

THEORIZING RACE AND RACISM: PRELIMINARY REFLECTIONS ON THE MEDICAL CURRICULUM

Lundy Braun[†]

The current political economic crisis in the United States places in sharp relief the tensions and contradictions of racial capitalism as it manifests materially in health care and in knowledge-producing practices. Despite nearly two decades of investment in research on racial inequality in disease, inequality persists. While the reasons for persistence of inequality are manifold, little attention has been directed to the role of medical education. Importantly, medical education has failed to foster critical theorizing on race and racism to illuminate the often-invisible ways in which race and racism shape biomedical knowledge and clinical practice. Medical students across the nation are advocating for more critical anti-racist education that centers the perspectives and knowledge of marginalized communities. This Article examines the contemporary resurgence in explicit forms of white supremacy in light of growing student activism and research that privileges notions of innate differences between races. It calls for a theoretical framework that draws on Critical Race Theory and the Black Radical Tradition to interrogate epistemological practices and advocacy initiatives in medical education.

I. INTRODUCTION

“[T]here are moments when the encounter between present and past suddenly forces itself to the centre of our field of vision. The moment of Trump is one of these. But this eruption does not mean simply that we should paste bits of the past onto the present and see if they fit. The point

[†] Professor of Medical Science and Africana Studies, Brown University; Johns Hopkins School of Public Health, Ph.D. I would like to extend my gratitude to the organizers, Khiara Bridges, Terence Keel, and Osagie Obasogie, and participants in the symposium on Critical Race Theory and the Health Sciences for their many insightful comments on this paper. I would also like to thank members of the RACEGEN listserv for astute analyses over the years of race, racism, and medicine. Special thanks go to the prolific Jay Kaufman who has shared so many examples of racial essentialism with the listserv.

is how the history we already know can be used to make sense of the present.”¹

We are in a historical moment of crisis, of “epic catastrophe,” to use the words of Robin Kelley.² In the years ahead, there will be much soul-searching—and much suffering—as the United States grapples with the fateful presidential election of Donald Trump on November 8, 2016. Simplistic blaming for the outcome will no doubt continue as mainstream media, politicians, pundits, experts, ordinary people—and professional medical societies—rush to normalize the aftermath of a presidential campaign rooted in white supremacy. One thing is certain. Without resistance, the consequences of a changing political, economic, and socio-cultural context for health inequality will be devastating.

This Article offers some preliminary reflections on the implications of this new iteration of racially structured capitalism for the health sector and the scientific knowledge-making systems that are an integral component of the state and its forms of rule. I raise issues important to theorizing racism as it intersects with medicine and medical education, arguing for critical distance on the dominant biomedical framing of disease, its history, and its reductionist logic. I make a very preliminary attempt to link current reform movements, political economy of health, and the long history of critical theorizing about racism and capitalism to systems of knowledge and power. Situating reform initiatives on race in medical education in the contemporary political context, I identify some of their strengths and limitations as presently conceptualized, and conclude by pointing to some hopeful possibilities for the coming period drawn from the insightful analyses of institutional racism by critical race theorists of race (CRT) and the work of the Black Radical Tradition to illuminate how “societies structured in dominance” inform the material practices of medical pedagogy, practice, and research.³

Such theoretical frameworks can provide insight into the cultural appeal of technical fixes for the social and biological complexity of health. Importantly, they can help us stay focused on how the political, economic, and ideological structures of racial capitalism, in which medicine is embedded, work to produce injustice in health and the consequences for knowledge production. Theorizing the relationship between race, racism, and health and the social order is not a mere academic exercise. Theory, as Stuart Hall has argued, has particular political consequences for projects of transformation.⁴ A critical theoretical framework, a framework that engages the historical specificity of medical practice and its interconnections with the market, legacies of slavery, knowledge production, and the changing nature of racial capitalism is necessary, indeed required, at this conjuncture.

¹ Jane Caplan, *Trump and Fascism: A View from the Past*, HIST. WORKSHOP (Nov. 17, 2016), <http://www.historyworkshop.org.uk/trump-and-fascism-a-view-from-the-past/> [https://perma.cc/UL2J-EZ6N].

² Robin D. G. Kelley, *After Trump*, BOS. REV. (Nov. 15, 2016), <http://bostonreview.net/forum/after-trump/robin-d-g-kelley-trump-says-go-back-we-say-fight-back> [https://perma.cc/C4ZX-8YQ7].

³ Stuart Hall, *Race, Articulation, and Societies Structured in Dominance*, in *SOCIOLOGICAL THEORIES: RACE AND COLONIALISM* 305 (UNESCO 1980). See PHILOMENA ESSED & DAVID THEO GOLDBERG, *RACE CRITICAL THEORIES: TEXT AND CONTEXT* (2001); *CRITICAL RACE THEORY: THE KEY WRITINGS THAT FORMED THE MOVEMENT* (Kimberlé Crenshaw et al. eds., 1996).

⁴ Hall, *supra* note 3, at 307.

II. THE ELECTION, THE HEALTH SECTOR, AND SCIENTIFIC KNOWLEDGE
PRODUCTION

Of the many horrific aspects of Trump's election, the targeting of students of color in the ivory towers of knowledge production is especially relevant to this discussion. In marshaling the long history of scientific racism to support a "white America," leaflets being distributed on campuses across the country⁵ demonstrate that conservatives have been busy excavating the history of race, science, and white supremacy. Journalists, academics, and commentators are quick to denounce the intensification of racist violence but they have largely been blind to the historic role of mainstream scientific research in constructing the normativity of whiteness that fuels racist violence. White supremacy, as we are witnessing, is not a thing of the past. What we are witnessing in the United States is no ordinary transfer of power. If there is any remaining uncertainty about the political significance of Trump's presidency as a social project of whiteness, the mobilization of the Ku Klux Klan, the Danish People's Party, and other white supremacist groups in the United States and Nazi-inspired groups all over Europe couldn't be more clear.

