

RACE AND MEDICAL DOUBLE-BINDS

*Craig Konnoth**

Race and medicine scholarship is beset by a conundrum. On one hand, some racial justice scholars and advocates frame the harms that racial minorities experience through a medical lens. Poverty and homelessness are social determinants of health that medical frameworks should account for. Racism itself is a public health threat. On the other hand, other scholars treat medicine with skepticism. Medical frameworks, they argue, will reify racially charged narratives of biological inferiority. This Piece affirmatively claims that the debate is unresolvable. Rather, the relationship between race and medicine should be conceptualized as a double-bind, a concept that creates space for mutually contradictory claims. Indeed, such contradictions are a feature of a double-bind such that the harm a minority faces is intensified. This understanding also breaks ground for antidiscrimination scholarship more generally, which historically has assumed that prominent double-bind frameworks do not apply to racial minorities. Accurately mapping all sides of the conceptual space that race and medicine advocacy scholarship occupies creates space for future work to think of ways in which to resolve the double-bind.

INTRODUCTION

The law deploys medicine across a range of institutions and a multitude of contexts to determine how society distributes burdens and benefits. Welfare and social security claims routinely turn on medical criteria.¹ Disability discrimination claims in employment, public accommodation, and other contexts similarly must adduce medical evidence.² And of course most prominently, medical frameworks form a cornerstone of healthcare—from healthcare delivery to medical research. In these contexts in which law invokes medicine (especially in healthcare), scholars of

* Professor of Law, University of Virginia School of Law. For substantive comments, my thanks to participants of the Reckoning and Reform Symposium, Guy Charles, Tim Lovelace, Veronica Root Martinez, and Bijal Shah. My thanks to Monae White and her colleagues for exceptional editing.

1. See Craig Konnoth, *Medicalization and the New Civil Rights*, 72 *Stan. L. Rev.* 1165, 1174–84, 1174 n.27 (2020) [hereinafter Konnoth, *Medicalization*] (“The law defines medical status as it does many other categories. Those statuses . . . produce legal rights.”).

2. *Id.* at 1182–84, 1215. Note that this is a descriptive claim, not a call for medical evidence to be required.

racial justice have debated how these medical frameworks construct and engage Black Americans. Some are skeptical of the promise medicine offers; others appear more optimistic.³ This yields the question: How should we conceptualize this relationship?

This Piece argues that the best conceptualization of medicine in relation to race is that of the “double-bind.” Failing to invoke medicine or to comply with medical norms harms Black Americans in many ways because it bars access to important, often lifesaving medical resources. On the other hand, invoking medicine and complying with medical norms also creates harm, as it can implicate historically discriminatory tropes regarding the physical and medical inferiority of Black people; expressing medical vulnerability may reinforce these narratives.⁴ This double-bind appears in numerous contexts and institutions where medical frames are used to distribute burdens and benefits.⁵ As a double-bind, both invoking and failing to invoke medicine can be coopted—systematically or at the individual level, deliberately or unconsciously—in ways that continue to oppress Black Americans.

The purpose of this Piece is simply to offer a framework for thinking about this double-bind, rather than to offer solutions. Recognizing the double-bind as a discursive framework designed to oppress is, in itself valuable, as it draws attention not simply to the costs and benefits of using medicine in a certain context, but also to its discursive possibilities. The tradition of double-bind scholarship recognizes that rather than static costs and benefits, each perspective in a debate can be coopted, recoopted, and leveraged by myriad groups in strategic ways to produce desired outcomes. The outcomes of such strategic maneuvering will be different in different contexts and must be analyzed in their own right. But rather than close off the invocation of medical frameworks, it is important to consider how medical frames can be strategically leveraged to produce change (a discussion that I reserve for future work).⁶

The double-bind conceptualization offered in this Piece proceeds in three parts. Part I explains the dilemma facing the scholarship on race and medicine. On one hand, some scholars argue for more fully recognizing the medical needs of Black Americans and forcefully articulating the medical harm they face from exclusion. On the other hand, other scholars fear the overmedicalization of Black individuals. When science *does* seek to remedy Black exclusion, it tends to shift focus away from structural harms to biological attributes, which, in turn, creates the danger of reanimating

3. See *infra* Part I.

4. Dorothy Roberts, *Fatal Invention: How Science, Politics, and Big Business Re-Crete Race in the Twenty-First Century* 180–81 (2011) [*hereinafter* Roberts, *Fatal Invention*].

5. See *supra* notes 2–3 and accompanying text.

6. Craig Konnoth, *Law, Minorities, and Medical Oppression* (2021) (unpublished manuscript) (on file with the *Columbia Law Review*) [*hereinafter* Konnoth, *Law, Minorities, and Medical Oppression*].

old and problematic chestnuts regarding biological differences between races. Thus, these scholars advocate against using medical narratives to conceptualize the issues that minorities face whenever possible. I believe that both sets of scholars are correct in identifying the respective benefits and burdens of medicine, despite how contradictory their positions may seem.

Part II offers the construct of double-binds to conceptualize this dynamic where a particular institutional discourse can create contradictory outcomes for vulnerable groups. Scholars have used the term “double-bind” to present such contradictions in various ways. Some scholars have used the term to denote simple dilemmas where a vulnerable group must choose between one of two courses of action (e.g., should one use or not use medical discourse). In more complex scenarios, there is no real choice: The “double-bind” means that no matter how a group presents its identity, the institutional discourse in question stigmatizes the group. Scholars of antidiscrimination law have raised the concept of the double-bind in numerous contexts, including those involving race discrimination. Part III then explains how medicine creates a double-bind for race in each of the ways that Part II documents.

This Piece addresses three audiences. First, it speaks to lay observers who might be puzzled by the seeming contradictions in racial justice movements. As we are repeatedly told, racial minorities, in particular, Black Americans, are neglected by medicine.⁷ At the same time, we are told that Black Americans mistrust medicine.⁸ The double-bind helps explain these contradictory impulses. Second, it speaks to insiders—scholars of racial justice who might embrace either the medicalization or anti-medicalization position. The answer is that both sides are correct because of the unique operation of double-binds. And third, it speaks to scholars of anti-discrimination law more generally. Some scholars have suggested that double-binds operate less prominently in the context of race compared to sex.⁹ This Piece shows why that claim does not stand in the medical context.

Recognizing that medicine creates a double-bind for race means that the solution lies neither in eschewing nor in embracing medicine as it currently stands. Rather, it requires us to change medical discourse itself to create a space for racial equity. Future work explores a blueprint for that project.¹⁰

7. Janice A. Sabin, *How We Fail Black Patients in Pain*, *Ass'n Am. Med. Colls.* (Jan. 6, 2020), <https://www.aamc.org/news-insights/how-we-fail-black-patients-pain> [<https://perma.cc/UF8H-QRKC>].

8. Dan Royles, *Years of Medical Abuse Make Black Americans Less Likely to Trust the Coronavirus Vaccine*, *Wash. Post* (Dec. 15, 2020), <https://www.washingtonpost.com/outlook/2020/12/15/years-medical-abuse-make-black-americans-less-likely-trust-covid-vaccine/> (on file with the *Columbia Law Review*).

9. See *infra* notes 56–61 and accompanying text.

10. See Konnoth, *Law, Minorities, and Medical Oppression*, *supra* note 6.

I. APPROACHES TO MEDICAL AND RACIAL JUSTICE SCHOLARSHIP

Racial justice scholars and advocates have largely taken two approaches to negotiating with medical institutions—deep skepticism and deep hope. The relationship is perhaps best captured by the divergent tactics racial justice advocates took in response to the approval of the drug BiDil by the Food and Drug Administration (FDA). BiDil was approved for addressing heart disease in people of color—the first (and only) drug ever approved by the FDA where race was one of the treatment indicators.¹¹ There was significant controversy over its approval. As pioneering scholar of race and health Dorothy Roberts noted, BiDil’s approval divided the racial justice community.¹² Some, like Roberts, opposed the approval of the drug precisely because it reanimated narratives of biological race and the idea that races were inherently different.¹³ On the flipside, representatives of prominent Black advocacy and medical groups, including the NAACP, opposed Roberts, believing that the approval of the drug would be in the interest of the community.¹⁴ While the NAACP did not elucidate their argument,¹⁵ one might speculate that for many, a focus on Black people in BiDil’s clinical trials was an important expressive and symbolic victory, given how invisible Black individuals have historically been to those running medical institutions. Accordingly, racial justice advocates took very different approaches in this case.

The BiDil situation is not unique. For example, in 2010, the National Collegiate Athletic Association mandated sickle cell screening for all incoming players after a Black athlete died following an intense football

11. *Id.* at 32.

