

INTRODUCTION: CRITICAL RACE THEORY AND THE HEALTH SCIENCES

Khiara M. Bridges, Terence Keel, and Osagie K. Obasogie^{1†}

This symposium volume begins with a simple provocation: race and racism are central to the development of medicine and the health sciences.² If pursuits of health equity are to be taken seriously, this repositioning of race as central rather than peripheral to science and medicine suggests that improved health outcomes and reduced disparities cannot be attained until we acknowledge that these fields are sustained by racialized social, political, and economic forms of governance. Despite the seemingly progressive and socially benevolent role assigned to the health sciences, we must expand our inquiries to understand how they are constituted by forms of reasoning, belief, and practice that cannot be decoupled from power relationships that create racial inequality. The authors in this symposium issue provide a framework for identifying the latent racism within the health sciences and in turn propose new directions for conceptualizing human difference and group disparities.

Within medicine and the health sciences, race is widely understood as a “natural” part of human diversity that scientists and physicians merely observe. These fields largely assume that the visual distinctions that align with social understandings of race reflect real and meaningful biological dispositions. Tied to this is the assumption that these racialized genetic and physiological dispositions explain why certain racial groups may be sicker—or healthier—than others. From this standpoint, racism is thought to be an external social or political variable that has little to do with the processes that shape health outcomes or that influence the measurement of human differences. This perspective is not only woefully inadequate, but also affirmatively harms human health by perpetuating theories of biological race in the clinic, the lab, and within our collective imaginations.

^{1†} Khiara M. Bridges, Professor of Law, Professor of Anthropology, Boston University; Columbia University Department of Anthropology, PhD; Columbia Law School, JD. Terence Keel, Associate Professor of History and of Black Studies, University of California, Santa Barbara; Harvard University, PhD. Osagie K. Obasogie, Haas Distinguished Chair, Professor of Bioethics, University of California, Berkeley, Joint Medical Program and School of Public Health; University of California, Berkeley, PhD; Columbia Law School, JD.

² By health sciences we broadly include any use of the scientific method that is leveraged to provide insight into human and/or population health and behavior. Examples include fields such as epidemiology, genetics, and public health.

Race is conceptually underdeveloped in the health sciences. The idea of race that operates in these fields is informed by nineteenth-century theories of human diversity that reify long discredited notions of racial typologies.³ This framework understands human variation as an expression of “natural laws” that shaped the ancestors of each race and continue to govern the health, behavior, and life chances of their descendants. This view of racial ancestry has been remarkably attractive for scientists and medical practitioners, as it reduces the complexity of human life to discrete, and therefore predictable, biological entities. Races as such can then be organized and governed according to habits of reason, belief, and social practice that sustain and exacerbate inequalities.⁴ As long as human biodiversity is thought to be derived from “nature” or the deep ancestral past, the social, political, and economic factors involved in how we study, imagine, and ultimately engineer the differences that manifest across the social body will remain hidden.

To see race as a natural phenomenon creates barriers for understanding how the human-made environment produces disease outcomes. Thus, the connections between social policy and racial disparities in health go unacknowledged at the level of research design within the laboratory. Rarely does the notion that society shapes biology become a guiding principle in doctor/patient relationships or those between researchers and human subjects. Thus, attention to the social determinants of health and behavior is vital for moving the health sciences toward more innovative conceptions of human biodiversity.

The claim that race is a social construct—a social, economic, and political creation tied to broader ideological commitments concerning racial hierarchy—has typically been used to reject statements of biological essentialism in scientific research. Yet, social constructionism is not the only contribution that a more critical theoretical approach can make. Drawing upon the development of Critical Race Theory (CRT) in fields such as law (where it originated) and education, we can see several possible benefits in bringing CRT to the health sciences.⁵

First, CRT normalizes the practice of documenting inequitable power formations in biomedical institutions and the professional fields that sustain them. A critical race framework would posit that racialized power relationships are a constitutive part of the health sciences. This is a view that directly challenges the more conventional idea that power inequities and racism are merely sporadic aberrations or distortions of an otherwise beneficent system of biomedical knowledge and health management.

³ See generally Terence Keel, DIVINE VARIATIONS: HOW CHRISTIAN THOUGHT BECAME RACIAL SCIENCE (forthcoming January 2018); ANN MORNING, THE NATURE OF RACE: HOW SCIENTISTS THINK AND TEACH ABOUT HUMAN DIFFERENCE (2011); THE NATURE OF DIFFERENCE: SCIENCES OF RACE IN THE UNITED STATES FROM JEFFERSON TO GENOMICS (Evelynn M. Hammonds & Rebecca M. Herzig, eds., 2008).