In such a poisonous context, tired narratives about intelligence, interracial mixing, and personal responsibility for social conditions abound, drawing now, as in the past, not only on extreme white nationalism but also on mainstream science. And mainstream journalists such as Nicholas Wade or libertarian John Tierney have given white supremacy cover. Some leaflets, for example, feature Wade's deeply disturbing book *A Troublesome Inheritance: Genes, Race, and Human History*.⁶ That the normalization of this horror has been so rapid is worrisome but it also tells us something profound about the United States, its history, and the ways in which racism has structured and continues to structure knowledge-making in science, public health, and medicine.

Un-interrogated and un-refuted whiteness has become free-floating and multi-faceted. As we theorize the present—and figure out how to organize and engage in a theoretically dynamic way—we must begin by acknowledging how these myriad hatreds undergird the political economic history of anti-black racism, supported and reinforced by the scientific and medical enterprise, which, in part unwittingly, has meticulously constructed a narrative of naturalized black deficiency and white superiority, rooted in culture and DNA.⁷

⁵ See, e.g., Steve Annear, *White Supremacist Posters Found at Emerson College*, BOS. GLOBE (Dec. 7, 2016), <https://www.bostonglobe.com/metro/2016/12/07/white-supremacist-posters-found-emerson-college-campus/w6VOW7FjvRPhpSxUgQ2nNI/story.html>; Matthew Rodriguez, *Anti-black Posters on University of Michigan Campus Warn White Women Not to Date White Men*, MIC (Sept. 26, 2016), https://mic.com/articles/155152/anti-black-posters-on-university-of-michigan-campus-warn-white-women-not-to-date-black-men#_7iI8nSlGa [<https://perma.cc/A4YU-MTXA>]; Alia Wong & Adrienne Green, *Campus Politics: A Cheat Sheet*, ATLANTIC (Apr. 4, 2016), <https://www.theatlantic.com/education/archive/2016/04/campus-protest-roundup/417570/> [<https://perma.cc/GM86-URZX>].

⁶ See Hailey Branson-Potts, *In Diverse California, a Young White Supremacist Seeks to Convert Fellow College Students*, L.A. TIMES (Dec. 7, 2016), <http://www.latimes.com/local/lanow/la-me-ln-nathan-damigo-alt-right-20161115-story.html> [<https://perma.cc/BFY3-HVPN?type=image>].

⁷ See LUNDY BRAUN, *BREATHING RACE INTO THE MACHINE: THE SURPRISING CAREER OF THE SPIROMETER FROM PLANTATION TO GENETICS* (2014); KHIARA M. BRIDGES, *REPRODUCING RACE: AN ETHNOGRAPHY OF PREGNANCY AS A SITE OF RACIALIZATION* (2011); TROY DUSTER, *BACKDOOR TO EUGENICS* (2d ed. 2003); ANTHONY RYAN HATCH, *BLOOD SUGAR: RACIAL PHARMACOLOGY AND FOOD JUSTICE IN BLACK AMERICA* (2016); JONATHAN KAHN, *RACE IN A BOTTLE: THE STORY OF BiDiL AND RACIALIZED MEDICINE IN A POST-GENOMIC AGE* (2012); JONATHAN M. METZL, *THE PROTEST PSYCHOSIS: HOW SCHIZOPHRENIA BECAME A BLACK DISEASE* (2011); MELISSA NOBLES, *SHADES OF CITIZENSHIP: RACE AND THE CENSUS IN MODERN POLITICS* (2000); ANNE POLLOCK, *MEDICATING RACE: HEART DISEASE AND DURABLE PREOCCUPATIONS WITH DIFFERENCE* (2012); SUSAN M. REVERBY, *EXAMINING TUSKEGEE:*

Absent from most analyses to date is that the election results represented an unwavering faith in a harsh and violent capitalist enterprise. As titans of racial capitalism, virtually all of Trump's mean-spirited, wealthy, and mostly white appointees are a stark reminder that intensified assaults on the bodies and minds of workers and non-working poor as well as societal safety nets, limited though they are, will be far-reaching in the coming period.

Early clues to how normalization of racism and whiteness will shape the political economy of health and its knowledge-making apparatuses are the responses of medical societies to Tom Price's nomination for Secretary of Health and Human Services. A wealthy orthopedic surgeon from the affluent suburbs of Atlanta, Georgia, Price is a long-term, ardent opponent of Obamacare, Medicare, Social Security, gay rights, and a particularly strident and mean-spirited supporter of personal responsibility constructed on an edifice of anti-black racism.⁸ Immediately after Trump nominated Price, the American Medical Association (AMA) released an unequivocal statement of support highlighting the importance of the market to healthcare and ignoring the long history of anti-black racism embedded in his programs. "Dr. Price," the AMA wrote, "has been a leader in the development of health policies to advance patient choice and market-based solutions as well as reduce excessive regulatory burdens that diminish time devoted to patient care and increase costs."⁹ That the Association of American Medical Colleges and the American Academy of Family Physicians also endorsed Price¹⁰ is a glaring illustration that medicine is part of a broader anti-black, anti-working class, anti-poor constellation of institutions of power, long committed to free markets and privatization and hostile to equitable distribution of healthcare.

