A Conversation with Terri Laws on “Race, Faith, and Health Justice” • December 10, 2020 • Sponsored by the Religion and Public Life Program at Rice University

Elaine Howard Ecklund is the Herbert S. Autrey Chair in Social Sciences at Rice University and Director of the Religion and Public Life Program. Her most recent book is *Why Science and Faith Need Each Other: Eight Shared Values That Move Us beyond Fear.*

Terri Laws is an assistant professor of health and human services and African and African-American Studies at University of Michigan Dearborn. Laws has a Master of Divinity from Interdenominational Theological Center in Atlanta and is currently writing a book on African American religion and health.

Rachel Schneider is a postdoctoral fellow in the Religion and Public Life Program at Rice University, where she focuses on race and religion. She is currently working on a book manuscript, *The Ethics of Whiteness: Race, Religion, and Social Transformation in South Africa.*

Elaine Howard Ecklund: Welcome everyone. It is just thrilling to see so many people here, really thrilling, and I think the topic we’re discussing this evening is so important. My name is Elaine Howard Ecklund and I am a professor of sociology and director of Rice University's Religion and Public Life Program. I am so pleased to welcome you to a Religious and Civic Leaders Gathering of the Religion and Public Life Program. I want to share just a second about our vision, since for some of you this is your first gathering.

The Religion and Public Life Program’s mission is to use research on religion to build common ground for the common good. And we have many initiatives that center around that vision, initiatives related to doing research, to teaching, and to outreach. You can find more at [www.rplp.rice.edu](http://www.rplp.rice.edu).

The particular vision of these Religious and Civic Leader Gatherings is to bring together faith and community leaders in an intimate setting to talk about timely issues, engage with research, and share resources.

Some of you may recall that these gatherings have typically been held in my home. Hence the phrase I used, “intimate setting.” But these have of course been moved online since late last spring, and there’s a kind of sadness to that. I loved having people in my home: people from the university and people from the community. I think a kind of redemptive or bright side to the loss of not being together physically, however, is that we have been able to gather together leaders from around the country, and so we are going to continue hosting these online over the next few months, which allows us to welcome those from around the nation and the globe.

[…]

1
I now want to introduce my colleague, Dr. Rachel Schneider, who is a postdoctoral fellow with the Religion and Public Life Program. She's a scholar of race, religion, and culture. Rachel's research primarily focuses on how religious commitments shape ethical and political practice and inspire social change. I want to turn the floor over to Rachel. Thanks so much, again, for being with us.

Rachel Schneider: Thank you, Elaine. It is a privilege to help facilitate today's important conversation on the role of religious communities in addressing racial health disparities. And it is my pleasure to introduce our guest Professor Terri Laws this afternoon.

Professor Laws is assistant professor of African and African American studies and religious studies at the University of Michigan-Dearborn. She teaches courses in African American religious experience, medical ethics, and womanist religious thought. Her research examines social and cultural issues in healthcare with an emphasis on African American religion and health inequity. Laws is currently writing a race, religion, and bioethics manuscript on African American religion and health. During her doctoral studies, Professor Laws completed a bioethics fellowship at the University of Texas MD Anderson Cancer Center. Welcome Professor Laws, and thank you so much for being with us. Your voice is so critical to this moment, and it has been a personal gift for me to learn from you over the years.

Terri Laws: Thank you so much, Rachel, for that introduction.

Rachel Schneider: Right, so why don’t we dive in. We know that COVID-19 has had a disproportionate impact on black and brown communities on so many levels in really deep, life-and-death ways. And, as a result, in 2020 we’ve had so many public conversations about racism, inequity, and health in the broadest sense. In your view, why are these conversations important and what are some of the ways that faith communities should be engaging with them?

Terri Laws: Thank you, Rachel. That’s a really important question, and COVID has brought the opportunity for us to think about these issues in very deep ways. We are really clear and can’t be more clear in the midst of the suffering that we’ve seen both medical as well as economic—in the ways that both fissures and chasms have been exposed to us in terms of inequality and inequity, both medical as well as economic. And so in thinking about COVID, we have an opportunity to do two things: I want to first talk about the way that we can talk about this in sort of a bioethical way by means of an example. But then I want to turn back to how we as religious folk and religious communities have a way to do what we are best at. And we can talk about what we need to critique ourselves for later. So, I’m going to give an example, because sometimes it’s easier to talk about a subject that’s just outside your purview, in order to grab hold of what we have to do inside our own communities. It feels a bit less threatening. Then I want to talk about just a couple of ethical principles and concepts.