12. Roberts, *Fatal Invention*, *supra* note 4, at 180–81.

13. *Id.* Indeed, around the same time, scientists claimed to have discovered a so-called “warrior gene,” which caused racists to speculate that “African-Americans possess [the] violence gene.” See generally Laurence Perbal, *The “Warrior Gene” and the Māori People: The Responsibility of the Geneticists*, 27 *Bioethics* 382 (2013) (describing the origin and backlash of the controversial findings of the “warrior gene” in Māori communities). Other studies similarly suggest that associations between race and traits exist, which perpetuates the notion that races are inherently different. See Kevin M. Beaver, John Paul Wright, Brian B. Boutwell, J.C. Barnes, Matt DeLisi & Michael G. Vaughn, *Exploring the Association Between the 2-Repeat Allele of the MAOA Gene Promoter Polymorphism and Psychopathic Personality Traits, Arrests, Incarceration, and Lifetime Antisocial Behavior*, 54 *Personality & Individual Differences* 164, 166 (2013) (finding that African American males in possession of a certain gene were more likely to be arrested and incarcerated than other African American males without the gene).

14. On one occasion, when Roberts stated that there was no consensus about the benefits of race-based therapeutics, the president of an NAACP affiliate “accused [her] of jeopardizing the lives of black people.” Roberts, *Fatal Invention*, *supra* note 4, at 184.

15. Roberts raised important concerns about the NAACP’s scientific reasoning and points out that the relevant drug company had contributed to the NAACP. *Id.* at 183–84. But she did not necessarily claim that the NAACP acted in bad faith.

workout in 2006.¹⁶ Some defended the program as a way to save lives, since it allowed those with the condition to participate in a modified training program; but since sickle cell is more prevalent among those with West African ancestry, other critics concluded that “[t]his could have an extraordinarily heavy impact on black athletes.”¹⁷ This controversy echoed those over sickle cell screening among Black individuals in the 1970s, when critics feared that emphasizing the disease would lend fodder to those claiming African Americans’ “inferiority.”¹⁸

These dramas capture two different trends in policy and scholarship on race and medicine more generally: Some advocates tend to engage with medical discourses and contexts, while others are more skeptical. At the outset, it would be unfair to characterize or caricature either group as blindly embracing or rejecting medicine altogether. All the cited scholars in this Piece take deeply nuanced positions that recognize the limitations of any available approach. Scholars that emphasize the importance of medicine would agree that the biologization of race is scientifically incorrect and socially pernicious, producing discrimination and harm. Scholars who are skeptical of engagement with medical institutions and contexts would probably recognize that it is important and inevitable for Black Americans to engage with the medical system to address very real medical needs. And both sets of scholars would agree that discrimination is a structural harm that demands structural solutions.¹⁹

Thus, on a spectrum that ranges from pro- to anti-medical engagement, most of the scholarship clusters around the middle. But relative to each other, it is fair to distinguish two approaches along the axis. One group of scholars rests on a portion of the spectrum that is more hopeful and more enthusiastic about creating deeper relationships between medical institutions and racial minorities and hopes to use medicine as a site for justice. A second group is far more skeptical and, in most cases, I believe, would prefer avoiding medical framing in racial justice advocacy where possible. Thus, where these scholars diverge is on the degree to which racial justice advocates should rely on medicine.

Scholars who seek to leverage medicine as a site for justice often begin by documenting medical disparities that show how Black individuals are overlooked by the medical system. Law professor Ruqaiijah Yearby, for example, has offered compelling accounts of the disparities in health care, including lack of access to insurance, providers, and preventive services,

16. Rob Stein, *Sickle Cell Testing of Athletes Stirs Discrimination Fears*, Wash. Post (Sept. 20, 2010), <https://www.washingtonpost.com/wp-dyn/content/article/2010/09/19/AR2010091904417.html> (on file with the *Columbia Law Review*).

17. *Id.*

18. Keith Wailoo, *Dying in the City of the Blues: Sickle Cell Anemia and the Politics of Race and Health* 185 (2001); see also *id.* at 179, 185–89 (discussing the controversy within the African American community).

19. This includes addressing housing, welfare, implicit bias, and a range of other harms in order to further racial equity throughout society.

and she argues for additional data collection to address these harms.²⁰ Dean Dayna Matthew has similarly explained how implicit bias among medical professionals means that patients of color do not get the treatment they need; many medical professionals fail to treat Black Americans properly, believing them to be untruthful or invulnerable to pain.²¹ In other contexts, scholars have sounded the alarm because drug trials have not included, or found it hard to recruit, minorities.²² Overall, Black Americans are nearly twice as likely to be uninsured and less than half as likely to have received mental health care than non-Hispanic white Americans.²³ Infant mortality within the Black community is nearly twice the national average.²⁴ During the COVID-19 pandemic, Black Americans died of the disease at nearly twice the rate of the general population; in some majority-Black counties, the death rate approached six times the death rate of majority-white counties.²⁵

Indeed, various advocates and medical professionals have gone further, using medical discourse and framings to conceptualize racial inequity even outside of medical contexts. For example, some have compared racism generally to “cancer” and an “epidemic,” and over one-hundred jurisdictions have called racism a public health emergency.²⁶ Similarly, scholars who see promise in medical framing look to housing, welfare, education, and the like, and argue that we should advance medical frames to promote claims in those spaces.²⁷ They draw on the scholarship of so-called social

20. Ruqaiyah Yearby, *Breaking the Cycle of “Unequal Treatment” With Health Care Reform: Acknowledging and Addressing the Continuation of Racial Bias*, 44 *Conn. L. Rev.* 1281, 1320 (2012) [hereinafter Yearby, *Breaking the Cycle*] (“Race matters because physicians continue to exhibit conscious and unconscious racial prejudice that affects physician’s treatment decisions (interpersonal), health care entities closures and relocations remain linked to race and re-enforce racial hierarchy (institutional), and the health care system is based on ability to pay not need (structural).”).

21. Dayna Bowen Matthew, *Just Medicine: A Cure for Racial Inequality in American Health Care* 176–80, 190 (2015).

22. Blake Farmer, *COVID Vaccine Trials Move at Warp Speed, but Recruiting Black Volunteers Takes Time*, *Kaiser Health News* (Sept. 16, 2020), <https://khn.org/news/covid-vaccine-trials-move-at-warp-speed-but-recruiting-black-volunteers-takes-time/> [https://perma.cc/6CVK-Q3MK].

23. Sofia Carratala & Connor Maxwell, *Health Disparities by Race and Ethnicity*, *Ctr. for Am. Progress* (May 7, 2020), <https://www.americanprogress.org/issues/race/reports/2020/05/07/484742/health-disparities-race-ethnicity/> [https://perma.cc/2TED-EKTZ].

24. *Id.*

25. Leana S. Wen & Nakisa B. Sadeghi, *Addressing Racial Health Disparities in the COVID-19 Pandemic: Immediate and Long-Term Policy Solutions*, *Health Affs.* (July 20, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20200716.620294/> [https://perma.cc/CF9B-UXSP].

26. Craig Konnoth, *Medical Civil Rights as a Site of Activism: A Reply to Critics*, 73 *Stan. L. Rev. Online* 104, 104–05 (2020) [hereinafter Konnoth, *A Reply to Critics*].

27. E.g., Dayna Bowen Matthew, *Health and Housing: Altruistic Medicalization of America’s Affordability Crisis*, 81 *Law & Contemp. Probs.* 161, 161 (2018) (“This article argues in favor of responding to the lack of affordable housing in America as a public health crisis.”).

determinants of health, which shows that lacking important resources can be as, if not more, detrimental to one's health as contracting a disease further down the line—and that addressing these harms by providing housing or income support can improve health more than many medical interventions.²⁸ Consequently, they may advocate for “removing the silos that view social aspects of life outside the jurisdiction of medicine” and integrating our understanding of social harms, such as homelessness, with medical burden.²⁹

However, many scholars have also warned about the overmedicalization of Black individuals. For example, following in the footsteps of other scholars, Colleen Campbell has recently interrogated the focus of some well-meaning actors on including minorities in COVID-19 clinical trials.³⁰ She raises the concern that the demands for racial inclusion in clinical trials rely on a narrative that racial minorities are biologically different and these differences therefore mean that existing trials will be of limited application to them unless they are part of the trial.³¹ Other scholars note that Black Americans are overrepresented at nearly twice the rate of their proportion in the population in early-stage clinical trials when the risk of a new drug is high and benefits are low;³² representation drops in later-stage trials, where benefits are high.³³ Further, given that Black Americans are nearly twice as likely as non-Hispanic white Americans to be uninsured,³⁴ access to drugs on the market is even lower. Similarly, Professor Matiangai Sirleaf explains how “inclusion” shades into exploitation when Black people are used as testing grounds for new drugs and medical techniques, as they have been for centuries.³⁵ More generally, while some scientific studies seek to be “inclusive” of race in medicine by seeking to understand the negative outcomes among Black Americans, many of them focus on biological difference which, at best, shifts focus away from the

28. See *id.* at 166–70 (“Housing, in particular, has been shown in a number of epidemiological studies to be an important determinant of population health.”).