Despite concerns about Trump's anti-science approach, the knowledge-making apparatuses of health may align quite seamlessly with his profit-driven approach, especially in the era of private-public partnerships lauded by the National Institutes of Health.¹¹ Of the world's eight richest people, who according to Oxfam own the same

THE INFAMOUS SYPHILIS STUDY AND ITS LEGACY (2009); DOROTHY ROBERTS, *FATAL INVENTION: HOW SCIENCE, POLITICS, AND BIG BUSINESS RE-CREATE RACE IN THE TWENTY-FIRST CENTURY* (2011) [hereinafter ROBERTS, *FATAL INVENTION*]; SAMUEL KELTON ROBERTS JR., *STUDIES IN SOCIAL MEDICINE: INFECTIOUS FEAR: POLITICS, DISEASE, AND THE HEALTH EFFECTS OF SEGREGATION* (2009) [hereinafter ROBERTS, *INFECTIOUS FEAR*]; MELISSA N. STEIN, *MEASURING MANHOOD: RACE AND THE SCIENCE OF MASCULINITY, 1830-1934* (2015); KEITH WAILOO, *DRAWING BLOOD: TECHNOLOGY AND DISEASE IDENTITY IN TWENTIETH-CENTURY AMERICA* (rev. ed. 1999); *THE NATURE OF DIFFERENCE: SCIENCES OF RACE IN THE UNITED STATES FROM JEFFERSON TO GENOMICS* (Evelynn M. Hammonds & Rebecca M. Herzig eds., 2009).

⁸ Amy Goldstein & Philip Rucker, *Trump Names Rep. Tom Price as Next HHS Secretary*, WASH. POST (Nov. 29, 2016), https://www.washingtonpost.com/news/powerpost/wp/2016/11/28/trump-to-name-rep-tom-price-as-next-hhs-secretary/?utm_term=.88c3609a522f [https://perma.cc/PKS3-G5CE]; Robert Pear, *Tom Price, Obamacare Critic, Is Trump's Choice for Health Secretary*, N.Y. TIMES (Nov. 28, 2016), https://www.nytimes.com/2016/11/28/us/politics/tom-price-secretary-health-and-human-services.html?_r=0.

⁹ Press Release, American Medical Association, *AMA Statement on the Nomination of Rep. Tom Price to be HHS Secretary* (Nov. 29, 2016), <https://www.ama-assn.org/ama-statement-nomination-rep-tom-price-be-hhs-secretary> [https://perma.cc/AU7C-8X9G]. Indeed, market solutions are the centerpiece of industry-supported replacement of an already privatized Affordable Care Act. Jessica Glenza, *Insurance Companies Take the Lead on Obamacare Replacement Ideas*, GUARDIAN (Feb. 18, 2017), https://www.theguardian.com/us-news/2017/feb/18/obamacare-repeal-insurance-companies-replacement-plan?CMP=share_btn_tw [https://perma.cc/NWP5-4UGY].

¹⁰ Press Release, Am. Acad. Family Physicians, *Nomination of Tom Price to HHS Secretary Brings Important Medical Perspective to Health Policy*, <http://www.aafp.org/media-center/releases-statements/all/2016/nomination-of-tom-price-to-hhs-secretary.html> [https://perma.cc/2UT4-A2MA].

¹¹ Sheila Kaplan & Dylan Scott, *NIH director Francis Collins Says He Would Remain in Post Under Trump*, STAT NEWS (Dec. 9, 2016), <https://www.statnews.com/2016/12/09/nih-director-francis-collins-says-wants-remain-post-trump/> [https://perma.cc/B3QF-8VJN].

amount of assets as the world's poorest fifty percent, four have invested heavily in health and health technologies.¹² As the already grossly inadequate infrastructure for medical care is dismantled under Price, other sectors of the medical industrial complex, such as the pharmaceutical industry, are poised to reap enormous profits with minimal benefit for the health of the working classes.¹³ Jim O'Neill, managing director at Mithril Capital Management, one of Trump's potential picks to head the FDA, made this later point quite clear when he invoked personal choice for his cynical argument that companies should only demonstrate the safety of a drug before approval—not that they should work!¹⁴ The case of BiDil, an expensive medication for congestive heart failure, which the Boston-based NitroMed, Inc. promoted as race-specific (even though the clinical trial only included African Americans), illustrates the compatibility of market incentives with some health disparities research, under the guise of “social justice.”¹⁵

As breathtaking as the scope of Trump's policies might appear, they will not be implemented without resistance. Activists hold the power to make change. Grassroots movements, committed to a robust social justice framework that centers redistribution of the wealth, anti-racism, and the perspective of the poor,¹⁶ are growing across the nation, providing a space for solidarity in the face of Trump's campaign for xenophobic white nationalism. Two days after Trump's announcement, for example, three medical students from Students for a National Health Program (SNaHP) denounced the selection of Price.¹⁷ A week later, a letter, titled “The AMA Does Not Speak for Us,” was submitted to the President of the American Medical Association with over 5,500 signatures.¹⁸ Medical students, physicians, and health care providers at Case Western Reserve and Harvard Medical School initiated campaigns for the Cleveland Clinic and Dana Farber, respectively to cancel major fundraisers at Trump's Mar-a-Lago estate.¹⁹

¹² Larry Elliott, *World's Eight Richest People Have Same Wealth as Poorest 50%*, GUARDIAN, (Jan. 15, 2017), <https://www.theguardian.com/global-development/2017/jan/16/worlds-eight-richest-people-have-same-wealth-as-poorest-50> [https://perma.cc/9DBY-DJQ9].

