since the work of public health demands a unit of analysis importantly different from the sharply bounded, atomistic conception of persons familiar from traditional liberal theory, Sherwin suggests that the core bioethical concepts of autonomy, social justice, and solidarity must also be reinterpreted through a relational lens. This makes a relational approach necessarily different from state-based and mixed approaches, which maintain liberalism’s exclusive focus on *individuals* (individual persons, organizations, or governments) as the units of analysis.

Sherwin (2012) introduces the concept of relational autonomy as “a way to retain the value of appeals to autonomy as a way of reducing oppression without accepting its baggage as a concept that sustains the ideals of individualism” (15). As she explains elsewhere,

Rather than pretending that individuals can make decisions “free” of outside influences, relational autonomy encourages us to pay close attention to the types of forces that may shape an individual’s decisions . . . . Each person’s values are chosen in contexts that involve learning from and engagement with others; moreover, each must learn and practice the skills necessary for making responsible choices in social circumstances. (Baylis et al. 2008, 202)

Relational autonomy makes visible how public health policies and practices differentially distribute opportunities to members of different social groups, while also limiting or expanding “the range of options available to individuals who will be called upon to make responsible decisions” (202).

For these reasons, relational autonomy plays an important role in understanding the extent to which public health policies can be oppressive, insofar as particular policies promote the autonomy of members of certain social groups at the expense of others. Sherwin (2012) draws a distinction between *autonomy* and *agency* to make sense of the fact that people frequently choose options that are ultimately detrimental to their own well-being and that of similarly situated others, as is the case in situations where “members of oppressed groups are



better off (at least in the short term) in pursuing options that are, in a deep sense, contrary to their broader interests” (17). Here, she reserves the term “autonomous” for actions that are consistent with a person’s broader interests, as well as the interests of the groups of which they are members, highlighting the extent to which “increasing autonomy requires making changes to the background conditions, not (only) the agent” (19).

In summary, Sherwin’s relational approach to public health ethics rests upon a rejection of the basic ontological assumptions about individuals that characterize both state-centered and mixed approaches. While both state-centered and mixed approaches understand agents and their responsibilities as isolated atoms, according to her relational conception of autonomy, not only agents themselves, but their responsibilities, too, cannot be considered separately from those of others. By shifting the unit of analysis from atomistic individuals to individuals-in-relation, Sherwin’s approach necessitates a shift in our understanding of agents and responsibilities at all other levels of human organization. Her view clarifies how autonomy is developed in and through social relations of various types and is thus a thoroughly social, rather than individual, achievement.

By drawing our attention to the material and social conditions constraining and enabling the actions of agents of various types, relational autonomy also directs us to explore the broader social and political contexts in which those conditions are created and maintained, bringing issues of social justice to the fore. Sherwin’s relational conception of social justice “asks us to look beyond effects on individuals and to see how members of different social groups may be collectively affected by private and public practices that create inequalities in access and opportunity,” which also calling on us to “correct patterns of systemic injustice among different groups, seeking to correct rather than worsen systematic disadvantages in society” (Baylis et al. 2008, 203). This requires that policymakers, and those charged with implementing public health practices, be attuned to ways in which members of oppressed groups are not only particularly at risk for having their autonomy undermined, but also tend to be particularly well-positioned to understand the nature and origins of those risks. Hence, policymakers and practitioners must “recognize the need for substantive participation in collective decision-making processes and policy adjustments” (Doan and Sherwin 2016, 84).

Working toward relational social justice thus requires a conception of solidarity that involves recognizing important differences among people—particularly those “special disadvantages that face members of social groups who are subject to systematic discrimination and reduced power” (Baylis et al. 2008, 204; see also Doan and Sherwin 2016, 85). By valuing interconnectedness while avoiding dubious assumptions of collective identity, a conception of solidarity as relational also eschews exclusion in all of its forms, aiming to “expand the category of ‘us’ to ‘us all’” (Baylis et al. 2008, 205). “What matters is a shared interest in survival, safety and security,” argues Sherwin, “an interest that can be effectively



pursued through the pursuit of public goods and through ongoing efforts to identify and unravel the complex webs of privilege and disadvantage that sustain and foster an ‘us’ versus ‘them’ divide” (Baylis et al. 2008, 205). Given that it is the function of public health to promote public goods, Sherwin suggests that the meaning of relational solidarity can be found “*within* public health itself” (Kenny et al. 2010, 10). Much as public health is concerned with what society does collectively to assure the conditions for people to be healthy, relational solidarity pushes us beyond the individualization of responsibility, helping “agents operating at multiple levels shift towards participation in genuinely *collaborative* forms of collective action” (Doan and Sherwin 2016, 85).