29. *Id.* at 162. See generally Yearby, *Breaking the Cycle*, *supra* note 20, at 1320 (arguing that physicians continue to express conscious and unconscious racial prejudice and so structural changes are required to better treat patients of color).

30. Colleen Campbell, *Racial Inclusivity in COVID-19 Vaccine Trials*, Bill of Health Harv. L. Petrie-Flom Ctr.: Bill of Health (Sept. 22, 2020), <https://blog.petrieflom.law.harvard.edu/2020/09/22/racial-inclusivity-covid19-vaccine-trials/> [https://perma.cc/V7RS-TGUF].

31. *Id.*

32. Jill A. Fisher & Corey A. Kalbaugh, *Challenging Assumptions About Minority Participation in US Clinical Research*, 101 *Am. J. Pub. Health* 2217, 2220 (2011).

33. See *id.* at 2217 (highlighting that existing research on minority participation in clinical trials tends to focus on their historical underrepresentation in Phase III clinical trials, when potential health benefits are greatest).

34. See *supra* note 20 and accompanying text.

35. See Matiangai Sirleaf, *Disposable Lives: COVID-19, Vaccines, and the Uprising*, 121 *Colum. L. Rev. Forum* 71, 79–83 (2021).

structural harm Black Americans experience and naturalizes racial difference as biologically based.³⁶ At worst, they partake of tropes of Black biological inferiority.³⁷

Consequently, many scholars advocate against linking race and medicine when possible. Some suggest that any attempt to use race in contexts involving medical research should implicate strict scrutiny or analogous approaches.³⁸ Some argue for so-called racial impact statements whenever race is to be included in research.³⁹ Others suggest that race should not be treated as a biological category in research—rather, it should be understood to be a social construct, used when it “further[s] compelling interests in improving health care and promoting racial equality” and is “narrowly tailored to further these interests.”⁴⁰

Both sets of scholars raise important considerations, but neither set of narratives fully captures the relationship between race and medicine. To the extent that precision is necessary to help identify a solution, it is important to precisely conceptualize how these contradictory narratives can coexist.

II. DOUBLE-BINDS IN LEGAL SCHOLARSHIP

The contradictory impulses that characterize medicine’s treatment of Black Americans and, thus, the contradictions in the scholarship that studies the relationship between race and medicine arise because medicine creates a double-bind for race. This Part elucidates the concept of the double-bind in legal scholarship, which the next Part then connects back to race and medicine.

The concept of the double-bind was itself developed in relation to the medical diagnosis of schizophrenia by anthropologist Gregory Bateson and his colleagues.⁴¹ They explained that a double-bind involves both a

36. Konnoth, *Law, Minorities, and Medical Oppression*, supra note 6 (manuscript at 46–47 & n.323).

37. *Id.* at 50–51.

38. Under strict scrutiny, a court will only permit the use of race if it is narrowly tailored to a compelling state interest. For an argument that the FDA should look to strict scrutiny to help guide when government should allow the usage of racial categories in biomedicine, see Osagie K. Obasogie, *Beyond Best Practices: Strict Scrutiny as a Regulatory Model for Race-Specific Medicines*, 36 *J.L. Med. & Ethics* 491, 491 (2008).

39. *Id.* at 496 (“These committee members . . . could play a critical role in assessing the social impact of a proposed racial indication relative to its benefits—including whether it promotes unfounded genetic theories of racial difference.”); see also Jonathan Kahn, *Genes, Race, and Population: Avoiding a Collision of Categories*, 96 *Am. J. Pub. Health* 1965, 1967 (2006) (requiring a “tight fit” in the analysis).

40. Dorothy E. Roberts, *Legal Constraints on the Use of Race in Biomedical Research: Toward a Social Justice Framework*, 34 *J.L. Med. & Ethics* 526, 532 (2006).

41. Gregory Bateson, Don D. Jackson, Jay Haley & John Weakland, *Toward a Theory of Schizophrenia*, 1 *Behav. Sci.* 251, 253–58 (1956).

figure of authority and a subject.⁴² This hierarchical relationship is a key aspect of the double-bind.⁴³ In addition to this relationship, there are three other factors. First, the authority figure imposes a “primary injunction” on the subject that requires the subject to follow a certain instruction or suffer some kind of negative consequence at the hand of the authority figure.⁴⁴ Second, the authority figure issues a “secondary injunction” in some other way, that not only negates the first injunction but also places a conflicting demand on the subject.⁴⁵ And, third, the subject cannot escape from the double-bind by, say, eschewing the relationship in which the hierarchy is embedded, at least not without some great cost.⁴⁶

The classic example that Bateson and his colleagues offered was a situation in which a mother told a child that she loved them (the primary injunction) while, at the same time, indicating aversion through her body language (the secondary injunction).⁴⁷ The child is thus caught in a dilemma—at one level of communication, the mother is indicating a willingness to be embraced, but, at another level or through a different form of communication, she is telling the child to stay away.⁴⁸ This dilemma is sharper than if the mother were to make a statement verbally and then verbally negate that statement. In such a situation, the second statement clearly negates the first. In Bateson’s example, however, since the signals are sent through different modes of communication (speech versus gestures), they both remain valid, creating the double-bind.⁴⁹ Bateson and his coauthors theorized that these kinds of demands played a role in producing schizophrenia.⁵⁰

In legal contexts, most prominently in antidiscrimination law, “double-binds” are described in three ways. First, there are double-binds that impose material harms: Whatever choice the subject makes, they suffer deprivation—choosing between food or shelter for example. Second, subjects may also have to make choices regarding social roles—in particu-

42. See *id.* (describing one of the necessary ingredients of a double-bind situation to be two or more people, one of whom is a victim).

43. See Michele Goodwin, *Assisted Reproductive Technology and the Double Bind: The Illusory Choice of Motherhood*, 9 *J. Gender, Race & Just.* 1, 9 (2005) (describing the hierarchical power relationship between parent and child as an example of double-bind theory).

44. Bateson et al., *supra* note 41, at 253.

45. *Id.* at 253–54.

46. See, e.g., *id.* at 254.

47. Mathijs Koopmans, *Schizophrenia and the Family: Double Bind Theory Revisited* (1997), <https://goertzel.org/dynapsyc/1997/Koopmans.html> [<https://perma.cc/K9J9-FQAC>].

48. Goodwin, *supra* note 43, at 9.

49. The child’s ability to “respond to the mother is incapacitated by such contradictions across communicative levels, because one message invalidates the other.” Koopmans, *supra* note 47.

50. Bateson et al., *supra* note 41, at 256.

lar, mainstream society might impose conflicting identity demands on minorities.⁵¹ Third, the subject may have to choose between roles imposed on them by *different* social groups: Mainstream society may demand some form of assimilation into mainstream identity, while the minority group they belong to may reject such assimilation.⁵² This Part lays these variations out below.

A. *Variation One: Material-Based*

First, double-binds are dilemmas in which society might impose conflicting material choices on individuals. With a limited amount of money, an individual might have to choose between food or housing, a dilemma that has become particularly stark during the pandemic.⁵³ But these conflicts may go beyond pure financial harm. As feminist legal scholar Mary Becker powerfully describes, “[m]others are often held criminally accountable for their children’s abuse by another . . . [y]et social and legal supports for their leaving are absent.”⁵⁴ Thus, mothers often have to choose between two material harms: risk the criminal liability that may come with staying with their abusive partner, or suffer the financial and other burdens arising from leaving. Furthermore, various racial and ethnic groups face consistent double-binds, experiencing life-long conflicts rife with choices that impose hefty costs.⁵⁵

51. This Piece separates symbolic and material roles based on the approach by scholars such as Nancy Fraser. See Craig Konnoth, *The Normative Bases of Medical Civil Rights*, in *Disability, Health, Law, and Bioethics* 200, 200–10 (I. Glenn Cohen, Carmel Shachar, Anita Silvers & Michael Ashley Stein eds., 2020).

52. This Piece is focused on double-binds as experienced by minorities, which some believe is characteristic. See Marilyn Frye, *Oppression*, in *Gender Basics: Feminist Perspectives on Women and Men* 10, 11 (Anne Minas ed., 2d ed. 2000) (“One of the most characteristic and ubiquitous features of the world as experienced by oppressed people is the double bind—situations in which options are reduced to a very few, and all of them expose one to penalty, censure, or deprivation.”).