¹³ Dylan Scott, *The Drug Industry's Stake in Trumpcare is Bigger Than You Think*, STAT NEWS (Dec. 2, 2016), https://www.statnews.com/2016/12/02/affordable-care-act-trump-pharma/?s_campaign=tw&utm_content=buffer14529&utm_medium=social&utm_source=twitter.com&utm_campaign=buffer [https://perma.cc/B75E-23D7].

¹⁴ Robert Valencia, *Jim O'Neill, Trump's Potential FDA Head, Thinks Drugs Should Be Approved Without Efficacy*, MIC (Dec. 9, 2016), <https://mic.com/articles/161744/jim-o-neill-trump-s-potential-fda-head-thinks-drugs-should-be-approved-without-efficacy#.I2TdfcXOY> [https://perma.cc/4F82-8J2U].

¹⁵ See KAHN, *supra* note 7.

¹⁶ See, e.g., PAUL FARMER, *Health, Healing, and Social Justice: Insights from Liberation Theology*, in *PATHOLOGIES OF POWER: HEALTH, HUMAN RIGHTS, AND THE NEW WAR ON THE POOR* 139 (2004) (describing grassroots movements promoting health).

¹⁷ Janine Petito, Andrew Hyatt & Michael Zingman, *We Condemn the AMA and AAMC Endorsements of Tom Price for HHS Secretary*, COMMON DREAMS (Dec. 1, 2016), <http://www.commondreams.org/views/2016/12/01/we-condemn-ama-and-aamc-endorsements-tom-price-hhs-secretary> [https://perma.cc/X4YW-T35R].

¹⁸ Manik Chhabra, Navin Vij & Jane M. Zhu, *The AMA Does Not Speak for Us*, MEDIUM (Dec. 9, 2016), <https://medium.com/@ClinicianAction/the-ama-does-not-speak-for-us-d697511267d5#.rzf71i88x> [https://perma.cc/M8FL-DRBZ] (the letter had over 6,400 signatures as of Jan. 1, 2017).

¹⁹ Liz Kowalczyk, *Harvard Medical Students, Doctors Urge Cancellation of Fund-raiser at Mar-a-Lago*, BOS. GLOBE (Jan. 31, 2017), <https://www.bostonglobe.com/metro/2017/01/31/harvard-med-students-doctors-urge-cancellation-dana-farber-fundraiser-mar-lago/rMMHQpZb8A6clvscAY3yZO/story.html>; Vanessa Elizabeth Van Doren, *An Open Letter Concerning the Cleveland Clinic Foundation's Support of President Trump*, MEDIUM (Jan. 31, 2017), <https://medium.com/@vanessaelizabethvandoren/an-open-letter-concerning-the-cleveland-clinic-foundations-support-of-president-trump-b6bd901fc711#.ws9dx3owc> [https://perma.cc/HB9J-FVHW] (the letter was delivered to Dr. Cosgrove of the Cleveland Clinic on Feb. 11, 2017).

As public health scholars have shown repeatedly, beginning with the emergence of public health in the United States, the knowledge produced about personal responsibility has been deeply racialized, gendered, and classed.²⁰ But because the history and social studies of race in science, medicine and public health are taught in only a few public health and medical schools,²¹ narratives of personal responsibility have not been adequately interrogated—or refuted—and therefore continue to inform research and explanatory narratives, re-emerging in new and sometimes more palatable guises depending on the larger political, economic, and cultural context. More critical analyses of race and health will be needed in the coming period to center anti-black racism and historic injustice in explanations of racial inequality and, importantly, to re-imagine the way we do science.²²

III. RACE AND MEDICINE: WHAT IS THE PROBLEM?

Trump's policies represent a violent assault on health. To be effective, resistance must link the entrenched history of white supremacy to the dominant theories and practices of public health and medicine as powerful institutions of the state. What, in other words, are the material practices through which racism works in medicine and how are they sustained and perpetuated under racial capitalism? The long history of racially essentialist research has constructed a formidable scientifically-grounded bedrock upon which both avowed white supremacists and well-intentioned physicians can draw, all too easily.

On December 7, 2016, for example, the *Los Angeles Times* published a story about the conversion of a former Iraqi veteran with Post-Traumatic Stress Disorder to white nationalism after he read books by the avowed scientific racist J. Philippe Rushton.²³ But he also read the mainstream journalist Nicholas Wade's *A Troublesome Inheritance*, which draws extensively on population genetics research for evidence that races differ in fundamental ways genetically.²⁴ Race-specific genetics, Wade claims,

²⁰ See Allan M. Brandt, *Behavior, Disease, and Health in the Twentieth-Century United States: The Moral Valence of Individual Risk*, in MORALITY AND HEALTH 53 (Allan M. Brandt & Paul Rozin eds., 1997); SUSAN CRADDOCK, CITY OF PLAGUES: DISEASE, POVERTY, AND DEVIANCE IN SAN FRANCISCO (2000); JUDITH WALZER LEAVITT, TYPHOID MARY: CAPTIVE TO THE PUBLIC'S HEALTH (1996); NATALIA MOLINA, FIT TO BE CITIZENS?: PUBLIC HEALTH AND RACE IN LOS ANGELES 1879-1939 (2006); SHELLEY Z. REUTER, TESTING FATE: TAY-SACHS DISEASE AND THE RIGHT TO BE RESPONSIBLE (2016); ROBERTS, FATAL INVENTION, *supra* note 7; WILLIAM RYAN, BLAMING THE VICTIM (rev. ed. 1976); NAYAN SHAH, CONTAGIOUS DIVIDES: EPIDEMICS AND RACE IN SAN FRANCISCO'S CHINATOWN (2001); KEITH WAILOO, DYING IN THE CITY OF THE BLUES: SICKLE CELL ANEMIA AND THE POLITICS OF RACE AND HEALTH (2001); KEITH WAILOO & STEPHEN PEMBERTON, THE TROUBLED DREAM OF GENETIC MEDICINE: ETHNICITY AND INNOVATION IN TAY-SACHS, CYSTIC FIBROSIS, AND SICKLE CELL DISEASE (2006); Terence D. Keel, *Charles V. Roman and the Spectre of Polygenism in Progressive Era Public Health Research*, 28 SOC. HIST. MED. 742 (2015).

