Commentary: Just What is Critical Race Theory and What's it Doing in a Progressive Field like Public Health?

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Gloria Ladson-Billings cautiously promotes the use of Critical Race Theory (CRT) to address racism's contribution to educational disparities. Nearly a decade ago, we issued a similar call to the multidisciplinary field of public health. Public health touts its progressive roots and focus on equity, but do those efforts draw on CRT? To answer this question, we define CRT, describe its origin in the field of law, and review the ways its use has grown in the field of public health. Public health interventions and policies rely heavily on evidence; therefore, we re-introduce the semi-structured research method we developed to facilitate empirical application of CRT, ie, the Public Health Critical Race Praxis (PHCRP). *Ethn Dis*. 2018;28(Suppl 1):223-230; doi:10.18865/ed.28.S1.223

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Background

In her seminal paper, "Just What is Critical Race Theory and What's it Doing in a Nice Field like Education?"[1] Gloria Ladson-Billings cautiously promotes the use of Critical Race Theory (CRT) to address racism's contribution to educational disparities. Nearly a decade ago, we issued a similar call to the multidisciplinary field of public health.[2] Public health touts its progressive roots and focus on equity, but do those efforts draw on CRT? To answer this question, we define CRT, describe its origin in the field of law, and review the ways its use has grown in the field of public health. Public health interventions and policies rely heavily on evidence; hence, this special issue's focus on empirical applications of CRT. We re-introduce the semi-structured research method we developed to facilitate the use of CRT in health equity research (ie, the Public Health Critical Race Praxis [PHCRP]), and clarify how PHCRP is related to but distinct from both CRT in the field of law and non-CRT health disparities research. We conclude with recommendations for integrating CRT into the racial health equity movement.

What is Critical Race Theory (CRT)?

Critical Race Theory (CRT) defines the set of anti-racist tenets, modes of knowledge production, and strategies a group of legal scholars of color in the 1980s organized into a framework targeting the subtle and systemic ways racism currently operates above and beyond any overly racist expressions.[3] CRT is but one of various strategies scholars use to understand and challenge racism. The name, Criti-

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cal Race Theory, distinguishes it from two other approaches in law: progressive approaches that are colorblind to racism (eg, critical legal theory, critical feminist theory) and civil rights approaches. With respect to the latter, civil rights approaches rely on the racially unjust legal system strategically, while CRT seeks to eradicate racism from it, which requires radical transformation of the system.[3]

CRT and Public Health: Major Epistemological Differences

Although public health interest in CRT has grown over the last decade, epistemological differences exist between CRT (as it is in law) and public health; therefore, to apply CRT empirically requires translational tools that account for these differences. The two fields differ regarding what constitutes theory vs research vs methods. In public health, 'theory' is a tool for organizing abstract concepts and relationships to predict the performance of exposures, outcomes and other variables under narrowly specified circumstances (eg, interventions). In CRT, theory also encompasses the intellectual and socio-political actions scholars take based on CRT's tenets, concepts and strategies. CRT's call to balance theory and research echoes the public health call issued by Lawrence Green[4] to combine evidence-based practice (as commonly advanced in public health) with practice-based evidence (as contained in the original framing of CRT).

CRT and public health differ regarding at least two fundamental assumptions about science: that science is objective and that a field's core evidence base provides its best approximation of the truth.

As we have discussed elsewhere,[5] the systematic nature of the scientific method enhances the reliability of empirical findings, but this does not necessarily eliminate the influence of racial bias.[6,7] Historically, the health sciences reflected whatever racial notions pervaded society at the time, and rarely included the intellectual contributions of people of color.[8] Racism was rarely considered an important determinant of health. The introduction of CRT for empirical research helps address these concerns directly. Its tools help researchers illuminate racial biases embedded in a field or in a study's aims, methods, conclusions, etc., and develop strategies to address them.

CRT and public health differ in how they perceive a field's core knowledge base. In science, a field's knowledge base centralizes the production of knowledge; each new study contributes at most a tiny increment to an established corpus of knowledge. In CRT, however, it is important to generate knowledge from outside a discipline's core knowledge base. By de-centralizing the knowledge production enterprise, CRT makes it easier for new discoveries not necessarily linked to the existing knowledge tree to emerge. Public health researchers who apply CRT assume the position of an "outsider within." From this perspective, they can more readily identify racial biases in the field and incorporate hither-to marginalized perspectives in their work.[9]

CRT and Health Equity Research

Health equity research can benefit from CRT in two important ways. First, for any field to develop nuanced understandings of complex phenomena requires a shared language. CRT provides an anti-racism lexicon that can serve as the foundation for health equity discourse.[10] The lexicon is more than just a list of terms. Each term has underlying connotations linking it to other concepts and implying logical next steps. Secondly, although CRT was originally intended for scholarship, it can also inform public health practice (eg, interventions, health care). The potential benefits of CRT can only be realized, however, if it is used appropriately; therefore, several public health critical race theorists (also known as healthcrits) have developed tools that help translate CRT for use in health equity research. As we discuss below, one of these tools, the Public Health Critical Race Praxis (PHCRP), includes a semi-structured research process.