We want to suggest that Sherwin’s vision for a relational approach to public health ethics, though not directly responding to the question of who should be responsible for safeguarding public health, has implications for debates surrounding that question. In particular, her work suggests that the question, “Who should be responsible for public health?” is not quite the right one to be taking as our focus, since it makes little sense to point to any single agent or group of agents as responsible outside of their relations with agents of many other types. Notice that this is precisely what both state-centered and mixed approaches do: whether singling out government entities alone, or governments plus nongovernment organizations, groups, and individuals, each invites us to divide up responsibilities among agents conceived of as sharply bounded, given what each is already capable of doing on its own. By way of contrast, Sherwin’s approach draws our attention to the need to conceive of the responsibilities of agents of every type *in relation to one another*, for what each is capable of doing is always conditioned by the actions of many others besides. Unlike state-centered and mixed approaches, then, a thoroughly relational approach eschews straightforward answers to questions of responsibility, refusing to point fingers and resisting the temptation to quantification expressed in pie charts.<sup>1</sup> Building on Sherwin’s reframing, we want to emphasize the dynamic character of agents of many types, and of the responsibilities each can have to change and participate in the changing of others, where these responsibilities too must be conceived relationally—that is, as responsibilities to be reconstituted through shifting relations with others.

In the next section, we turn to two examples of health-related organizing and activism in conditions of precarity to do two things: to explain why the state-centered approach is not best and hence to build a case for a need to further decenter the state; and to establish a need to further develop Sherwin’s relational approach to public health ethics, focusing on the need for certain agents to be reconstituted in pursuit of health-related goals.<sup>2</sup> Whereas a mixed approach recognizes that involving government entities in public health initiatives may not always be necessary, let alone helpful or desirable, and Sherwin’s relational approach emphasizes what the state cannot do without the cooperative and enabling actions of others, our case studies focus on the role of state

agents and agencies in creating and maintaining public health crises. As we aim to show, the health organizing of the Black Panther Party and Common Ground Collective demonstrates why and how the state would need to undergo a radical restructuring in order to avoid neglecting and actively compromising the health of historically marginalized groups. By prefiguring public health programs that embody the values of solidarity, mutual aid, and community control, the work of these groups draws attention to ordinary people reorganizing their relationships, changing themselves and others with a view to modeling better integrated forms of care.

### 3. Public health and precarity

#### ***a. The Black Panther Party: Public health in the shadow of the state***

The Black Panther Party provided a wide range of healthcare services to poor black and oppressed people during a period when state-driven provision in the United States was arguably nearing its zenith. We see the work the Panthers did to provide necessary health care, to create conditions for medical knowledge to be owned and produced by communities, and to reconceive of what is involved in “health” not as taking over responsibilities for public health but instead as embodying a recognition that Party members as agents would need to work in relationship with other actors (including state actors), and in part with the goal of insisting that those agents become different.

As Alondra Nelson (2011) points out, the Panthers’ health politics and activism during the late 1960s and early 1970s was propelled by the fact that African Americans continued to suffer disproportionately from ill health and substandard care, were routinely disrespected and disempowered by medical professionals, and were treated as fodder for experiments, as witnessed mostly infamously in the Tuskegee syphilis study (12–15; see also [Goldstein 2012](#), esp. ch. 5; [Washington 2007](#)). Highlighting the extent to which the achievement of formal civil rights had not guaranteed citizenship for African Americans in any meaningful sense, health proved a particularly revealing area of focus for the Panthers. As their organizing made clear, the federal government’s continued collusion with the private insurance industry cast a long shadow of neglect over predominantly black communities. Especially for African Americans who were under- or unemployed, engaged in informal labor, or whose work was not recognized as deserving of monetary compensation (i.e., primarily women; domestic workers; the elderly; children; and people with disabilities; as well as people without documents and returning citizens), access to medical care was contingent on unpredictable fluctuations in political sentiments, insurance markets, and foundation coffers.