53. See David Noriega, “Paying Rent or Buying Food”: Meet the People Fueling the Movement to Cancel Rent During the Pandemic, *Vice News* (May 1, 2020), <https://www.vice.com/en/article/pke749/paying-rent-or-buying-food-meet-the-people-fueling-the-movement-to-cancel-rent-during-the-pandemic> [<https://perma.cc/ZCH8-GR4G>]; Clare O’Connor, “I Have to Choose Between Food and Rent”: Meet the McDonald’s Workers Fighting for Fair Wages, *Forbes* (July 22, 2013), <https://www.forbes.com/sites/clareoconnor/2013/07/22/i-have-to-choose-between-food-and-rent-meet-the-mcdonalds-workers-fighting-for-fair-wages> [<https://perma.cc/63P5-PEBJ>].

54. Mary E. Becker, *Double Binds Facing Mothers in Abusive Families: Social Support Systems, Custody Outcomes, and Liability for Acts of Others*, 2 *U. Chi. L. Sch. Roundtable* 13, 20 (1995).

55. John O. Calmore, *A Call to Context: The Professional Challenges of Cause Lawyering at the Intersection of Race, Space, and Poverty*, 67 *Fordham L. Rev.* 1927, 1938 (1999); Catherine O’Neill, *Variable Justice: Environmental Standards, Contaminated Fish, and “Acceptable” Risk to Native Peoples*, 19 *Stan. Env’t L.J.* 3, 11 (2000); Pamela A. Wilkins, *Rethinking Categorical Prohibitions on Capital Punishment: How the Current Test Fails Mentally Ill Offenders and What to Do About It*, 40 *U. Mem. L. Rev.* 423, 427, 470 (2009).

Recognizing the material harms that individuals experience is important. But those material harms often arise because individuals must conform to certain social roles. The distribution of social goods often depends not just upon the material resources an individual has but the social role they occupy—whether they are a racial, sexual, or other minority. Those who occupy these roles often experience conflict. Thus, as philosopher Marilyn Frye explains, there are costs both to assimilating into stereotypes and failing to do so: “[I]t is often a requirement . . . that we smile and be cheerful. If we comply, we signal our docility . . . [and] participate in our own erasure. On the other hand, anything but the sunniest countenance exposes us to being perceived as mean, bitter, angry, or dangerous.”⁵⁶ Law professors Devon Carbado and Mitu Gulati have produced work showing that racial minorities thus “work” their identity, caught between the demands of being authentic and not seeming dangerous.⁵⁷ And society might impose even more nuanced but conflicting demands. As Professor Michele Goodwin explains, a woman who seeks to have a career is “always going to bump up against notions of what her ‘ideal’ behavior and image should be as a mother, worker, daughter, and caregiver.”⁵⁸

The second and third kinds of double-binds arise from these conflicting demands based on social roles; I refer to them as stereotype-based double-binds.

B. *Variation Two: Stereotype-Based, Single Dominant Group*

The second double-bind variant is what I will call the *classic* “double-bind” concept because it appears in the famous case of *Price Waterhouse v. Hopkins*.⁵⁹ In this case, Ann Hopkins sought partnership at Price Waterhouse. Hopkins was the only woman up for promotion to partner, and her record surpassed those of the eighty-eight other individuals—all men—who were also up for promotion, but nevertheless she was passed over.⁶⁰ The firm told her that to improve her chances, she should “walk more femininely, talk more femininely, dress more femininely, wear make-up, have her hair styled, and wear jewelry.”⁶¹ At the same time, Hopkins was subjected to a conflicting demand, as a classic double-bind scenario envisages: The firm asked her to be more feminine to succeed professionally, but the professional role required her to act in ways that are stereotypically masculine. Thus, as the Court noted, “an employer who objects to aggressiveness in women but whose positions require this trait places

(claiming that mental illness can “point simultaneously to reduced culpability and to potentially enhanced future dangerousness”).

56. Frye, *supra* note 52, at 11.

57. Devon W. Carbado & Mitu Gulati, *Acting White? Rethinking Race in “Post-Racial” America* 24 (2013).

58. Goodwin, *supra* note 43, at 10.

59. 490 U.S. 228, 251 (1989).

60. *Id.* at 233; *Hopkins v. Price Waterhouse*, 618 F. Supp. 1109, 1112 (D.D.C. 1985).

61. *Price Waterhouse*, 490 U.S. at 235.

women in an intolerable and impermissible catch 22: out of a job if they behave aggressively and out of a job if they do not. Title VII lifts women out of this bind.”⁶²

The stereotype-based “double-bind” that women find themselves in has been subject to academic commentary far too extensive to recount here.⁶³ What is notable, however, is that race is largely absent from this kind of double-bind scholarship and some scholars have suggested that sex discrimination is subject to this kind of double-bind more than race. Dean Kim Yuracko:⁶⁴ “[R]acial conformity demands do not place workers in the kind of narrow double-bind at issue in *Price Waterhouse*.”⁶⁵ To be sure, she notes that it is possible to imagine such double-binds arising: In some cases, “[i]f the black man satisfies his role demands, he fails his cultural conformity demands and is likely to be viewed as an uppity and arrogant black man If he satisfies the cultural conformity demands, he almost certainly fails his role demands.”⁶⁶ She argues, however, that “in practice . . . this is not how assimilationist demands operate on racial minorities.”⁶⁷ For women, “[s]exualization demands undermine all female workers both by taking their attention away from nonsexualized skill development and by diminishing how seriously they are taken by others. The double-bind does not depend on the specific subjectivity of any particular female worker.”⁶⁸ On the other hand, “[t]he double bind imposed on racial minorities by normatively white conformity demands is different. The extent to which a minority worker is distracted and

62. *Id.* at 251. Whether the Court’s optimistic assessment of Title VII is accurate, of course, is questionable.

63. See, e.g., Joan C. Williams, Rachel M. Korn & Sky Mihaylo, *Beyond Implicit Bias: Litigating Race and Gender Employment Discrimination Using Data From the Workplace Experiences Survey*, 72 *Hastings L.J.* 337, 406, 431 (2020); Kenji Yoshino, *Covering*, 111 *Yale L.J.* 769, 916 (2002); Kimberly A. Yuracko, *The Antidiscrimination Paradox: Why Sex Before Race?*, 104 *Nw. U. L. Rev.* 1, 32 (2010). On the ground, important reports have referenced the double-bind. See, e.g., Williams et al., *supra*, at 429 (summarizing reports that discuss the bias pattern); Catalyst, *The Double-Bind Dilemma for Women in Leadership: Damned If You Do, Doomed If You Don’t* (2007), https://www.catalyst.org/wp-content/uploads/2019/01/The_Double_Bind_Dilemma_for_Women_in_Leadership_Damned_if_You_Do_Doomed_if_You_Dont.pdf [<https://perma.cc/LDF8-LWST>].

64. Apart from Yuracko, Professor Kenji Yoshino also seems to treat this kind of double-bind as particular to women. Discussing *Hopkins*, he notes that the Court “recognizes that women may be differently situated from other groups in having the dominant group consistently impose seemingly contradictory demands upon them.” Yoshino, *supra* note 63, at 918; see also *id.* at 916 (“[W]omen are also differently situated from [gays and racial minorities] because they are caught in a particularly severe double-bind.”). However, he does not engage in the same degree of comparative reasoning as Yuracko, so this Piece focuses on her work.

65. Yuracko, *supra* note 63, at 32.

66. *Id.* at 33.

67. *Id.*

68. *Id.* at 34.

disadvantaged by having to conform to culturally white norms depends on the subjectivity of the particular employee.”⁶⁹

C. *Variation Three: Stereotype-Based, Demands From Multiple Groups*

Scholars, however, have imagined situations in which racial minorities can be subject to stereotype-based double-binds that address precisely the conflict between the “cultural conformity” and “professional role” demands that Yuracko envisages. Professors Devon Carbado and Mitu Gulati powerfully explore how when one considers *two* sets of authority figures, the double-bind becomes readily apparent. If racial minorities “act white” to conform to mainstream demands, they may attract opprobrium from other minority employees. But if they act too much like a minority, they may not be perceived as sufficiently mainstream. Thus, “[t]he central conflict is to demonstrate that one is black enough from the perspective of the supporting cast and white enough from the perspective of the main characters. The ‘double-bind racial performance’ is hard and risky.”⁷⁰ The world is therefore divided into “good blacks” and “bad blacks.”⁷¹ A similar dynamic is apparent in the LGBT rights context, where LGBT—especially gay—individuals try to assimilate to gain rights,⁷² which in turn, generates criticism from more radical LGBT activists.⁷³ Even so, there remains a premium on being “straight-acting” in the queer community.⁷⁴

Yet, these kinds of demands appear to be a third kind of double-bind, which is subtly different from the second variation that Yuracko explores and that appears in *Price Waterhouse*. In the second variant, it is the dominant group that penalizes the minority group no matter what they do. Thus, the partners of Price Waterhouse wanted Hopkins to behave both feminine and masculine at the same time. In the third variant, there are two groups with different demands—members of the minority group, such as Black colleagues, who demand assimilation into norms associated with the group, and members of the dominant group, such as white bosses, who demand assimilation into norms perceived as more mainstream.