Growth of CRT in Public Health

Table 1 presents our experience of significant developments in the uptake of CRT in public health. Health equity advocates were fighting racism (eg. community organizing) and its health implications (eg, building community health clinics) for several decades before CRT was formally introduced to the public health community.[11,12] Such efforts constitute public health's "organic CRT"; they mirror CRT tenets, but developed

Table 1. Timeline of the growth of Critical Race Theory (CRT) in the field of public health

Year	Highlight
Pre-1989	Health equity advocates form professional societies, establish health care facilities, educate communities, lobby policymakers, and engage in social action in myriad ways to counter racism and its health implications in diverse communities
	1985 – U.S. Secretary of Health and Human Services, Margaret Heckler, releases the *Secretary's Task Force Report on Black and Minority Health* (Heckler Report)
	Derrick Bell, the father of Critical Race Theory (CRT): 1973 – publishes *Race, Racism and American Law* and other works laying the foundation for critical race studies; resigns faculty positions in protest of failures
	Kimberle Crenshaw coins the term *intersectionality*
1989	Legal scholars of color formally establish the CRT movement
	Derrick Bell, the father of CRT, publishes the seminal work, *Faces at the Bottom of the Well*
1991	CDC conference: "Is it Race or Racism?"
1993	Cornel West publishes *Race Matters*
	Airhihenbuwa teaches Bell and (other critical race theorists) in health education courses – emphasizing the need to decolonize standard approaches to health education in global settings
1995	Airhihenbuwa publishes *Health and Culture: Beyond the Western Paradigm* (1995) bringing to light imperialism/colonialism embedded in much global public health work and proposing strategies to re-frame such work from the perspectives of those we serve
2000	Camara Jones publishes "Levels of racism: a theoretic framework and a gardener's tale"[13] in the *Am J Pub Health*
	Measures of Racism Working Group established at the US Centers for Disease Control and Prevention (CDC) under Camara Jones
2003	Tony Brown applies CRT to mental health[28]
2006	Schulz and Mullings publish text on Intersectionality geared toward public health community[33]
	Airhihenbuwa publishes *Healing our Differences: The Crisis of Global Health and Politics of Identity* further advancing the theme introduced in *Health and Culture*.
2007	Jennifer Jee-Lyn Garcia and other graduate students establish a multi-disciplinary student-led course on CRT for professional disciplines (eg, public health, public affairs, social welfare)
2008	Centers for Disease Control and Prevention establishes the Racism and Health Workgroup as an official CDC entity
2009	UCLA School of Public Health hosts, "Critical Race Theory and HIV/AIDS Disparities: A Multidisciplinary Think Tank"
2010	Ford and Airhihenbuwa paper[2] in the *American Journal of Public Health* formally introduces CRT to the public health community
	Ford and Airhihenbuwa paper[5] in *Social Science and Medicine* establishes the Public Health Critical Race Praxis (PHCRP) empirical approach
2011	Louis Graham presents a way to apply CRT to research by treating CRT as a theoretical framework and analysis tool[29]
	Thomas and colleagues call for the use of PHCRP to guide future health disparities research and practice[10]
2014	University of Maryland Center for Health Equity sponsors national training institute on PHCRP
	University of Denver sponsors Critical Race Theory & Empirical Methods (eCRT) Symposium launching the eCRT spinoff movement
2015	*UC Irvine Law Review* publishes the special issue, *Critical Race Theory and Empirical Methods*[19]
2016	The *Wisconsin Law Review* publishes the symposium issue, *Critical Race Theory and Empirical Methods*
	Then-president of APHA, Camara Jones, launches a national anti-racism campaign
2017	The *American Journal of Law and Medicine* publishes the symposium issue, Critical Race Theory and the Health Sciences
	Using Public Health Critical Race Praxis as an organizing framework, the UCLA Fielding School of Public Health establishes the Center for the Study of Racism, Social Justice & Health
2018	Social Medicine Consortium launches a global anti-racism campaign
	Ethnicity & Disease is the first biomedical journal to publish a supplement on Critical Race Theory research

Table 2. A comparison of the core elements of six research approaches used to study the health implications of racism