There are four primary principles in bioethical decision-making. Very quickly the principles are: autonomy, beneficence, non-maleficence, and justice. But what does that mean? In terms of a patient, from the autonomy perspective, it’s that I want to make sure that all persons
have a right to make decisions about their own bodies in care decisions. In beneficence, we want to act in the welfare of someone else. Non-maleficence—we’re all familiar with the phrase from the Hippocratic Oath—do no harm. We often add “first,” as in “First, do no harm.” And then lastly, justice, in which we want to think about the realities that persons who are the same in some way should be able to have access to some fair treatment that’s similar to other similar persons. So, COVID gives us a way to really think clearly and concretely about those four principles. And we could think about the suffering, the economic and the health suffering, in the midst of those that the ongoing inequities that are made clear to us in COVID this year. So we can no longer say that we’re not sure what inequity is. And we can no longer turn our backs on the inequities that we have seen in both. And I guess I just want to bring it back again, it’s health disparity, but it’s also the ways that economic disparity makes health disparity prominent and brings it to the forefront.

Rachel Schneider: Do you want to talk about faith communities and how they can engage with these principles?

Terri Laws: Thank you. So faith communities, then, this gives us an opportunity to think about what we do. So now we have the structure right now, borrowing from that bioethical framework. We, in faith communities, know what we’re really good at. We’re really good at that “B” one, right? Beneficence, benevolence. That’s what we’re really good at in faith communities. And so, I want to find fault in my own thinking, right, as a matter of reflection. So, I work in systems. And so, those of us who work in systems see the capacity of systems to be sinful and we are often somewhat dismissive of the personal level, of the benevolent feature of religious communities.

So we’ll say, oh, well, you know, giving a food box is great, but what about the systems that created the need, right? So that’s what those of us who look at the structural sins often talk about, but COVID gives us an opportunity to think about extraordinary ways to be benevolent, as we might say, “raise our game,” for those of us who are in religious communities. Raise our game for what we think about in terms of what it means to be benevolent. We can think about the food box, but we can also think about the structures that create the food box. We can think about giving a donation to a family in need, but that donation might be extraordinary. It may be, for example, a medical bill, right, that we pay. And we have faith communities who are doing things like this but want to think about those things in terms of this “extraordinary benevolence,” because that’s what we’re good at, those of us who are in faith communities.

Rachel Schneider: I love that idea of “extraordinary benevolence.” Thank you for that. You’ve been doing a lot of thinking about ethical issues in your work and the kinds of things that impact trust and connection between faith communities and religious people and medical and science institutions and health institutions, especially as it relates to black and African American communities. What are some of the issues tied to trust that you see are particularly pressing right now?

Terri Laws: Okay, so, um, a couple of things come to mind. I would like to sort of place in the realm of policy as well as practices. So two areas where I’ve been working in the last couple
of years are medical aid and dying or physician-assisted suicide as a legalization issue, a health policy legalization issue. But of course with COVID, I’m also thinking a lot about vaccinations and what does it mean to just roll out vaccinations. And one more I’ll put on the table, and that is: What does it look like to provide spiritual care to caregivers? We’re hearing a lot about the trauma that health providers are experiencing. And so this is an area where again faith communities can reach in and provide extra care. Because trauma, for sure, is being experienced; it’s being experienced on the patient side, but it’s also, as we know, being experienced on the health provider side.

In terms of vaccinations, I’m part of the conversation that I’ve been trying to have of late is this idea of justice, that if we are not required to separate economics from health disparity. So if we think about rolling out vaccines in terms of the workforce, the portions of the workforce that, yes, experienced the most exposure but also experience the least amount of ability to take care of themselves. What I mean by that is, for example, is we’re going to provide vaccinations to health providers first, but who’s included as a health provider? I would argue the person who cleans the floors, right, environmental services is a part of the healthcare team. They’re not there in direct patient care, but if we take care, you know, from my own tradition of “the least of these,” we are in fact taking care of all of us. So environmental services, food services, patient transport—these are all people who we don’t necessarily always think of as being on the healthcare team.

Rachel Schneider: Absolutely. I think we’ve already talked about this in our personal conversations and in this conversation, but I think that’s so critical to expand our conception of who’s really at the forefront of needing the vaccine and who should be prioritized, and then adjust this framework by attending to these racial and economic inequities.

