Editorial: Critical Race Theory – We Are all Others

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Over the past two years, the persistence of racism in the United States has been particularly pronounced in the policies and actions of the administration of President Donald J. Trump; however, the structure of the United States has been racialized since its inception. This supplement of *Ethnicity & Disease* uses Critical Race Theory (CRT) to explore several implications for public health and public health research. We intend for it to spark conversations in the classroom and among researchers on how racial phenomena operate and how we as a field can address racism. *Ethn Dis*. 2018;28(Suppl 1):219-222; doi:10.18865/ed.28.S1.219.

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Editorial

In her latest book, *The Origin of Others*, Toni Morrison describes how racism persists as celebrated White fiction writers inscribe and normalize it in their work – hence, the assiduous focus on racism in Morrison's books. She also describes how, in seeking to define one's self, Whites created the notion of a racial other, and science played a foundational role in advancing racism.[1] In the introductory tribute to *The Origin of Others*, Ta-Nehisi Coates declares that, "Racism matters." Not only does racism matter, but "To be an 'Other' in [the United States] matters–and the disheartening truth is that it will likely continue to matter."[1] That racism matters in how we understand persistent inequity echoes what Coates argued in his book *Between the World and Me*. Contrary to conventional reasoning about historical discourses, which treats "race" as if it preceded racism, Coates argues—and we agree—that racism preceded race. Indeed, racism created race.[2]

Over the past two years, the persistence of racism in the United States has been particularly pronounced in the policies and actions of the administration of President Donald J. Trump. There are notable actions supporting racist acts as well as inactions, including the refusal of President Trump to denounce the behaviors of White supremacists holding a Unite the Right rally in

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Charlottesville, Virginia.[3] At the same time, perhaps as a result of the open embrace of overt White supremacist acts directed at persons of color, anti-racism activism in scholarly communities has increased in

ways not seen in a long time. It is leading many cities to re-evaluate the meaning of monuments to the confederacy, acknowledging that their placement in some public settings celebrates racist moments of the past. For example, thanks to the efforts of scholar activists like Vanessa Northington Gamble, a medical historian, New York City brought down the Central Park monument to the medical personality, J. Marion Sims. In the 1840s, Sims conducted numerous racist medical experiments on enslaved women. He performed surgical procedures without anesthesia to repair vaginal fistulas.[4] His work was tremendously influential among scientists, earning him the title, the "father of gynecology"; however, "he manipulated the social institution of slavery to perform human experimentations, which by any standard is unacceptable."[4]

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As these converging events reveal, the actions and policies of the present are bound to those of the past. A 2018 incident of two African American men arrested at Starbucks because they wished to use the restroom before making a purchase further highlights just one of the many ways racism persists. The Starbucks organization responded by implementing a system-wide training. This was a step in the right direction; however, continuous evaluation and training will be needed to maintain zero tolerance for discrimination in the organization.

The actions and inactions that prompted the development of Critical Race Theory by Derrick Bell and others more than three decades ago remain central to questions of health inequities today. They continue to render African Americans and other persons of color mere *Faces at the Bottom of the Well,*[5] to quote the title of one of Bell's most influential books.

This supplement of *Ethnicity & Disease* is both timely and critical. The topics addressed represent only a partial story about the persistence of health inequities and the myriad of strategies public health scholar activists use to unpack and address both health inequities and issues of racism. For example, morbidity and mortality data continue to be very important measures of health outcomes; but, they are often attributed primarily to SES, which fails to capture the primacy of racism as a root cause of health inequities.[6] While we acknowledge the impact of economic status on health disparities, racism impacts persons of color at all social and economic levels. Its effects are not limited to people in the lower socioeconomic classes as many social class analyses suggest.[7-9] Conventional SES analyses do not explain why, for example, African Americans and other persons of color in middle or higher socioeconomic classes have elevated rates of hypertension, diabetes, and maternal or child mortality.[10] High economic status does not protect against these conditions. In fact, racism may be an important determinant of the disproportionately higher rates of such conditions in diverse, higher SES populations as shown in the work of public health scholars like David Williams, Thomas LaVeist, Vanessa Gamble, Nancy Krieger, and others.[11-18]

This special issue offers a space in which to tackle structural racism operating through the different socio-ecologic levels. Both racism and the health inequities it produces will persist in our society unless the structural and systemic issues are addressed. Although several recent racist encounters provide evidence of racism's persistence, simply pointing a finger at individual racist actions has little impact on health inequities. For instance, while police officers involved in individual cases of police brutality can be identified and disciplined or even dismissed, it will take comprehensive, system-level change to achieve a zero-tolerance climate for racial profiling in policing. The changes must include new training protocols and provide rewards and consequences for behaviors as appropriate.

Our experience compiling this supplement speaks to its timeliness and the need to clarify further exactly how CRT can inform health equity research. We were only able to include a fraction of the many com-

pelling submissions we received. Ultimately, we included those advancing CRT concepts of particular relevance for public health. All the manuscripts we reviewed purported to use Critical Race Theory; in truth, however, a minority of them lacked any substantive engagement with CRT and, therefore, they were indistinguishable from other "health disparities" studies. Because CRT is a set of strategies for achieving equity, to use the rhetoric of CRT while ignoring the underlying power differentials it targets takes the teeth out of its anti-racism strategies and creates confusion about what CRT really is, which ultimately undermines efforts to achieve equity.[19] To address this concern requires incentivizing comprehensive applications of CRT. A majority of submissions were from junior researchers, including postdoctoral trainees and doctoral students. We see this as a promising sign that more CRT-based research is on the horizon. We recognize how challenging it is to engage CRT empirically and translate the scholarship in ways that are accessible to both critical race scholars and population health scientists.

The articles that make up this collection engage CRT innovatively to conceptualize risk factors and/or risk conditions and their potential health implications. Most of them report findings from qualitative research, which is an essential first step for the field in bringing to light nuanced connotations of various racial concepts. We expect the number of quantitative studies that estimate the effects for public and population health to grow as the field matures.

We could envision no better home for this collection than *Ethnicity & Disease*. To our knowledge, this marks the first time any biomedical journal has published a special issue dedicated to Critical Race Theory. We thank the editors for their vision and enthusiasm for welcoming new approaches to the study of health inequities.

Public health does not function in a vacuum. It reflects the confluence of structure and system in society. The structure of the United States has been racialized since its inception. This supplement uses CRT to explore several implications for public health and public health research. We intend for it to spark conversations in the classroom and among researchers on how racial phenomena operate and how we as a field can address racism. As we see it, the field cannot eliminate national and global inequities unless we tackle racism.

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