In some ways, the third variant of the double-bind is more permissive than the second variant as it allows the oppressed group to obtain relief to some degree. For example, one might theoretically escape—perhaps by

69. *Id.*

70. Carbado & Gulati, *supra* note 57, at 1. While Carbado and Gulati do offer examples where white individuals might simultaneously demand that certain actors act both Black but not too Black, placing them in the first variant of the double-bind, these examples are mostly offered in passing and are not distinguished from their main examples where it is other members of the minority group imposing demands for perceived authenticity. See *id.* at 9.

71. *Id.* at 100.

72. Courtney Megan Cahill, *The Genuine Article: A Subversive Economic Perspective on the Law’s Procreationist Vision of Marriage*, 64 *Wash. & Lee L. Rev.* 393, 462 (2007).

73. *Id.* at 461.

74. Luke A. Boso, *Acting Gay, Acting Straight: Sexual Orientation Stereotyping*, 83 *Tenn. L. Rev.* 575, 633–64 (2016).

choosing to engage with white over Black colleagues—and gain some (though, probably not full) acceptance from those colleagues by conforming to the norms they impose. However, the second double-bind variant renders wanted (or needed) acceptance from the dominant group impossible. Whatever one does will lead to oppression. In that context, the double-bind is a discursive technique used by the dominant group. Because of its ability to control the discourse, the dominant group can always flip the script in order to engage in oppression. As queer theorist and law professor Janet Halley observes, “The master of a double-bind always has somewhere to go.”⁷⁵

And yet, Yuracko suggests, it would appear that the second variant—the classic, less permissive double-bind—is endemic primarily to sex-based oppression. The relationship between medicine and race proves otherwise.

III. RACE AND THE MEDICAL DOUBLE-BIND

This Part shows how medicine has created double-binds for racial minorities. While each type of the double-binds previously described are relevant, in many ways, the classic, *Price Waterhouse* double-bind, which gives racial minorities no option out, is the most pervasive. To emphasize this point, I reorder the variations, listing the first variation (material double-binds), then the third (stereotype-based double-binds when there are two groups placing demands), and finally, culminating with the second variation—that from *Price Waterhouse* (stereotype-based where demands come from a single dominant group).

A. *Variation One: Material-Based*

To be sure, there are material double-binds—the first of the variants discussed above. Black Americans experience poverty over 2.5 times more than white Americans.⁷⁶ Hence, they are likely to experience double-binds with respect to resources like other poor Americans, in having to choose between medical care and other necessities.⁷⁷ But this double-bind is intensified in the case of Black Americans because, even controlling for income, they experience worse health outcomes and experience worse medical care than other races. As research shows, quite apart from their income levels Black Americans experience worse health results, in part, because of the stressors they are subject to in everyday life, including

75. Janet E. Halley, Reasoning About Sodomy: Act and Identity In and After *Bowers v. Hardwick*, 79 Va. L. Rev. 1721, 1748–49 (1993).

76. John Creamer, Inequalities Persist Despite Decline in Poverty for All Major Race and Hispanic Origin Groups, U.S. Census Bureau (Sept. 15, 2020), <https://www.census.gov/library/stories/2020/09/poverty-rates-for-blacks-and-hispanics-reached-historic-lows-in-2019.html> [https://perma.cc/8R4D-X258].

77. See supra note 2.

racism and discrimination.⁷⁸ Additionally, harms such as employment discrimination can result in lack of access to health insurance and stable incomes, which further impact health.⁷⁹ Access to substandard education and housing segregation (often in areas where there are higher levels of environmental pollution than elsewhere) are other determinants of health that result in worse outcomes for racial minorities.⁸⁰ Further, minorities have more limited access to the healthcare they have a greater need for: They are less likely to have insurance than white Americans;⁸¹ less likely to live in proximity to providers (meaning that they have to take more time

78. David R. Williams, Stress and the Mental Health of Populations of Color: Advancing Our Understanding of Race-Related Stressors, 59 *J. Health & Soc. Behav.* 466, 468–69 (2018) (“Discrimination, like other stressors, can affect health through both actual exposure and the threat of exposure.”); Bobbi M. Bittker, Racial and Ethnic Disparities in Employer-Sponsored Health Coverage, ABA (Sept. 7, 2020), https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/health-matters-in-elections/racial-and-ethnic-disparities-in-employer-sponsored-health-coverage/ (on file with the *Columbia Law Review*) (“White supremacy influenced an evolving, private, job-based, health care infrastructure that deliberately excluded the Black population, preventing it from sharing in its societal benefits.”).

79. See Bittker, *supra* note 78 (“Many [BIPOC] are working low-wage, essential jobs, exposing themselves to health risks, while they lack insurance. Health care linked to employment is neither a sustainable nor equitable model.”).

80. See George T. O’Connor, Lucas Neas, Benjamin Vaughn, Meyer Kattan, Herman Mitchell, Ellen F. Crain, Richard Evans III, Rebecca Gruchalla, Wayne Morgan, James Stout, G. Kenneth Adams & Morton Lippman, Acute Respiratory Health Effects of Air Pollution on Children With Asthma in US Inner Cities, 121 *J. Allergy & Clinical Immunology* 1133, 1138 (2008) (observing associations between short-term increases in air pollutant concentrations and health outcomes, including reduced pulmonary function, respiratory symptoms, and missed school days related to asthma among urban children with moderate-to-severe asthma); Rebekah J. Walker, Joni Strom Williams & Leonard E. Egede, Influence of Race, Ethnicity and Social Determinants of Health on Diabetes Outcomes, 351 *Am. J. Med. Scis.* 366, 368–69 (2016) (“[A]n important component that is often ignored is the role of social determinants of health on outcomes, and the possible role these determinants play in disparities Material factors include factors such as income, housing and neighborhood quality, education level and the physical work environment.”).

81. Samantha Artiga, Latoya Hill, Kendal Orgera & Anthony Damico, Health Coverage by Race and Ethnicity, 2010–2019, Kaiser Fam. Found. (July 16, 2021), <https://www.kff.org/racial-equity-and-health-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018/> [<https://perma.cc/5VCU-8SWG>] (“As of 2019, nonelderly [American Indians and Alaska Natives], Hispanic, [Native Hawaiians and other Pacific Islanders], and Black people remained more likely to lack health insurance than their White counterparts.”).

off to travel and spend more resources on travel);⁸² and more likely to experience worse treatment when they do go to providers.⁸³ Thus, Black Americans will have to determine how much of their resources they should spend on healthcare, as opposed to other needs, while getting diminishing returns for their expenditures. In other words, because of their race, they have to expend greater resources to experience the same health outcomes as other racial groups.

The COVID-19 pandemic has intensified these dilemmas. Black Americans are more likely to work in jobs that increase their exposure to the virus. As ReNika Moore, director of the ACLU's Racial Justice Program notes, Black Americans are more likely to work "low-wage, no-benefit jobs deemed 'essential,' like grocery store clerks, warehouse employees, and home health aides."⁸⁴ They also have higher rates of underlying health conditions for the reasons described above.⁸⁵ Yet, as Moore continues, "Without health insurance, sick leave, or savings, these workers still show up, because the alternative—unemployment, eviction, and starvation for themselves and their families—is worse."⁸⁶

B. *Variation Three: Stereotype-Based, Multiple Dominant Groups*

Next, medical frameworks also subject Black Americans to stereotype-based double-binds where different groups subject them to conflicting demands—the third of the variants described in the previous Part. In other words, conforming to mainstream medical frameworks requires deviating

82. See Elizabeth J. Brown, Daniel Polsky, Corentin M. Barbu, Jane W. Seymour & David Grande, Racial Disparities in Geographic Access to Primary Care in Philadelphia, 35 *Health Affs.* 1374, 1378 (2016), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2015.1612> [<https://perma.cc/KR36-N85B>] (2016) (finding that areas of Philadelphia where more than eighty percent of residents were African American have twenty-eight times higher odds of falling into the lowest-primary-care-access regions, and that if there is a low supply of providers relative to the population, people might have to travel farther or wait longer).

83. See Monique Tello, Racism and Discrimination in Health Care: Providers and Patients, *Harv. Health Publ'g* (Jan. 16, 2017), <https://www.health.harvard.edu/blog/racism-discrimination-health-care-providers-patients-2017011611015> [<https://perma.cc/8VB5-LM6Y>] ("Doctors take an oath to treat all patients equally, and yet not all patients are treated equally well. The answer to why is complicated We know that our own subconscious prejudices, also called implicit bias, can affect the way we treat patients.").