While the Panthers’ publications drew attention to the continuation of state neglect after Jim Crow, the critique implicit in their organizing work went deeper. The emergence of the Panthers’ health politics and activism was driven,

in part, by the political limitations, inefficiencies, and sheer negligence of public health programs initiated under the aegis of President Johnson's "War on Poverty," many of which targeted predominantly black communities (Nelson 2011, 55–60). As Nelson observes, "The Party regarded the War on Poverty as a plan that would not end poverty but merely amount to control and surveillance of the poor" (58). While government-run antipoverty programs sought to offset the harms of a profit-driven system by addressing persistent gaps in healthcare provision, the Panthers recognized that the federal government was not equipped to solve the public health crises it was responsible for creating, whether directly—through its own policies, actions, and omissions—or indirectly—through its intimate relationship with the private insurance industry. In other words, the problem with the capitalist state's healthcare system was not simply its *neglect* of poor black and oppressed people, but also its peculiar way of *attending and ministering to them*. Several of the Party's founding members had firsthand experience working in and with these federal antipoverty programs. Based on their own frustrations and disillusionment—particularly with the conception of "health" upon which state-driven public health initiatives were based, how they were structured, and the limited aims they sought to achieve—the Panthers later established the People's Free Medical Clinics (PFMC) as an alternate source of care, embodying a fundamentally different set of principles and aspirations.

The purpose of the PFMCs was to "provide free medical treatment and preventative medical care for the community" (Hilliard 2008, 21; Newton 2009, 103). Beyond providing free services, each survival program was designed to build the capacities of community members and inspire them to engage in collective struggle, to serve as a model of the actions that can be taken to bring about desirable changes in social conditions, and to model the ways in which more just institutions might work (Hilliard 2008, 3; Newton 2009, xv). The clinics were no different. They provided basic healthcare services to people who would otherwise go without, demonstrating that it is possible to receive good quality, preventive care without needing to buy into the private health insurance industry or pay fees out of pocket (Hilliard 2008, 23).

By 1970 the leadership of the Black Panther Party mandated that each chapter would be required to establish a free health clinic. Party leadership relied on the ability of local members to recruit and mobilize volunteer nurses, doctors, and staff; to raise funds and build relationships with sympathetic funders; and to acquire all the other resources needed to operate a clinic, including everything from a suitable building and furniture to medical supplies and pharmaceuticals. Between 1968 and 1973, the Panthers' free clinics opened their doors for various stretches of time, usually for a few days each week, in a total of thirteen major cities. While each clinic had its own capacities, the PFMCs were generally able to provide first aid, basic preventive care, and essential services such as physicals, vaccinations, and diagnostic screenings for various common ailments,

including high blood pressure, diabetes, and lead exposure. Certain clinics also offered more specialized care, including eye exams, dental care, pediatric services, and gynecological exams. The Winston-Salem clinic even operated its own ambulance, called the People's Free Ambulance Service (Hilliard 2008, 27–29; Nelson 2016a, 1736). The Panthers' health activism extended beyond the walls of the clinics and into surrounding neighborhoods, where teams of nurses, doctors, and community health workers conducted door-to-door diagnostic screenings and provided what later came to be known as “community-based referrals” (Nelson 2016b, 1746).

In 1972, the Panthers revised their Ten-Point Platform to include an explicit demand for “completely free health care for all black and oppressed people.” The revised version reads:

We believe that the government must provide, free of charge, for the people, health facilities that will not only treat our illnesses, most of which are a result of our oppression, but that will also develop preventative medical programs to guarantee our future survival. We believe that mass health education and research programs must be developed to give all Black and oppressed people access to advanced scientific and medical information, so we may provide ourselves with proper medical attention and care. (Hilliard 2008, 75)

Through this layered demand, the Panthers affirmed the principle that access to healthcare is a universal human right, directly opposing the prevailing view that healthcare is a human need, but not a right, and so ought to be considered a privilege available only to those with the requisite means and status.

Point Six also captures an important pillar of the Panthers' health politics and activism: an understanding of “health” as inseparably linked with prevailing social conditions. Nelson argues that the Party developed a distinctive approach to understanding health, which she calls “social health” — “an outlook on well-being that scaled from the individual, corporeal body to the body politic in such a way that therapeutic matters were inextricably articulated to social justice ones” (Nelson 2011, 11–12; cf. Marmot and Wilkinson 2005). For the Panthers, the prevalence among African Americans of a hereditary disease such as sickle cell anemia was not merely a problem for and of individual bodies; hence, it would be a mistake to seek a remedy within the individual or by focusing on an individual's “lifestyle choices.” Instead, sickling ought to be understood as a public health problem created by the state's well-documented failure to prioritize research, diagnostic screenings, and treatment for a disease that affects African Americans at far higher rates than the general population. More pointedly still, sickling ought to be regarded as part of a more complex, state-sponsored effort to foreshorten black lives that included everything from the forced sterilization of women to the mass conscription of men; from redlining in mortgages, insurance, and home repair loans to culturally biased testing in public schools; to streets allowed to be flooded with drugs, to unchecked terror and abuse at the

hands of police. “Sickle cell was not merely a debilitating condition,” argued the Party, “but also the state’s biological weapon” (Nelson 2011, 133).