²¹ See David S. Jones et al., *Making the Case for History in Medical Education*, 70 J. HIST. MED. ALLIED SCI. 624 (2015) (citing a 2008 survey finding that 98–112 of 174 medical schools in the United States and Canada had no indication that they offered history courses).

²² See RUHA BENJAMIN, PEOPLE'S SCIENCE: BODIES AND RIGHTS ON THE STEM CELL FRONTIER (2013).

²³ Branson-Potts, *supra* note 6.

²⁴ *Id.* In a letter to the editor of the *New York Times* over 100 population geneticists strongly objected to "Wade's misappropriation of research from our field to support arguments about differences among human societies." Graham Coop et al., Letter to the Editor, '*A Troublesome Inheritance*', N.Y. TIMES (Aug. 8, 2014), <https://www.nytimes.com/2014/08/10/books/review/letters-a-troublesome-inheritance.html>.

have shaped the progress of “civilizations.”²⁵ At first glance, Wade’s ideas might seem shocking. He is, however, no ordinary journalist. A longtime editor of the *New York Times* as well as *Science* and *Nature*, with special interest in genetic findings of racial difference, Wade regularly featured genetic research in the Science section of the *Times* for years. He was thus ideally positioned to influence popular—and most likely scientific—understandings of genes as causes of racial inequalities in disease.²⁶ That he wrote this book soon after resigning from the *New York Times* strongly suggests that his racist ideology did indeed structure his framing of genetic research studies in the *Times*.

While the language, goals, and methodologies of white supremacists, such as Rushton, are unambiguous, Wade drew on well-intentioned scientific research to construct an argument of deep difference. The systematic study of race has been an integral component of knowledge production in what we recognize as “modern” Western science, at least since the Enlightenment.²⁷ Thus the science, which has grounded medical authority even before the Flexner Report of 1909 established medicine on a scientific foundation, is deeply, though often invisibly, racialized.²⁸

The current iteration of reductionist racialized medicine stems in part from the 1993 NIH mandate to include women and minorities in all research.²⁹ As the National Institutes of Health tied government funding to mandates for inclusion and social justice, population geneticists, interested mainly in migratory patterns, recast their research to account for racial disparities in disease.³⁰ Consequently, different types of genetic studies (Ancestry Informative Markers, Genome-wide Association Studies, etc.), structured by race and ethnicity and claiming to causally link genetic markers to complex diseases, such as asthma, diabetes, kidney function, lung function or coronary heart disease, has created much confusion for physicians, medical students, biomedical researchers, and educators.³¹ While the full implications of reductionist explanations have yet to be interrogated in depth, addressing this confusion and the subtle ways in which it has re-vitalized notions of race-as-biology and informed knowledge production about racial inequality in health are important goals of medical education reformers.

²⁵ Michael Balter, *Geneticists Decry Book on Race and Evolution*, SCIENCE (Aug. 8, 2014), <http://www.sciencemag.org/news/2014/08/geneticists-decry-book-race-and-evolution> [<https://perma.cc/BM2M-YPEF>].

²⁶ Lundy Braun, *Reifying Human Difference: The Debate on Genetics, Race, and Health*, 36 INT’L J. HEALTH SERVS. 557, 565-66 (2006).

²⁷ See, e.g., EMMANUEL CHUKWUDI EZE, RACE AND THE ENLIGHTENMENT: A READER (1997); ROBERTS, INFECTIOUS FEAR, *supra* note 7; Jean Comaroff, *The Diseased Heart of Africa: Medicine, Colonialism, and the Black Body*, in KNOWLEDGE, POWER, AND PRACTICE: THE ANTHROPOLOGY OF MEDICINE AND EVERYDAY LIFE 305 (Shirley Lindenbaum & Margaret M. Lock eds., 1993); Terence D. Keel, *Religion, Polygenism and the Early Science of Human Origins*, 26 HIST. HUM. SCI. 3 (2013).

²⁸ See, e.g., BRAUN, *supra* note 7; REUTER, *supra* note 20; ROBERTS, FATAL INVENTION, *supra* note 7; ROBERTS, INFECTIOUS FEAR, *supra* note 7; STEIN, *supra* note 7.

²⁹ National Institutes of Health Revitalization Act of 1993 § 131, 42 U.S.C. § 289a-2 (2012).

³⁰ See, e.g., Esteban Gonzáles Burchard et al., *The Importance of Race and Ethnic Background in Biomedical Research and Clinical Practice*, 348 NEW ENG. J. MED. 1170 (2003); Sarah A. Tishkoff & Scott M. Williams, *Genetic Analysis of African Populations: Human Evolution and Complex Disease*, 3 NATURE REV. 611 (2002).

³¹ Linda M. Hunt et al., *Genes, Race, and Culture in Clinical Care*, 27 MED. ANTHROPOLOGY Q. 253 (2013); Kelsey Ripp & Lundy Braun, *Race/Ethnicity in Medical Education: An Analysis of a Question Bank for Step 1 of the United States Medical Licensing Examination*, TEACHING AND LEARNING MED. (2017); Shedra Amy Snipes et al., *Is Race Medically Relevant? A Qualitative Study of Physicians’ Attitudes About the Role of Race in Treatment Decision-Making*, 11 BMC HEALTH SERVS. RES. 183 (2011).