84. Hospitalization and Death by Race/Ethnicity, CDC, <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html> [<https://perma.cc/YRQ3-42WP>] (last updated July 16, 2021) ("Race and ethnicity are risk markers for other underlying conditions that affect health, including socioeconomic status, access to health care, and exposure to the virus related to occupation, e.g., frontline, essential, and critical infrastructure workers."); ReNika Moore, If COVID-19 Doesn't Discriminate, Then Why Are Black People Dying at Higher Rates?, ACLU (Apr. 8, 2020), <https://www.aclu.org/news/racial-justice/if-covid-19-doesnt-discriminate-then-why-are-black-people-dying-at-higher-rates> [<https://perma.cc/8J6K-9LAB>].

85. Hospitalization and Death by Race/Ethnicity, *supra* note 84.

86. Moore, *supra* note 84.

from the unique outlook that the Black community has toward medicine because of the discrimination it has experienced at the hands of medical institutions.

Thus, many Black Americans were opposed to the COVID-19 vaccine⁸⁷ due to the understandable fear arising from the ruthless experimentation historically perpetrated upon Black bodies in the United States.⁸⁸ For example, in the 1800s, the so-called father of gynecology, James Marion Sims, perfected his techniques by performing surgeries on enslaved women without using anesthesia, leaving each woman's body "a bloodied battleground."⁸⁹ Similarly, over the course of forty years the federal government conducted experiments on poor Black sharecroppers in the South.⁹⁰ Government officials told them that they were being treated for syphilis.⁹¹ But, instead, the subjects were injected with fake medications, some that were poisonous, rather than cures such as penicillin, while doctors watched them die to examine the hypothesis that syphilis manifested differently in Black bodies.⁹²

Conforming to mainstream demands to take the vaccine, in some ways, can reasonably be seen by some in the Black community as eliding this history. A Black person taking the vaccine must thus negotiate these conflicting demands from separate communities. Similarly, in other medical contexts, a Black person may have to determine whether to evince trust in medical institutions, or whether to harken back to the barbaric experiences of the Black community and relate more skeptically to medical institutions and medical actors.

This often anti-medical stance may be mediated by other frameworks. Commenters have noted that many men who experience discrimination adopt hypermasculine attributes as a coping mechanism—and Black and

87. See Adom M. Cooper, Opinion, America's Health System Betrays Black People Like Me. But I Got the COVID Vaccine Anyway., USA Today (Jan. 12, 2021), <https://www.usatoday.com/story/opinion/voices/2021/01/12/african-americans-black-race-health-care-covid-19-vaccination-column/6622889002/> (on file with the *Columbia Law Review*) (recounting the author's decision to get vaccinated and discussing why many Black Americans fear taking a coronavirus vaccine); Dezimey Kum, Fueled by a History of Mistreatment, Black Americans Distrust the New COVID-19 Vaccines, Time (Dec. 28, 2020), <https://time.com/5925074/black-americans-covid-19-vaccine-distrust/> (on file with the *Columbia Law Review*) ("A poll released by the Kaiser Family Foundation on Dec. 15 revealed that among racial and ethnic groups, Black Americans are the most hesitant to get a vaccine, and continue to remain skeptical.").

88. See Harriet A. Washington, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans From Colonial Times to the Present* 7 (Harlem Moon ed., 2006) ("The experimental exploitation of African Americans is not an issue of the last decade or even the past few decades. Dangerous, involuntary, and nontherapeutic experimentation upon African Americans has been practiced widely and documented extensively at least since the eighteenth century.").

89. *Id.* at 2, 61–66.

90. *Id.* at 159, 164–70.

91. *Id.*

92. *Id.*

Hispanic American men are particularly subject to such discrimination.⁹³ Masculinist frameworks, for various reasons, reject medical care.⁹⁴ Thus, many Black and Hispanic men have to determine whether to conform to the masculinist frameworks that help cope against discrimination or obtain medical care, which again reflects a choice between community and mainstream norms. Engaging with one can lead to rejection from another, resulting, once more, in a double-bind.

C. *Variation Two: Stereotype-Based, Single Dominant Group*

Yet, as noted above, in the context of race, medicine most frequently produces the classic, *Price Waterhouse* double-bind where a single authority group can impose conflicting or inconsistent demands. This can occur in two ways. First, *within* medicine, minorities face a dilemma. On one hand, they seek to invoke medicine to advance equity, as some scholars and activists recommend. On the other hand, invoking medicine might subject them to medicine's coercive power. Second, mainstream medicine itself might impose a set of demands that are inconsistent with the demands of some *other* mainstream framework that apply to minorities, as described more fully below.

Medicine—and its historical analogs—has been used in ways that create double-binds for people of color throughout the American past.⁹⁵ For example, to justify slavery, enslaved persons were painted as uniquely medically inferior.⁹⁶ Some suggested that Black people were born with an “incurable disease” or were “mentally imbecile” or “idiotic.”⁹⁷ Others pointed to physical characteristics as proof of this inferiority as

[p]hysiologists . . . agree[d] that the different complexions among the higher orders of creation [were] too deeply seated in nature to be the effect of climate, food, or disease . . . the negro[’s] . . . complexion and his skullbones . . . [were] thicker than those of the white man or Indian . . . his facial and other bones; his form, and the peculiar structure of his skin, with other differences which might be mentioned.⁹⁸

Simultaneously, slavery was justified because Black people also lacked medical vulnerability. “Such is the constitution of the negro,” explained one defender of slavery, “that he can remain with his feet in the water, and

93. See Wizdom Powell, Leslie B. Adams, Yasmin Cole-Lewis, Amma Agyemang & Rachel D. Upton, *Masculinity and Race-Related Factors as Barriers to Health Help-Seeking Among African American Men*, 42 *Behav. Med.* 150, 157–59 (2016).

94. *Id.*

95. Literature scholar Anna Mollow makes a similar observation. See Anna Mollow, *Unvictimized: Toward a Fat Black Disability Studies*, 50 *African Am. Rev.* 105, 105–07, (2017) (“[F]atphobia and ableism work in conjunction with racism to construct an ideological double bind that rhetorically positions black bodies as incapable of being victimized.”).

96. *Cong. Globe*, 39th Cong., 1st Sess. 246 (1866) (statement of Sen. Davis).

97. *Cong. Globe*, 36th Cong., 1st Sess. 452 (1860) (statement of Sen. Clingman).

98. *Cong. Globe App.*, 34th Cong., 1st Sess. 983 (1856) (statement of Rep. Stewart).

his head exposed to the hottest sunshine, without injury to his health [This] would generally be fatal to white men.”⁹⁹ This medical invulnerability, pro-slavery advocates argued, made Black people particularly suited to enslavement—such that those who sought to escape slavery were simply diagnosed with “drapetomania,” or a desire to run away.¹⁰⁰ Thus, an enslaved Black person was medically sound, but one that sought freedom was pathologized.¹⁰¹

This kind of double-bind continues today because medicine can be used both to liberate and to oppress. Black people are demedicalized when medicine might provide benefits. For example, consider substance abuse treatment within the prison system. Professor of social welfare, Erin Kerrison, argues that white people’s substance abuse “is medicalized and perceived as treatable illness, while non-white substance abusers must confront criminal sanction for the very same behaviors.”¹⁰² In the school setting, Black students are 20% less likely to be diagnosed with autism.¹⁰³ Professor LaToya Baldwin Clark explains that an autism label, instead of the emotional disturbance and intellectual disability labels typically attributed to Black children, yields “more educational resources, such as special aides and expensive therapies, higher high school graduation rates and lower rates of suspensions and expulsions.”¹⁰⁴ Conversely, Black students are more likely to be medicalized when medicine can oppress—thus, they are, on some accounts, twice as likely to be diagnosed with emotional

99. Cong. Globe, 31st Cong., 1st Sess. 1698 (1850) (statement of Rep. Clingman) (arguing for expansion of slavery to the new territories); see also Cong. Globe App., 30th Cong., 1st Sess. 1168 (1848) (statement of Sen. Underwood) (stating that Black people are better able to labor in the Southern climate); Cong. Globe App., 34th Cong., 1st Sess. 985 (1856) (statement of Rep. Stewart) (stating labor is dangerous to white men, while “[t]he negro is in his happy element on a sugar or cotton plantation, and in this condition will laugh [at those who want to] send him to college”).

100. See Konnoth, *Law, Minorities, and Medical Oppression*, supra note 6 (manuscript at 25).

101. *Id.*

102. Erin M. Kerrison, *White Claims to Illness and the Race-Based Medicalization of Addiction for Drug-Involved Former Prisoners*, 31 *Harv. J. Racial & Ethnic Just.* 105, 107 (2015).