The Panthers were also sympathetic to the expansive definition of health articulated in the 1948 constitution of the World Health Organization (WHO), which characterized health as a basic, universal right (see Nelson 2011, 11; Garvey et al. 2016, 1749). According to the WHO’s (1948) definition, “Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity.” By way of contrast, definitions of “health” prevalent within state agencies and private healthcare institutions were inherently limited, as were criteria for what qualifies as a “public health issue.” These understandings generally conformed to the “biomedical model of health and disease,” which locates the source of and solutions for health problems within the individual and characterizes health negatively, privileging a disease-free baseline. The Panthers contended that, in a society in the grips of white supremacist capitalism, it would be impossible for black and oppressed people to ever meet such a baseline, much less realize the WHO’s loftier target. Rejecting as inadequate the state’s conception of health, the Panthers’ social health praxis linked the provision of free healthcare to broader revolutionary ambitions, rooted in “the fundamentally radical idea that achieving health for all demands a more just and equitable world” (Nelson 2011, 12; Bassett 2016, 1741).

In addition to challenging the state’s conception of “health,” the Panthers also took issue with how state-based initiatives were structured and what they sought to achieve (Nelson 2011, 57). From an organizational standpoint, the Panthers joined many other black activists in calling for “community control” of health-related institutions and practices, reflecting a shared commitment to the view that “black well-being could not be achieved without self-determination” (57). Federal antipoverty programs often claimed to invite the full participation of black and oppressed people in day-to-day decision-making and administration. Yet, what they actually offered were, at best, “partnerships” between those perceived to be community leaders, the poor, and government administrators, and special care would always be taken to ensure that state agents’ roles remained central.

As Party members were well aware, state-driven public health initiatives—particularly those conceived of in alliance with private commercial interests—must always work to constrain and ultimately thwart self-determination at the community level. Otherwise, such initiatives would risk bringing about their own obsolescence, loosening the relations of dependence that help to justify their existence. As Nelson (2011) adds, “Black activists’ demands for ‘community control’ of healthcare facilities was also a call to change an often harrowing, disrespectful, and unaccountable culture of medical practice” (60). The Panthers’ free clinics were instituted as a more democratic and participatory alternative, not only for the sake of building self-determining communities but also for the sake of restoring and preserving the dignity of individuals in community.

Indeed, the “democratization of both medical practice and knowledge in the clinic setting was a tactical cornerstone of the Party’s health politics” (18), not to mention of the broader free clinic movement of the 1960s and 1970s (Bloomfield and Levy 1972, 35).

We appreciate that the Panthers’ health politics could be interpreted as a state-centered approach to public health, particularly if their demand that the federal government provide “completely free health care for all black and oppressed people” is taken at face value, out of the context of their everyday organizing work. However, such a reading fails to reckon with the depth of the Panthers’ critique of the capitalist state’s healthcare system, which covers everything from the state’s conception of “health” to its insistence on centering itself through the control of all aspects of its own healthcare initiatives. Point Six of the Panthers’ Platform was not merely a demand for the state to *do* something different (i.e., to provide the resources and infrastructure for free, universal care). For one thing, the Panthers were well aware of the impossibility of such a demand being met by the state as currently constituted. More importantly, even if the state could meet such a demand, everything from the administration of healthcare services to medical knowledge to the way care is provided would need to undergo a radical restructuring to facilitate, rather than undermine, the self-determination of poor black and oppressed people. Insofar as the state would have some role to play in a more just healthcare system, that role could only be assumed by *becoming something fundamentally different* in and through shifting relations with those populations currently subjected to systematic ill-treatment.

Far from proposing a simple redistribution of responsibilities among agents taken as they are, the Panthers set about changing themselves and others through their organizing to bring about wide-ranging changes in the institutional contexts of their lives. By amplifying calls for “community control,” they were not simply proposing that activists and volunteers provide healthcare services when the state refused to. After all, the Panthers’ survival programs were conceived not as “answers or solutions” to problems created by governments but as vehicles for building power at the community level and, ultimately, for tilting the balance of power toward the people whose needs state agents and agencies are meant to serve.