But, as Steven Epstein's insightful analysis of what he terms the "inclusion-and-difference paradigm" highlights, there is a lack of clarity on the simple question "How different is different?"³² Under the mantle of social justice, biomedical research "spawned an impressive quantity of 'difference findings'" in the wake of the 1993 mandate³³ that quickly became marketized, as illustrated not only by BiDiI but also by more public-private "entrepreneurial" partnerships of recent precision medicine initiatives. Thus, without a critical theoretical framework to explain health inequality that takes into account the extraordinary concentration of wealth in the hands of a few globally—and a history of racialized medicine *that was never refuted*—genetic explanations, together with stigmatizing behavioral and cultural explanations for racial disparities came to dominate the scientific literature on racial disparities in basic science, medicine, and public health. Indeed, in 2008, there were nearly 500-fold more NIH-funded research studies devoted to genetics and race than to racism and health.³⁴

In fact, the drive to interpret any observable racial difference as genetic is so powerful that even when a study provides strong evidence for environmental influences, researchers invoke genetics to explain any remaining difference.³⁵ These are not mere "difference findings." Rather, they are constitutive of the genetically reductionist "evidence-base" to which clinicians turn to guide practice decisions. Such evidence, thin though it might be,³⁶ passes as the truth. In the minds of many biomedical researchers and physicians, races are biologically circumscribed units, not social formations.³⁷

Coincident with the revitalization of essentialist notions of race in medicine, however, a rich body of interdisciplinary scholarship contesting the uncritical and routinized use of race in medicine, especially genetic explanation for racial disparities, has emerged.³⁸ Informed by critical theories of race, this work has triggered a rich and illuminating debate over the nature of race and racial difference, systems of classification, standards, whiteness, the root causes of racial inequality in health, and race-based treatments. Focused mainly on the United States, critical race theorists have

³² STEVEN EPSTEIN, INCLUSION: THE POLITICS OF DIFFERENCE IN MEDICAL RESEARCH 6, 203 (2008).

³³ *Id.* See CATHERINE BLISS, RACE DECODED: THE GENOMIC FIGHT FOR SOCIAL JUSTICE 22-24 (2012); Duana Fullwiley, *The "Contemporary Synthesis": When Politically Inclusive Genomic Science Relies on Biological Notions of Race*, 105 ISIS 803, 804 (2014); David E. Winickoff & Osagie K. Obasogie, *Race-specific Drugs: Regulatory Trends and Public Policy*, 29 TRENDS PHARMACOLOGICAL SCI. 277, 277 (2008).

³⁴ Nancy Krieger, *Stormy Weather: Race, Gene Expression, and the Science of Health Disparities*, 95 AM. J. PUB. HEALTH 2155, 2159 (2005).

³⁵ Paulo S. Pinheiro et al., *Black Heterogeneity in Cancer Mortality: US-Blacks, Haitians, and Jamaicans*, 23 CANCER CONTROL 347, 354-55 (2016).

³⁶ John P.A. Ioannidis, *Why Most Clinical Research is Not Useful*, 13 PLoS Med. at *2 (2016) (original pagination unavailable); John P.A. Ioannidis, *Why Most Published Research Findings are False*, 2 PLoS Med. 696, 699 (2005).

³⁷ Snipes et al., *supra* note 31, at 187 (finding that many white physicians felt "race . . . provided little information over medical history").

³⁸ See, e.g., BRAUN, *supra* note 7; BRIDGES, *supra* note 7; DUSTER, *supra* note 7; EPSTEIN, *supra* note 32; KAHN, *supra* note 7; ANN MORNING, THE NATURE OF RACE: HOW SCIENTISTS THINK AND TEACH ABOUT HUMAN DIFFERENCE (2011); NOBLES, *supra* note 7; ROBERTS, FATAL INVENTION, *supra* note 7; JANET K. SHIM, HEART-SICK: THE POLITICS OF RISK, INEQUALITY, AND HEART DISEASE (2014); WAILOO, *supra* note 20; Troy Duster, *Social Diversity in Humans: Implications and Hidden Consequences for Biological Research*, COLD SPRING HARBOR PERSP. BIOLOGY (2014); Troy Duster, *Race and Reification in Science*, 307 SCIENCE 1050 (2005); Keel, *supra* note 20; Nancy Krieger, *Shades of Difference: Theoretical Underpinnings of the Medical Controversy on Black/White Differences in the United States, 1830-1870*, 17 INT'L J. HEALTH SERVS. 259 (1987); Osagie K. Obasogie et al., *Race in the Life Sciences: An Empirical Assessment, 1950-2000*, 83 FORDHAM L. REV. 3089 (2015); David R. Williams, *Black-White Differences in Blood Pressure: The Role of Social Factors*, 2 ETHNICITY DISEASE 126 (1992); David R. Williams, *Race and Health: Basic Questions, Emerging Directions*, 7 ANNALS EPIDEMIOLOGY 322 (1997).

made clear that while race is a social formation,³⁹ it is nonetheless real with concrete, biological consequences mediated through historically-specific racism, discrimination, and neoliberal forms of rule.