103. Spotlight On: Racial and Ethnic Differences in Children Identified With Autism Spectrum Disorder (ASD), CDC, <https://www.cdc.gov/ncbddd/autism/addm-community-report/differences-in-children.html> [<https://perma.cc/47TU-ZFVN>] (last updated Aug. 27, 2019).

104. LaToya Baldwin Clark, *Beyond Bias: Cultural Capital in Anti-Discrimination Law*, 53 *Harv. C.R.-C.L. L. Rev.* 382, 383, 395–404 (2018) (noting that in the 2012–2013 academic year, 87% of children with autism diagnoses graduated with a diploma or certificate, compared to 80% of all children with disabilities, and 64% of children labeled emotionally disturbed; the latter were suspended at seven times the rate of children labeled autistic).

and intellectual disabilities, which are associated with less assistance and high rates of discipline.¹⁰⁵

More broadly, Roberts suggests that if Black people invoke medicine to obtain equity, it will preclude other solutions: We will look “toward genetic explanations and technological solutions,” rather than address broader social manifestations of racism such as housing segregation, employment discrimination, police brutality, and other social ills.¹⁰⁶ Yet, a failure to invoke medical frames can reinforce the medical erasure that Black people experience within medical institutions. Thus, some scholars continue to invoke medicine precisely to advance the structural goals that Roberts promotes.¹⁰⁷ Here we see the classic double-bind, where if Black people invoke medicine then medical institutions and the state will turn away from social and structural solutions and likely deploy medicine in punitive ways. But if Black people eschew medicine, they will lack representation in clinical trials and be forgotten by the medical establishment. If they emphasize their medical needs, those needs will be treated as biologically defining them as inferior.

The narrative, contrary to what Yoshino and Yuracko suggest, closely tracks the *Price Waterhouse* script. In that case, a woman had to appear vulnerable to still be considered sufficiently womanly but also sufficiently nonvulnerable to be considered for a promotion. Here, Black people must appear vulnerable to get medical care but still sufficiently nonvulnerable to avoid being beset by racist tropes.

105. *Id.* at 401 (“[C]hildren who face even one out-of-school suspension are more likely to have contact with the criminal justice system than are children without such a suspension.”); see *id.* at 402 (“[S]tates spent approximately 32% more on children with autism than they did for children diagnosed as emotionally disturbed, and 17% more than they did for children labeled intellectually disabled.”).

106. Dorothy E. Roberts, *Is Race-Based Medicine Good for Us?: African American Approaches to Race, Biomedicine, and Equality*, 36 *J.L. Med. & Ethics* 537, 538 (2008); see also Sharona Hoffman, “Racially-Tailored” Medicine Unraveled, 55 *Am. U. L. Rev.* 395, 420 (2005) (arguing that “because ‘race’ is an incoherent term that eludes clear definition and because its use reinforces misconceptions about biological differences among human populations, it should not be the focus of medical inquiry”); Jonathan Kahn, *From Disparity to Difference: How Race-Specific Medicines May Undermine Policies to Address Inequalities in Health Care*, 15 *S. Cal. Interdisc. L.J.* 105, 125–29 (2005); Craig J. Konnoth, *Drugs’ Other Side-Effects*, 105 *Iowa L. Rev.* 171, 191–93 (2019); Britt M. Rusert & Charmaine D. M. Royal, *Grassroots Marketing in a Global Era: More Lessons From BiDil*, 39 *J.L. Med. & Ethics* 79, 81–82 (2011) (assessing the failure of a drug marketed as a race-based pharmaceutical); Alexandra Shields, Michael Fortun, Evelyn M. Hammonds, Patricia A. King, Caryn Lerman, Rayna Rapp & Patrick F. Sullivan, *The Use of Race Variables in Genetic Studies of Complex Traits and the Goal of Reducing Health Disparities: A Transdisciplinary Perspective*, 60 *Am. Psych.* 77, 78–9, 89–93 (2005); Sarah Tate & David Goldstein, *Will Tomorrow’s Medicines Work for Everyone?*, 36 *Nature Genetics Supp.* S34, S37 (2004).

107. This is precisely what occurred in 2005, when Schering Plough excluded African Americans from trials for a drug for Hepatitis C (a disease that disproportionately affects African Americans). See Lisa Eckstein, *Engaging Racial and Ethnic Groups in the Regulation of Research: Lessons From Research in Emergency Settings*, 12 *Hous. J. Health L. & Pol’y* 1, 32 (2011); see also Tate & Goldstein, *supra* note 106, at S39.

But there is more. This is not the only way in which medicine creates a *Price Waterhouse* double-bind for minority individuals. Medicine sometimes places demands on Black Americans that conflict with the demands that arise from *other* frameworks.¹⁰⁸ A pertinent example of this involves the mask mandates implemented during the COVID-19 pandemic.¹⁰⁹ Early in the pandemic, to preserve a supply of surgical masks for medical personnel, both the CDC and states recommended that individuals wear other types of masks, including homemade covers made from bandanas and T-shirts.¹¹⁰ So in order to comply with the social imperatives of COVID-19, all individuals were supposed to wear some type of mask. However, Black Americans, especially Black men, can be profiled as dangerous for wearing a face covering.¹¹¹ Researchers have empirically established that some respondents find Black men wearing homemade cloth coverings and bandanas more threatening, though white individuals experience no change in attitude when wearing similar face coverings.¹¹²

As a result, Black individuals have faced police harassment and arrest both for *not* wearing masks,¹¹³ as well as *for* wearing masks.¹¹⁴ In an empiri-

108. Note that this is *not* the third variant, where members of the minority group and members of the dominant group place incompatible demands. Here, it continues to be mainstream society placing conflicting demands on individuals—but using different frameworks. This might merit a fourth variation, but I continue to classify it within the *Price Waterhouse* framework.

109. I thank Tim Lovelace for noting this example.

110. Your Guide to Masks, CDC, <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-to-make-cloth-face-covering.html> [<https://perma.cc/D2ED-J82Y>] (last visited Aug. 17, 2021); see also Caroline V. Lawrence & the COVID-Dynamic Team, Masking Up: A COVID-19 Face-off Between Anti-Mask Laws and Mandatory Mask Orders for Black Americans, 11 Calif. L. Rev. Online 479, 484 & n. 27 (2020).

111. See Maria Boynton, Black While Masked “Dangerous”, V-103, at 01:55–02:50 (Apr. 11, 2020), <https://www.audacy.com/v103/blogs/maria-boynton/naacp-joins-call-to-suspend-georgia-anti-mask-law> [<https://perma.cc/7SSF-KD2Y>] (noting instances where Black persons have been profiled for wearing homemade masks and expressing concern over this trend).

112. Leah Christiani, Christopher J. Clark, Steven Greene, Marc J. Hetherington & Emily M. Wager, Masks and Racial Stereotypes in a Pandemic: The Case for Surgical Masks, *J. Race, Ethnicity & Pol.*, June 2021, at 1, 9.

113. See Lawrence et al., *supra* note 110, at 495–97 (discussing selective enforcement of mask laws against Black persons); Chas Danner, Philly Police Drag Man From Bus for Not Wearing a Face Mask, *N.Y. Mag.: Intelligencer* (Apr. 10, 2020), <https://nymag.com/intelligencer/2020/04/philly-police-drag-man-from-bus-for-not-wearing-a-face-mask.html> [<https://perma.cc/2V7M-E2L6>] (describing an incident where police forcibly removed a Black man from public bus for not wearing a mask).

114. Jeanie Stephens, (Updated) Video: Wood River Officer Made Men Leave Walmart Because They Wore Masks, *Telegraph* (Apr. 7, 2020), <https://www.thetelegraph.com/news/article/Video-Wood-River-officer-has-men-leave-Walmart-15154393.php> (on file with the *Columbia Law Review*) (describing an incident where a police officer enforced a law prohibiting persons from wearing masks against two Black men).

cal study, Black respondents noted that their primary concern about wearing masks was “police interaction or racial profiling.”¹¹⁵ As the ACLU’s Moore notes, “Not wearing a protective bandana goes against CDC recommendations and increases the risk of contracting Covid-19, but wearing one could mean putting their lives at risk of getting shot or killed because of racially-biased targeting.”¹¹⁶

This, then, is another classic double-bind—Black Americans are endangered both for, and for not, wearing masks. Or as one educator explained: “I want to stay alive but I also want to stay alive.”¹¹⁷ And as a professor of health policy stated, the choice depended on “[w]hich death . . . they choose . . . Covid-19 or police shooting.”¹¹⁸ But the double-bind here is not based solely on medical frameworks. Rather, it is multiple conflicting frameworks that create the dilemma. On one hand, medical institutions and norms place certain demands on Black Americans. On the other hand, other coercive forces to which Black Americans are subject, including police profiling, penalize them for conforming to those norms.