### ***b. The Common Ground Collective: Public health in the midst of disaster***

Whereas the Panthers’ public health organizing drew attention to the long shadow of racist neglect cast by the state on an everyday basis, underscoring the state’s inability to cast its own shadow aside, the work of the Common Ground Collective grew in response to the more acute public health crises that emerge in the midst of disaster. The Common Ground Collective was founded in the overwhelmingly poor, largely black neighborhood of Algiers, New Orleans, on September 5, 2005, just days after Hurricane Katrina flooded homes and devastated communities across the Gulf Coast. Common Ground was a

community-initiated, all-volunteer organization whose mission was “to provide short-term relief for victims of hurricane disasters in the Gulf Coast region, and long-term support in rebuilding the communities affected in the New Orleans area” (crow 2014, 229). Common Ground was also nourished by a more direct, experiential lineage to the Panthers’ survival programs. One of its cofounders, Malik Rahim, is a veteran community organizer and former member of the Black Panther Party’s New Orleans chapter who helped run free breakfast for children and community safety programs in two of the city’s most poverty-stricken housing projects. On September 13, 2005, Common Ground set up a distribution center at his home in Algiers, where food, supplies, and a variety of services were made available to people struggling to survive in the storm’s aftermath. The collective established a first aid station soon thereafter, which quickly evolved into the Common Ground Health Clinic. This clinic—one of three collective members would set up—eventually morphed into a nonprofit that still operates to this day. We suggest that Common Ground modeled through their organizing a fundamentally different way of working *as* and *with*—rather than on behalf of or for—people struggling to cope with the sudden absence of basic amenities.

Cofounder and longtime community organizer scott crow (2014) describes Common Ground as a “revolutionary aid organization,” recounting their first three years in Algiers as “a story of ordinary people compelled to act for justice in an extraordinary situation” (59, 4). In his own retelling, crow offers an extensive account of why so many people were compelled to rush *into* the flooded streets of New Orleans with “emergency hearts” (65), precisely when the federal government and military were struggling to evacuate everyone they could. As crow insists,

We must never forget these facts that made Hurricane Katrina a travesty: That climate change is creating unprecedented storms in size and intensity. Katrina was one of them. That ongoing ecological destruction in the name of profits has been perpetuated for more than a hundred years . . . . The government response at all levels left thousands of people to die who had no means to evacuate due to health, age, and lack of funds, transportation, or connections. Individuals and families were trapped in their homes, on the streets, on their rooftops, and in their attics. Power reacted with brute force and criminalization of the people. It was criminal neglect. (4)

While thousands of people were voluntarily evacuated in the days and weeks following the storm, many others were forcefully displaced by government agencies to disparate locations hundreds of miles away, often without any means of finding their way home. Meanwhile, houses, schools, and community centers were destroyed, left underwater, and, in some cases, smoldering in flames. Utilities were downed or disconnected, with reconnections for low-income and poor people among local authorities’ lowest priorities. Local businesses and jobs were swiftly relocated, rendered irrelevant, or vanished altogether. Opportunistic



landlords raised rents amidst growing land and real estate speculation. Developers and investors scooped up bundles of properties for a song, often holding buildings left vacant and in disrepair (many of them the very same structures that were formerly homes to those forcefully—and in some cases, permanently—displaced), banking on skyrocketing values to come. Dozens of charter schools swooped in to take the place of an underfunded public school system left further in disarray, saddled with dozens of ruined facilities: roofs leaking, mold spreading, immersed in a soup of floodwaters laced with gasoline, chemicals, debris, and animal carcasses.

Those whom the federal government left behind, or who were unable or refused to be evacuated, were joined by a group of volunteers from across the country who arrived in the storm's wake. The Common Ground Collective was born amidst the efforts of those who remained to come together and make the best out of an enormously challenging situation. While local authorities moved to get downtown New Orleans back open for business, courting developers and demolishing houses along the periphery, people who stayed in their homes set to work on gutting houses and neighborhood buildings to save them from ruin and demolition. Harking back to the Panthers' community self-defense programs, Common Ground began setting up safety patrols around their distribution center, taking up a practice of community armed self-defense—a practice that crow (2014) notes was adopted as a last resort, following a series of tense confrontations with white vigilantes (55; see also [Thompson 2008](#)).