While invoking the mantra of social justice, physicians and biomedical researchers, however, have largely ignored critical social analyses of race, health, and genetics. For many biomedical scientists in academia and industry scientists, race is simply a self-evident, measurable variable, analogous to sex/gender and age, to be entered into a database, analyzed, and transformed into a publication. Understanding why social justice activism centered on health disparities resulted in a revitalization of essentialist notions of race with little contestation requires more in-depth cultural histories of medicine grounded in changing political economies of health. Such analyses would explore the interconnections between structures of power and racism; biomedicalization, race, and genetic reductionism; the cultural enthusiasm for privatization and corporatization of medicine and the academy; medicine and the academy's growing relationship with the private sector; the restructuring of labor in the academy and society at large; the normalization of career and corporate practices in medicine; and the growing appeal of entrepreneurialism—all of which have shaped the questions researchers can even imagine about the social experience of injustice, as manifested in health. Despite the conflict-of-interest forms academics must complete on a yearly basis, independence from the private sector is no longer the norm in academic medicine and researchers' relationship to the market is already having profound consequences for healthcare and for knowledge production.

Uncritical acceptance of routinized documentation of difference and genetically-rooted explanatory frameworks in biomedicine, intertwined with stigmatizing narratives of cultural difference, present a significant challenge for re-conceptualizing how race and racism is taught in medical schools. At the same time, the inescapable materiality of health and disease and the unworkability of simplistic racial categories in the clinical context make medicine a uniquely rich and illuminating site to study the relationship between whiteness, racial capitalism, health, and what it means to be human.

IV. RACE AND RACISM MEETS MEDICAL STUDENT ACTIVISM

A. THE NATIONAL CONTEXT

In recent years, there has been a robust wave of student-led reform across the country centered on race and racism in the medical curriculum and community-based advocacy for marginalized communities. Joining national anti-racist social movements, such as #BlackLivesMatter, medical students have contested both the neglect and the content of lectures on race and racism. At the same time, this activism has also exposed some of the limitations and constraints of looking to institutions of power to make substantive social change.

The current wave of activism has taken place in the context of a recently integrated pre-clinical curriculum. Beginning in the 1990s, medical educators across the world redesigned medical curricula to integrate and condense the basic sciences and to develop more clinical competence in the first two years.⁴⁰ An analysis of what

³⁹ MICHAEL OMI & HOWARD WINANT, *RACIAL FORMATION IN THE UNITED STATES* (3d ed. 2014).

⁴⁰ David G. Brauer & Kristi J. Ferguson, *The Integrated Curriculum in Medical Education: AMEE Guide No. 96*, 37 *MED. TEACHER* 312, 313-315 (2015).

was largely a top-down process of integration is beyond the scope of this Article. Suffice it to say that the integrated curriculum has taken many different forms with varying perspectives on what integration means—and the pedagogical implications are numerous.⁴¹ The important point for this discussion, however, is that integration occurred before recent efforts to include social sciences on the premedical Medical College Admission Test (MCAT) exams and to incorporate some social science (mostly quantitative) material into the medical curriculum.

Student activists were particularly dissatisfied with the routinized presentation of racial disparities and stigmatizing explanations for differences in lectures, clinics, and question banks that medical students use to prepare for medical licensing examinations.⁴² Activists found that medical faculty rarely probe the political economy of race and racism, the cultural history of medicine, and the root causes of poor health—or even provide a working definition of race.⁴³

Given this context and the epistemological complexity of racism as materialized in health, most curricular reform efforts turned to implicit bias—for some good reasons. There is a large and growing body of research demonstrating that implicit racial bias is rife in the clinical context.⁴⁴ Although class bias is not typically measured, recent work suggests that first-year medical students (except for Latinos and African Americans whose numbers were too small for statistical significance), prefer white—and upper class—patients.⁴⁵ Other studies have drawn strong correlations between beliefs about biological race and treatment decisions for pain.⁴⁶ Clinicians, sometimes, unconsciously, describe Latinas experiencing pain in the dehumanizing language of “total body dolor.”⁴⁷ Others use objectifying acronyms, such as “HONDAs” to describe Latinx with diabetes—or “sicklers” to describe human beings suffering from sickle cell anemia.⁴⁸

By using an easily measurable psychological test that locates racism in unconscious beliefs of individuals, the notion of implicit bias essentializes, naturalizes, and universalizes prejudice,⁴⁹ equating every imaginable type of bias and discrimination (such as dislike of poisonous insects). Surely not all bias can or ought to

⁴¹ *Id.*

⁴² Ripp & Braun, *supra* note 31; Jennifer Tsai et al., *Race Matters? Examining and Rethinking Race Portrayal in Preclinical Medical Education*, 91 ACAD. MED. 916 (2016); Ike Swetlitz, *Teaching Medical Students to Challenge ‘Unscientific’ Racial Categories*, STAT (Mar. 10, 2016), https://www.statnews.com/2016/03/10/medical-schools-teaching-race/?s_campaign=tw&utm_content=buffer8c024&utm_medium=social&utm_source=twitter.com&utm_campaign=buffer [<https://perma.cc/G7QN-59H8>].

⁴³ Tsai et al., *supra* note 42, at 917–18.

⁴⁴ See Katherine C. Brooks, *A Silent Curriculum*, 313 JAMA 1909 (2015) (describing personal anecdotes of racial bias in the clinical context).

⁴⁵ Adil H. Haider et al., *Association of Unconscious Race and Social Class Bias with Vignette-Based Clinical Assessments by Medical Students*, 306 JAMA 942, 945 (2011).

⁴⁶ Kelly M. Hoffman et al., *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites*, 113 PROC. NAT’L ASS’N SCI. 4296, 4297–98 (2016).

⁴⁷ *Total Body Dolor*, DOCTOR LINGO, <https://doctorlingo.com/total-body-dolor/> [<https://perma.cc/FET6-QPQ5>].