	Research Approach						
Essential Characteristics[a]	**Public Health Critical Race Praxis (PHCRP)**	**Critical Race Theory (CRT)**	**Critical Race Empiricism (eCRT)**	**Racism and Health**	**Health Disparities/ Health Equity**	**Social Epidemiology**	**Multiculturalism**
Based on CRT	Yes	Yes	Yes	No[b]	No	No	No
Racism focus	Yes	Yes	Yes	Yes	No[b]	No[b]	No[b]
Health focus	Yes	No	No	Yes	Yes	Yes	No
Centered in the margins	Yes	Yes	Yes	No[b]	No[b]	No	Yes[c]
Empirical	Yes	No	Yes	Yes	Yes	Yes	No
Accounts for research context	Yes	Yes	Yes	No	No	No	No
Ordered process	Yes[d]	No	No[b]	Yes	Yes	Yes	No

a. For each research approach, all such studies share certain characteristics. *Yes* indicates the specified approach requires studies to have the characteristic. *No* indicates the study characteristic is not essential to the approach.
b. The approach does not require studies to have this characteristic, though health equity research based on the approach often do.
c. Optimally, multiculturalism centers the perspectives of diverse persons; however, many projects described as multicultural do not address attendant racial and power hierarchies.
d. Although PHCRP is a research process, some have drawn on it as an organizing framework only.

independently of CRT. For example, counterstorytelling is a strategy critical race theorists use to challenge dominant narratives about a problem. The article in the *American Journal of Public Health* of the now popular allegory, "A Gardener's Tale," by Camara Jones,[13] which links health disparities to three socioecologic levels of racism, is counterstorytelling, though it was not based on CRT.

CRT is making important conceptual contributions to public health.[14] Critical race theorists publish works that illuminate racial biases woven into scientific understandings. Although the work may not be labeled CRT, the ideas, methods and authors are tied to it directly. *Killing the Black Body,*[15] written by Dorothy Roberts, is an example of this. Researchers engage a single CRT concept to inform health equity research, as exemplified in the relational ethnicity concept from Ford and Harawa.[16,17] Drawing on CRT's social construction of race concept, it proposes strategies for mapping social etiologies linking racism to ethnically (rather than racially) defined populations.[16] Finally, a small but growing number of health equity studies use a CRT-derived framework, such as critical race empiricism (eCRT)[18,19] and, most notably, Public Health Critical Race Praxis (PHCRP), to examine health inequities or produce knowledge[20,21] about them empirically.

Applying CRT Empirically

Informing policy and practice requires studies that build on the CRT-based conceptual advances occurring in public health.[22] In this section, we describe PHCRP, and contrast it with overlapping but not synonymous approaches.

Defining and Using Public Health Critical Race Praxis (PHCRP)

Table 2 lists the essential characteristics of the PHCRP research approach and indicates whether each is essential to six other approaches. CRT focuses on understanding the many contemporary ways racism operates in society. Disparities research examines the causes of racial/ethnic patterns of health and disease. PHCRP applies CRT concepts and methods to studies of racial/ethnic disparities. In addition to examining racism in the focal relationship, PHCRP simultane-

Table 3. PHCRP model by focus and its related CRT-based affiliated principles

Focus	Affiliated Principles
Focus 1: Contemporary Racialization	Primacy of racism – racism is a dominant social force in society
	Race as social construct – phenotypic characteristics have meaning because of socio-political, not biological, factors
	Ordinariness of racism – racism exists in all facets of everyday life, even if not perceived
	Structural determinism –systems of power preserve the interests of dominant group members
Focus 2: Knowledge Production	Social construction of knowledge – study findings reflect research-related biases (eg, a priori assumptions)
	Critical approaches – to challenge initial understandings, "question the question" and perform self-critiques
	Voice – to privilege the perspectives of marginalized communities
Focus 3: Conceptualization & Measurement	Race as social construct – socio-political factors give meaning to phenotypic characteristics
	Intersectionality – oppressive social forces produce interlocking effects and social identities
Focus 4: Action	Critical approaches – to challenge initial understandings, questioning the questioner and perform self-critiques
	Disciplinary self-critique - collective assessment by members of a discipline of unintended racial influence on assumptions, methods, etc.
	Intersectionality – oppressive social forces produce interlocking effects and social identities
	Voice – to privilege the perspectives of marginalized communities

ously examines the racial context in which the research is conducted.

The PHCRP model (Table 3) indicates the major racial equity issues to address at key stages of the research process and the CRT tools to use. As discussed below, PHCRP has three functional components: its race conscious orientation to research; four major focus areas; and CRT-derived lexicon.