Having established some semblance of security, Common Ground birthed a wide range of programs organically, out of necessity, grounded in a keen understanding of evolving local problems and needs, and with a creative outlook on the future. As crow (2014) puts it, "Our intentions were to create permanent and sustainable solutions with and for those who were the most affected," grounded in the practice of solidarity and, eventually, "mutual aid" (103, 165). In addition to protecting poor and racialized people from white militias, collective members fought for displaced residents' rights to return; provided legal aid and safe shelter for women; pressured police for accountability and supported prisoners' rights; prevented housing demolitions by gutting, cleaning, and repairing dozens of structures; used legal means and direct action to halt evictions; and worked together with neighborhood councils ([crow 2014](#), 165, Appendix). The collective included a team of street medics and, eventually, nurses and doctors, some of whom helped set up a first aid station as well as three medical clinics. Collective members also engaged in Latinx healthcare outreach; cleaned up garbage and toxic floodwaters in streets and houses; provided soil and water testing in and around peoples' homes; offered bioremediation services for damaged soils; made counseling and social work services available at clinic sites, as well as massage, acupuncture, and herbal remedies; constructed compost toilets for homes facing plumbing problems and water shutoffs; helped clean up household gardens and planted community gardens to bring people together

growing food. “We provided vital services to people with ongoing health issues who weren’t getting their medications or hadn’t been able to check in with a doctor for weeks,” notes crow (2014): “The clinic also provided a place for people to relieve their emotional traumas with the help of others who listened and cared. In short, we provided free holistic health care to communities on the West Bank who hadn’t had access to it in years” (101).

Unlike state-based and nonprofit relief organizations, crow (2014) adds that Common Ground refused to see the people they were serving as “faceless or helpless victims,” insisting instead on interacting with others as “active participants in the struggle to make their lives better”—that is, as *people* who were coming together “to struggle for survival, justice, and self-determination” (103, 60). Rather than setting up potentially permanent relations of dependence between long-time residents, on the one hand, and relief organizations staffed by out-of-towners, on the other, Common Ground worked to support those most directly affected by the storm in taking charge of their own lives, analyzing deeply rooted problems in the process of developing solutions, and rebuilding their own communities in self-determining ways. It wasn’t merely that those working on behalf of government and professional aid organizations tended to adopt paternalistic attitudes toward native New Orleanians, or that these organizations pushed band-aid approaches to problems created or exacerbated by the storm. In places like Algiers, state-sponsored and philanthropic relief was either entirely absent, or unhelpfully, inflexibly, insultingly, inefficiently present. As crow (2014) explains,

The state was off balance and unresponsive. The entities within it were failing to grasp the developing issues. The Red Cross wasn’t doing any better. They were raising *billions* of dollars while people were still suffering. For me, it was the closest thing to seeing those in Power lose their stranglehold of control. (65; see also [Tessman 2017](#), ch. 1)

Regaining control over people and their relationships seems to have been among the state’s top priorities, ahead of attending to the needs of those struggling to pick up what remained of their lives. While mainstream media depicted looters on the loose, the state prioritized a return to “law and order,” establishing military checkpoints and patrols to supplement existing police command structures. Due to incessant stops and searches, Common Ground experienced considerable difficulty transporting people from outside the city to their distribution and clinic sites. “The first doctor we tried to get in was denied entry multiple times at military checkpoints, apparently because he was black,” recalls crow (2014): “It was as if they had set up an apartheid system to determine who came into the area” (95).

When the Federal Emergency Management Agency (FEMA) and large nonprofits like the Red Cross began acting as though the people living in Algiers required assistance, crow (2014) notes bitterly that they “would announce it all with huge fanfare to the neighborhood, only to provide very little aid” (107). To make matters worse, FEMA required would-be aid recipients of to fill out

application forms over the Internet, communicating the farcical presumption that Algiers residents would all have access to personal computers, could afford private Internet service, and were equipped to navigate online bureaucracies. Meanwhile, the Red Cross “spread the word of their arrival far and wide for days beforehand” (128). But when their arrival finally came and people crowded together in the streets to receive the help they had been promised, the results were beyond disappointing: “All of those resources, all of those volunteers, all of that money, and all they brought were napkins, plastic utensils, and baby-wipes! The crowd was insulted and angry, and the Red Cross volunteers were as surprised as anyone . . . This made it perfectly clear how out of touch the Red Cross was with what was happening” (128–29). Predetermined understandings of whom FEMA and the Red Cross would be serving and what the capacities and needs of those people would be consistently led to embarrassment and neglect. A combination of centralized, top-down decision-making, complicated bureaucracies, and inflexible framings and programs severely sabotaged state workers’ and volunteers’ efforts to be more responsive to people’s needs and change course when those needs continually went unmet.