⁴ See generally STEPHEN JAY GOULD, THE MISMEASURE OF MAN (1981); DOROTHY ROBERTS, FATAL INVENTION: HOW SCIENCE, POLITICS, AND BIG BUSINESS RE-CREATE RACE IN THE TWENTY-FIRST CENTURY (2012)

⁵ Our insights here draw upon the work of Chandra Ford and Amani Nuru-Jeter who have incorporated CRT within the field of epidemiology and public health. See Chandra Ford & Collins Airhihenbuwa, *Critical Race Theory, Race Equity and Public Health: Toward Antiracism Praxis*, 100 AM. J. PUB. HEALTH S30 (2010); Chandra Ford & Collins Airhihenbuwa, *The Public Health Critical Race Methodology: Praxis for Antiracism Research*, 71 SOC. SCI. & MED. 1390 (2010); Amani Nuru-Jeter & Thomas LaVeist, *Racial Segregation, Income Inequality, and Mortality in US Metropolitan Area*, 88 J. URB. HEALTH 270 (2011). See also Osagie K. Obasogie, Irene Headen & Mahasin S. Mujahid, *Race, Law, and Health Disparities: Towards a Critical Race Intervention*, ANN. REV. L. & SOC. SCI. (forthcoming 2018).

Second, CRT emerged as an intervening theoretical model capable of rejecting essentialist understandings of human identity. In so doing, it captured the multi-layered and intersecting forms of discrimination experienced by Black women and other social groups who exist dynamically across multiple axes of identity.⁶ If the health sciences were to take intersectionality seriously, this theoretical orientation would limit the racial essentialism that pervades the field, where social categories such as “Black,” “woman,” and “disabled” are used to capture the totality of a person’s health status without appreciating how these and other social, economic, and political positionalities intersect to shape health outcomes.

Third, one of the major interventions of CRT within the context of law has been documenting the instability of legal protections and exposing the contradictions of rights discourse. The distribution and maintenance of health remains an elusive right for historically marginalized populations despite the fact that the government has facilitated a market for health disparities research and the production of potential drug interventions.⁷ CRT allows us to evaluate how these seemingly progressive biopolitical interventions promise to bring solutions that either reproduce the belief that race is genetic or downplay the structural racism that produces and exacerbates inequality. In the long run, delegating the management of health to the for-profit medical system, genomic research initiatives that reify race, or the pharmaceutical industry abrogates the state’s commitments to providing for the health of the polity and to eliminating the social inequalities that leave some sick and others healthy.

Lastly, incorporating CRT into the study of human populations prompts us to go beyond the quantitative measures fetishized in medical and scientific research. We understand CRT to be inclusive of other disciplinary approaches and therefore synthetic in its analysis. Incorporating this approach to health science research involves understanding the benefits of mixed methods, qualitative analysis, and the role of narrative in articulating scientific claims. It also involves an appreciation for the historical and philosophical implications of documenting biodiversity across the social body. Racism and racial inequalities are not exclusively scientific problems. Yet privileging quantitative methods in our understanding of biodiversity sustains the post-enlightenment fantasy that the “hard sciences” alone can address our social issues. What is needed within the health sciences are new theoretical and conceptual tools capable of recognizing how bodies inherit not merely genes but power relationships, legacies of discrimination, the ideological effects of past social policy, and generational systems of belief.

The articles that make up this special issue explore the embedded nature of race and racism in the health sciences and identify opportunities to disrupt and rethink these arrangements in pursuit of social justice and health equity. Discussed in this issue are the interconnected histories of science, medicine, and law that lead racial differences and disparities to be mistakenly understood as natural phenomena while obscuring their social, political, and economic determinants. Also explored are the theoretical and empirical interventions that bring attention to the constructed nature of our racial imaginations in the health sciences. Additionally, the contributions in this issue expose the methodological challenges associated with developing intersectional

⁶ Kimberle Crenshaw, *Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women*, 43 STAN. L. REV. 1241 (1991).

⁷ For an example, see JONATHAN KHAN, *RACE IN A BOTTLE: THE STORY OF BIDIL AND RACIALIZED MEDICINE IN A POST-GENOMIC AGE* (2012).

approaches that bring focus to other identity standpoints—such as sex, gender, class, sexuality, and disability—when exploring race in the health sciences.

Our hope for this symposium issue is to begin a new conversation on race and the health sciences that appreciates how the biological consequences of discrimination shape our approaches to thinking about human difference and group disparities. We acknowledge, however, that race is not the only form of power that influences the relationships and dynamics within science and medicine; similar patterns can be seen with regard to how sex, gender, sexuality, able-bodiedness, and class mediate scientific knowledge and health outcomes. By bringing CRT to these conversations, this symposium issue can be seen as an early model of how to blend critical theoretical traditions with health sciences conversations in the interest of greater inclusion, better science, improved health outcomes, and social justice.