But this dilemma is more generalizable. Critical theorists have long problematized mandates that society imposes on and inculcates in individuals to engage in self-discipline.¹¹⁹ These practices promote surveillance and strongarm individuals into certain behaviors in ways that do not conform to science. One fraught example is the case of obesity. Scholars problematize the medicalization of obesity, accompanied with social pressures that demand healthy eating and certain forms of physical activity. Some suggest that the medical evidence for many antiobesity claims is limited; rather, these claims derive from the financial incentives of the diet and fitness industry.¹²⁰ The pressures which obese individuals experience range from the creation of a culture of surveillance through various tracking devices,¹²¹ financial penalties from employer wellness programs, higher out

115. Lawrence et al., *supra* note 110, at 502 (“Black respondents . . . listed police interaction or racial profiling as the greatest harm that could come to them from wearing a mask.”).

116. Fernando Alfonso III, *Why Some People of Color Say They Won’t Wear Homemade Masks*, CNN (Apr. 7, 2020), <https://www.cnn.com/2020/04/07/us/face-masks-ethnicity-coronavirus-cdc-trnd/index.html> [<https://perma.cc/CLB3-YKTU>] (quoting ReNika Moore).

117. *Id.* at 497–98.

118. Usha Lee McFarling, ‘Which Death Do They Choose?’: Many Black Men Fear Wearing a Mask More Than the Coronavirus, *Stat News* (June 3, 2020), <https://www.statnews.com/2020/06/03/which-deamany-black-men-fear-wearing-mask-more-than-coronavirus/> [<https://perma.cc/V63G-YZ2F>].

119. Konnoth, *Law, Minorities, and Medical Oppression*, *supra* note 6 (manuscript at 15–18) (discussing disciplinary forms of medical power).

120. Mollow, *supra* note 95, at 110.

121. See Rachel Sanders, *Self-Tracking in the Digital Era: Biopower, Patriarchy, and the New Biometric Body Projects*, 23 *Body & Soc’y* 36, 39 (2017) (“[T]he construction of an American ‘obesity epidemic’ enables biopower to extend bodily surveillance and regulation in the name of public health. Digital self-tracking devices are the latest element of a vast

of pocket health costs, and shaming.¹²² Similarly, drug companies, through advertising, collusion with doctors, and other methods, “mold[] . . . our dispositions and orientations toward pharmaceuticals” and play a role in creating in us an “enthusiasm for diagnosis.”¹²³ They encourage the medicalization of problems such as erectile dysfunction and baldness, among others.¹²⁴ As prominent philosopher of medicine, Nikolas Rose, explains, as a result of these forces, social norms increasingly dictate that “every citizen must now become an active partner in the drive for health, accepting their responsibility for securing their own well-being,” through regular medical checkups for themselves and their children, a focus on diet, fitness, and regular pharmaceutical interventions.¹²⁵

As society maintains these medical norms, good citizens conform to them while those who cannot or do not conform to them are framed as bad citizens.¹²⁶ As scholars have shown, Black Americans who cannot conform to these dictates are disproportionately punished. For example, those who do not conform to norms regarding body weight are painted as lazy and unwilling to eat the proper foods—notwithstanding evidence that health is not uniformly correlated to weight and that weight itself is generally a function beyond the control of the individual, implicating genetics, segregation, and finances.¹²⁷ Black Americans are disproportionately subject to such critiques.¹²⁸ Other scholars make similar observations. For example, law professor and anthropologist Khiara Bridges shows how poor pregnant women of color on Medicaid become “racialized objects of contempt,”¹²⁹ being both medicalized but also failing to conform to the imperatives of self-care for themselves and their fetuses.

assemblage of biometric and regulatory mechanisms granted new legitimacy in the wake of ‘fat panic.’”).

122. Lindsay F. Wiley, *Shame, Blame, and the Emerging Law of Obesity Control*, 47 U.C. Davis L. Rev. 121, 154–60 (2013) (discussing workplace and school-based interventions against obesity).

123. Black Hawk Hancock, Michel Foucault and the Problematics of Power: Theorizing DTCA and Medicalized Subjectivity, 43 J. Med. & Phil. 439, 457 (2018) (internal quotation marks omitted) (quoting Joseph Dumit, *Drugs for Life: How Pharmaceutical Companies Define Our Health* 10 (2012)).

124. Peter Conrad, *The Medicalization of Society: On the Transformation of Human Conditions Into Treatable Disorders* 23–46 (2007).

125. Nikolas Rose, *The Politics of Life Itself*, 18 *Theory, Culture, & Soc’y* 1, 6 (2001).

126. See *id.* at 25 (identifying “an ethic in which the maximization of lifestyle, potential, health, and quality of life has become almost obligatory, and where negative judgments are directed toward those who will not, for whatever reason, adopt an active, informed, positive, and prudent relation to the future”).

¹²⁷ 127. Mollow, *supra* note 95, at 111 (the message that “anyone can (and should) be thin if only they try hard enough . . . function[s] as a weapon of the ‘new racism,’ an ideology that blames racialized social inequalities less on inherited biological deficiencies than on African Americans’ supposed failures of ‘personal responsibility’”).

128. *Id.*

129. Khiara Bridges, *Reproducing Race: An Ethnography of Pregnancy as a Site of Racialization* 127 (2011).

The dilemma of mask mandates is therefore generalizable. On one hand, Black Americans must conform to certain medical norms that society imposes. On the other hand, given social circumstances—poverty, segregation, and criminalization—they often cannot. Consequently, no matter what they do, they are subject to social condemnation.

Where, then, does this leave us?¹³⁰

CONCLUSION

First, the key understanding of the double-bind is that it can never be escaped.¹³¹ I do not believe that rejection of or skepticism toward medical discourse and framing that some scholars evince will solve the problem. Indeed, in some ways it might intensify the problem for precisely the reasons I believe underlie NAACP support for BiDil—eschewing medicine might mean that medical institutions fail to engage with the problems of Black Americans. Further, given how integral a part medical and health framing is to the development of consciousness, activism, and policy—as the racism-as-virus narratives suggest—abandoning medical framing can only be harmful. It will render medicine a tool only for those who are not focused (and perhaps opposed) to improving the plight of Black Americans.

Even so, we cannot apply medicine as-is to the situations that Black Americans face. To be clear, I do not believe that that is what scholars of racial and social justice who seek to engage medicine believe we should do. Indeed, the forceful focus on social determinants of health and changes to medical education, among other policy recommendations, show that they seek to change medicine in foundational ways.¹³² These are important interventions, but medical language and concepts should adopt clearer, more targeted changes when it comes to race and oppression more generally to address the double-binds that medicine creates.

The purpose of this Piece has been to argue that we do not need to choose sides in the medicalization debates in racial justice scholarship. Both sides get it a little right. And while that ambivalence seems strange given that the positions seem so divergent, I offer the double-bind framework to allow us to make space for these opposing views in a conceptually stable way. This also shows that there is space for traditional double-bind theory in the way we think of race.

130. The purpose of this Piece is to explore double-binds in medicine, so I can only sketch a few preliminary thoughts here that await further elaboration in other work. See Konnoth, *Law, Minorities, and Medical Oppression*, *supra* note 6.

131. See Bateson et al., *supra* note 41 (describing inescapability as the third of three factors pertinent to a double-bind nexus).

132. See generally Ruqaiyah Yearby, *Structural Racism and Health Disparities: Reconfiguring the Social Determinants of Health Framework to Include the Root Cause*, 48 *J. L. Med. & Ethics* 518 (2020) (discussing the need to include racism as a social determinant of health).

The solution then is not to choose one side over the other but to disrupt the system and discourse that create the double-bind. At base, that strategy involves activism and advocacy *within* medicine. Rather than taking medicine as is, the racial justice movement must speak to medicine from within its institutions and medical contexts. That engagement should not only involve error correction—for example, teaching doctors that certain ideas that they have are incorrect and eliminating racist views among medical practitioners, though that is a necessary component of the project. Rather, it requires transforming medicine into a space of social justice that places a greater premium on the dignity and autonomy of discriminated-against groups and recognizes how bodies, minds, and health are harmed by the injustices that individuals face both inside and outside of medical contexts. Such an approach takes lessons from both sets of scholars—it engages with medicine and its institutions. At the same time, the vision of medicine with which it engages seeks to disrupt the traditional medical discourses that create the double-bind.¹³³ Explaining how to imbue such narratives within medicine remains the task of future work.

133. Some of my past work does begin to briefly address this idea. See Konnoth, *Medicalization*, *supra* note 1, at 1249–62. See generally Konnoth, *A Reply to Critics*, *supra* note 26 (describing an activist understanding of medical discourse).