As Crow (2014) makes plain, Katrina was the kind of catastrophe it was for historically marginalized communities in large part because of the way state-based and professional aid organizations dealt with the situation: prioritizing controlling the movements and relationships of New Orleanians over learning about and addressing their needs, and treating storm survivors as helpless victims, entrenching existing relations of dependence and instituting new ones. These failures, and the broader context of repeated failures to provide reliable, adequate healthcare to African Americans and other racialized groups, reflect, in part, failures to hold people, groups, and institutions in relation. Treating these agents and their responsibilities as isolable creates conditions that facilitate buck passing, denials of obligation, and lack of accountability. Instead of accusing governments of failing to safeguard public health in the storm’s wake (which presupposes that such entities are already well-positioned to meet the charge), and without proposing that, after all, people ought to be doing all the work as volunteers, Common Ground’s collective members demonstrated through their actions what is possible outside of dominant framings, organizational structures, and ways of relating to one another. In so doing, they showed how organizations such as the Red Cross might be reconstituted in the course of working to shift relations between givers and receivers of care.

#### **4. Relational public health ethics, reconsidered**

The Panthers’ public health organizing and the Common Ground Collective’s work in post-Katrina New Orleans can be read as embodying the core values articulated in Sherwin’s relational public health ethics. In closing, we want to highlight how the work of these organizations, at their best, points to the possibility of a more nuanced response to state-centered approaches than might otherwise be obvious.

Both the Panthers and Common Ground responded to public health crises that were partly created and certainly exacerbated by state responses. They identified the sources of such crises as partly (though not exclusively) based in the operating principles, structures, and processes of government entities, and they took great care in creating non-state-centered responses that would both protect and be led by historically marginalized communities. For the most part, they functioned completely separately from and in opposition to the state, recognizing when state involvement would compromise the well-being and self-determination of their communities and doing whatever possible to limit such effects. On occasion, though, they wisely recognized when they could coordinate their activities with, or function in the role of challenging state organizations to act. At times they went even further by challenging the state to *become something fundamentally different*: a form of organization that embraces an expansive, thoroughly social understanding of “health,” and that enables, rather than undermines, community self-determination as a condition for all people to be healthy.

We want to suggest that these ways of engaging with the state demonstrates a subtler approach to addressing the question “Who should be responsible for providing public health?” As Sherwin’s work suggests, it is not very helpful to answer this question straightforwardly by pointing to particular institutions, organizations, or groups, since agents of many types at all levels are necessarily in relationship as they act and condition the possibility of each other’s actions. Furthermore, we want to add, agents understood relationally need not be accepted as currently constituted, particularly when they are, by their nature, contributing to the perpetuation of public health crises and are ill-equipped to provide the conditions for people to be healthy. The main lesson we draw from our two case studies is not that the state has repeatedly failed to meet its responsibilities to safeguard public health and should be called upon to live up to them. After all, such a view supposes, naively, that the state as currently constituted could succeed. Nor are we suggesting that leaning on private, nonprofit, or volunteer healthcare providers is the best or most justifiable answer in circumstances where government entities predictably fall short. The Panthers and Common Ground were not merely providing services others had failed to provide. In the course of meeting the healthcare needs of people otherwise subject to systematic ill-treatment, they were modeling ways of organizing and relating to one another that make it possible to more accurately recognize and respond to those needs on an ongoing basis.

As *revolutionary* aid organizations, the Panthers and Common Ground worked to reorganize relationships between all of the agents involved in effecting public health. We find it helpful to conceive of these transformative efforts as aspiring to realize what Joan Tronto (1993) describes as *more integrated and well-accomplished processes of care* (109)—processes that we believe would more fully exemplify Sherwin’s core values of relational autonomy, social justice, and solidarity. Our case studies illustrate how perceptions of health-related needs