Race Conscious Orientation to Research

Whether focused on racism or not, every study occurs within a racial context. So, the first step in the PHCRP process is for researchers to understand and explicate how aspects of the racial context may influence the immediate study. For instance, how might race have shaped the study aims? Which structural factors are at play (eg, funding opportunities that imply a particular racial frame)? After developing racial consciousness about the personal and contextual salience of racism, researchers refine the study based on what is learned.

Four Focus Areas

The focus areas provide the structure needed for optimal use of the CRT concepts. Each focus targets a major sphere of influence through which racism can unwittingly influence a study. The study moves sequentially though iteratively through the four areas of focus as outlined in Table 3. For each focus, researchers use the associated CRT-based principles to understand and address issues of contemporary race relations (Focus 1), knowledge production (Focus 2), conceptualization and measurement (Focus 3), and action (Focus 4), respectively, as they pertain to the study. We briefly describe each focus below.

Focus 1. Contemporary Race Relations

Structural racism evolves over time and context; otherwise it would become obsolete whenever a society's norms or policies change.[23,24] In Focus 1, researchers clarify how racism is salient in the study's time period and account for this in the conceptual model. Retrospective analysis enables one to recognize historical racial mechanisms (eg, racial eugenics);

however, recognizing the ubiquitous structural mechanisms by which racism operates in the early 21st century is more difficult.[24-26]

Focus 2. Knowledge Production

A field's cumulative understandings, including its prior and current racial biases, are contained within its evidence base. In Focus 2, researchers try to understand specific implications of this for their study. For instance, they may reject a widely held theory, contesting the assumptions on which it relies. These decisions naturally influence the study's conceptual model and may influence some methods.

Critical Race Theory is an anti-racist intellectual movement to identify, understand and undo the root causes of racial hierarchies. PHCRP is one of several models that translates CRT for empirical research.

Focus 3. Conceptualization and Measurement

In Focus 3, researchers build on the information gained while working in Focuses 1 and 2 to operationalize the study's racism-related and seemingly non-racial (eg, health outcomes) variables.

Focus 4. Action

The findings should do more than merely support a research industrial complex, they should help unpack and undo the power differentials between professional researchers and the racialized health disparity populations we study. To the extent possible, research should benefit communities directly (eg, researchers should share the findings with them). Researchers take actions that draw on knowledge gained either from the analyses or from the research process.

For guidance on how to achieve the aims of each focus, researchers rely on the set of CRT principles associated with each focus. Table 3 lists each focus and its principles.[5]

CRT-Derived Lexicon

Together the principles and focuses form the PHCRP lexicon. CRT has many core tenets[27]; therefore, frameworks[20,28,29] have sought to distill from CRT those that are most relevant for health equity research.

Discussion

CRT is an anti-racist intellectual movement to identify, understand and undo the root causes of racial hierarchies. PHCRP is one of several models that translates CRT for empirical research. PHCRP's semi-structured process and its attention to the research context distinguish it from other approaches. Based on our review of the literature, we urge health equity researchers to: 1) Learn CRT terminology and integrate it into their work. The limited fluency in CRT that currently characterizes public health sometimes leads researchers to conflate racial, racist and anti-racist concepts. Familiarity with CRT will strengthen effective communication about racial phenomena and develop more advanced conceptual models; 2) Use CRT to conduct empirical research. This can illuminate the mechanisms linking racism to disease, enhance the validity of findings and provide policymakers and interventionists the evidence needed to guide their work; 3) Use CRT to develop and test interventions. CRT's self-reflexivity lends itself well to the three-part approach of the PEN-3[30-32] culturally engaged health education model. PEN-3 challenges interventionists to differentiate positive, existential and negative health behaviors in communities, in part, by taking stock of the assumptions and forms of cultural imperialism that tend to inform their interactions with communities from the global South;[30-32] and 4) Reflexively critique our disciplines. Collective self-critiques can help us understand how our norms and conventions may unwittingly undermine efforts to achieve health equity.

Conclusion

In conclusion, despite the thousands of millions of dollars spent

studying individual-level differences and outcomes, racial health inequities have persisted for decades. Excellent tools exist for studying racial phenomena, but they are underutilized. If public health does not engage CRT, it will be left out of the wider antiracism intellectual movement that is expanding across disciplines. The social and political crises of the present underscore the need for resoluteness in addressing structural racism, a root cause of racial health inequity. PHCRP offers one resource for doing so empirically.

Conflict of Interest

No conflicts of interest to report.

Author Contributions

Research concept and design: Ford, Airhihenbuwa; Acquisition of data: Ford; Manuscript draft: Ford, Airhihenbuwa

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