Terri Laws: And we want to think about it as being “just” because it is both just as well as following the science, right. We know, for example, that some of our first outbreaks on the West Coast were in nursing care facilities. Oftentimes, it was exposure from nursing assistants, for example, or persons who were working in the facility, who were working two or three jobs across multiple facilities. And that they would have exposure in one but because they were working in more than one facility, they would actually bring the exposure to the next one. But again, they were working multiple jobs. So this actually points us again to economic inequity, right, for insufficient pay, for example, that exacerbates the health crisis.

Rachel Schneider: Absolutely, that kind of connection between economic precarity and health vulnerability. I really appreciate your thoughts on this because I know that you’ve been doing a lot of deep thinking as it relates to bioethics and emerging issues in bioethics. From your vantage point as a scholar of religion and African American studies, what would you like to see done differently or hope to see done better in the future? And maybe you can talk about it, both from the science/medical side and from the faith leader and faith community side.

Terri Laws: So I’m going to lean on that, that great philosopher of science, Anthony Fauci, who recently gave a presentation to a bioethics center. And I was so appreciative that he said the conversation was around, you know, COVID, of course, and he said something that
has been so near and dear to many of us. And that is, very simply, that for the next decade, now that we know about the fissures as well as the chasms of health inequity and their connections to economic inequities, for the next decade, he said, this is the opportunity for us to work very specifically on those places of inequity. And I was so pleased to hear someone of his prominence say something that specific. But this again is where health and where faith communities fall into line right where we talked about—that we're good at benevolence.

But then this becomes our requirement to act in justice as well. Right, that's that last principle of bioethics that I mentioned. And justice, quite honestly, is the least developed of our bioethical principles. And for me as a person who is both a practitioner, as well as a scholar of African American religion, I know that justice has been the center of African American religion from its very beginnings. And it isn't just the African American community, but in many faith communities we seek to embody justice. And in terms of advocacy, but also in terms of a couple of different economic or health policy/health disparities areas, as well as health legalization of physician-assisted suicide or medical aid and dying. We need to be thinking about what brings these topics to the front. What has made medical aid in dying such a key issue in the last few years? What will the next pandemic look like? Because the structure will essentially be the same, in that suffering and inequity will be at the center. So what can we do now to stem the tide of what is to come because it really doesn't matter what the specifics are. It matters that we understand the framework and move forward again, like I said earlier, we can no longer say we don't know. We know for sure now. And we know exactly the areas where we need to be working.

May I add one thing that you asked earlier and I want to go back to: the area of trust. Trust and reconciliation are at the center of some of our issues in equity. We have African American, black, and brown families who are going to be unwilling to take the vaccination. Based on history, based on, at its root is the loss of trust. And so we've been talking for decades now about faith communities reconciling across racial lines. And here we are with ample opportunity to do so. There's more I can say, but...

Rachel Schneider: I would like you to maybe just say a little bit more. What do you have in mind, because I think so often we can hear the term reconciliation, it seems like it can potentially paper over the kinds of issues that you are discussing. So maybe just say a bit more about what you have in mind when you talk about this opportunity for faith communities to practice reconciliation.

Terri Laws: So if I may do this through an example as well. I just want to go back to the one that I just gave about black and brown communities, right. If we had been working on faith communities, and medical communities, had been working across racial lines and I'm using those in part because both for those of us who are in faith traditions, as well as those of us who are in health professions. Both of those areas of thought have contributed to race conversation, not in a good way. Both of those areas have contributed to racism in various forms. So if we had been working on reconciliation—for at least 60 years we've been talking about racial reconciliation as faith activity. So if we had been working on it—not just talking about, but working on it—now that we're in a space where we're so interconnected that it will matter to us that black and brown folks choose not to participate in vaccinations, right.
it will matter. It will make a difference to all of us. We will be wearing masks, right, and social distancing for probably another year, vaccine or not, if all of the persons, especially those across the racial line, from wherever I am right. All of us who are not taking the vaccination based on this distrust, right, that's how much longer we will be wearing masks and social distancing and keeping kids out of school. This, if we had been doing it for the last 60 years in the way that we really are interconnected, we would work our way out of our current pandemic. Science and health go with reconciliation and race. Does that make sense?

Rachel Schneider: Yes, thank you. I'm going to turn it over now to some large group discussion based on the reflections that Prof. Laws has provided us.