and how best to meet them can be flatly wrong or, in some cases, missing entirely, in ways that invite careful reflection on who is playing which roles in the ongoing work of caring. As Tronto points out, “Often in bureaucracies those who determine how needs will be met are far away from the actual care-giving and care-receiving, and they may well not provide very good care as a result” (109). If we consider the way acts of care involve four analytically separable phases—namely, caring about, taking care of, care-giving, and care-receiving—then it becomes possible to evaluate processes of care in terms of how well integrated they are in practice. As Tronto argues convincingly, processes of care have grown increasingly *fragmented* in the context of the United States, which “should call attention to a possible problem in caring” (110). It is partly for this reason that conflicts continually arise between those who see themselves as chiefly responsible for noting and assessing others’ needs (caring about) and determining how best to respond to them (taking care of), and those charged with actually meeting those needs (care-giving) and responding to the manner in which they are addressed (care-receiving). In light of such conflicts, Tronto notes how care-receivers “may want to direct, rather than simply to be the passive recipients, of the care-giving that they receive” (109)—a desire expressed clearly in ongoing struggles for “community control.” In working toward community self-determination, care-givers and receivers can be understood as challenging the disintegration of care work, calling into question social arrangements in which caring about and taking care of, are tasks for those in power, particularly state agencies staffed by doctors and administrators, whereas care-giving and receiving are less valuable forms of work left to the more vulnerable (114).

As our case studies illustrate, part of the work of public health organizing in conditions of precarity is to exhibit wisdom in recognizing when and how agents must be restructured and reconstituted in and through shifting relations with others—whether they are state agents, nonprofits, or individuals in community. It is a mistake, then, to either wholly disregard certain types of agents as potential contributors to better integrated processes of care (as right-libertarian, neoliberal, and other dogmatically nonstatist approaches do), or to relate to agents as though their current constitution is to be taken for granted, as static rather than dynamic (as both state-centered and mixed approaches do). The values central to Sherwin’s relational approach to public health ethics provide rationales for insisting that agents be reconstituted in order to accomplish specific health-related goals, and relating to agents as alterable and moveable may allow for greater creativity in responding to pervasive problems in public health.

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## NOTES

1. We are not suggesting, of course, that no one can be held responsible for safeguarding public health. Suppose, for example, that one of the health-related goals of a small, rural community is to reduce the spread of infectious disease in the regional hospital. It would be strange to single out nurses, doctors, and other hospital staff as responsible for current rates of infections given that there is only a single bathroom on each floor of the aging institution, with only a single sink to share for handwashing purposes. It would also be strange to insist that staff wash hands more often and for longer, for they are simply incapable of doing better given the opportunities available to them. In a case of this sort, there are a great many things that agents of several different types would need to do to make possible improved handwashing practices (e.g., funds would need to be raised; contractors would need to be hired to install handwashing booths in every hallway; staff would need to undergo training; signs would need to be posted; and so forth). Moreover, certain of those agents would need to change in significant ways in order to perform the required tasks, thereby enabling significant changes in the behavior of others (e.g., the funding priorities of local and state governments would need to shift; the local population would need to stop voting solely for tax cuts and start electing officials who promise to prioritize improvements in public health). Situations of this sort are fairly common, as are responses that assume that an agent (or agents) as currently constituted ought to do *x*. By starting instead with the questions of who all is actually involved, whose relationships would need to shift in what ways, and who would need to do what and for whom in order to accomplish specific health-related goals, we believe that more context-sensitive, genuinely helpful assessments of responsibility will result—assessments that show that and how various agents would need to change in relation to others over time.
2. One of the basic claims of relational theories of agency is that agents of all kinds are constituted in and through relations with others (Downie & Llewellyn 2012). A person's values and beliefs are formed in contexts that involve learning from and engaging with others, and the skills and capacities through which they express who and what they care for are significantly shaped by the social circumstances of their cultivation and operation. Thus, to be reconstituted as an agent—that is, to undergo a significant change in who one is and what one can do—involves, and often requires, changes in the nexus of relationships that frame and constrain one's actions. For example, you may find that I am “not the same person” since having enlisted in the military, my values, abilities, and self-understanding having evolved in numerous ways. Relatedly, I may find that the federal government would need to radically shift its priorities—to become something other than it currently is—in order for there to be more life-affirming employment opportunities available to the young people in my neighborhood. What it means for an agent to be “reconstituted” will depend on what type of agent it is, what modes of internal restructuring are possible, and how such internal restructuring is enabled by shifts in relations of what sorts. Our case studies focus primarily on grassroots activists changing one another in the course of pushing government agencies to change in ways that would enable rather than thwart the agency of historically marginalized groups. Other types of transformation would, of course, be worth exploring in the context of public health as well. As we show in what follows, state-centered and mixed approaches are unable to pose the question of whether certain agents may need to be reconstituted for the sake of meeting particular health-related goals because both approaches assume that (state

and other) agents as currently constituted must *already* be capable of protecting and promoting public health. There is, in other words, a critical temporal dimension to responsibility that these approaches leave unexamined.

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