⁴⁸ See Decision Resources, *The HONDA Patient Population – Hypertensive, Obese, Non-Compliant, Diabetic and Asthmatics – in the U.S. is a Significant Driver of Healthcare Costs*, PR NEWswire, <http://www.prnewswire.com/news-releases/the-honda-patient-population--hypertensive-obese-non-compliant-diabetic-and-asthmatics--in-the-us-is-a-significant-driver-of-healthcare-costs-225047002.html> [<https://perma.cc/G5DE-2JGT>]; Yash Gulati et al., *Short Term Results of Cementless Total Hip Arthroplasty in Sicklers*, 49 INDIAN J. ORTHOPAEDICS 447 (2015).

⁴⁹ Daniel A. Yudkin & Jay Van Bavel, *The Roots of Implicit Bias*, N.Y. TIMES (Dec. 9, 2016), <http://www.nytimes.com/2016/12/09/opinion/sunday/the-roots-of-implicit-bias.html>.

be equally weighted. The focus on individual bias obscures and erases the structural dimensions of racism.⁵⁰ While workshops on implicit bias might ameliorate some aspects of racism in the clinic, a singular focus on implicit bias as hard-wired, nonetheless, silences the ways that racism is actively structured into—and actually is constitutive of—a racialized social order and its knowledge systems. As Hall has so poignantly written, “[a]ppeals to ‘human nature’ are not explanations; they are an alibi.”⁵¹ Discussions of implicit bias have left unexamined—and, in fact, substituted for—an examination of the intersectional, political, and structural nature of race, class, and gender discrimination, whiteness, power, and hierarchy and the ways they are embedded in a range of medical practices, genetic counseling, treatment protocols, and laboratory tests such as lung function measurements, glomerular filtration rate, and fetal growth rates as well as clinical guidelines, such as that of the JNC8 for blood pressure.⁵²

Drawing on critical theories of race and health, students and some public health researchers have moved beyond implicit bias to incorporate structural racism into their teaching, research, and practice.⁵³ Invoking the rich tradition of physician-activists, in July 2016 a group of young physicians and medical students publicly pledged to systematically address racism in the clinic by dismantling structural racism.⁵⁴ Though short on specifics for interrogating the structures of knowledge-making in biomedicine, by highlighting the need for structural change, the ambitious pledge of these young physicians and medical students presents a fundamental challenge to the status quo. This pledge, together with the recent publication of a commentary on structural racism in the *New England Journal of Medicine* and the call published in *Science* last year to remove race from genetics research, has opened a space in biomedicine for much more robust discussions about the connections between biomedical knowledge-making practices, power, and the racial state.⁵⁵ As Hardeman and colleagues have suggested, to develop more careful analyses of disparities, researchers and educators must learn about the racist roots of U.S. society and how this structures knowledge and care.⁵⁶

In other words, to end racism, you first have to acknowledge the visible and invisible ways in which it is woven into the very fabric of the social order. Because

⁵⁰ Eduardo Bonilla-Silva, *Rethinking Racism: Toward a Structural Interpretation*, 62 AM. SOC. REV. 465, 467 (1996).

⁵¹ Hall, *supra* note 3, at 338.

⁵² Lundy Braun et al., *Defining Race/Ethnicity and Explaining Difference in Research Studies on Lung Function*, 41 Eur. Respiratory J. 1362 (2013); Germaine M. Buck Louis et al., *Racial/Ethnic Standards for Fetal Growth: The NICHD Fetal Growth Studies*, 449 AM. J. OBSTETRICS GYNECOLOGY e1 (2015); Robert N. Foley et al., *NHANES III: Influence of Race on GFR Thresholds and Detection of Metabolic Abnormalities*, 18 J. AM. SOC. NEPHROLOGY 2575 (2007); Paul A. James et al., *Evidence-based Guideline for the Management of High Blood Pressure in Adults*, 311 JAMA 507 (2014).

⁵³ Chandra L. Ford & Collins O. Airhihenbuwa, *The Public Health Critical Race Methodology: Praxis for Antiracism Research*, 71 SOC. SCI. MED. 1390 (2010); Charlotte Austin et al., *Beyond Implicit Bias: A Medical Student Course on Race and Racism in Medicine*, Presentation at American Public Health Association Annual Meeting and Expo (Nov. 1, 2016) (recording available at <https://apha.confex.com/apha/144am/meetingapp.cgi/Paper/355725>) [<https://perma.cc/AW6R-G9XA>].

⁵⁴ Rachael Bedard et al., *A letter to our Patients on Racism*, MEDIUM (July 12, 2016), <https://medium.com/@docs4blm/a-letter-to-our-patients-on-racism-4b71a3e6917c#.6sgbesdle> [<https://perma.cc/22MJ-DC7U>]; Phillip Murray, *A Letter to our Patients on Racism*, HUFF. POST BLOG (Sept. 6, 2016), http://www.huffingtonpost.com/phillip-murray/a-letter-to-our-patients-on-racism_b_11877852.html [<https://perma.cc/CH9S-GPFR>].

⁵⁵ Rachel R. Hardeman et al., *Structural Racism and Supporting Black Lives – The Role of Health Professionals*, 375 NEW ENG. J. MED. 2113 (2016); Michael Yudell et al., *Taking Race out of Human Genetics*, 351 SCIENCE 564 (2016).

⁵⁶ Hardeman et al., *supra* note 55, at 2113.

both medical care and research are deeply racialized, a major task going forward is to learn to “see” differently – and that includes learning to “see” people and the context in which they live and work differently. Growing activism suggests that we are at a historical moment of possibility for re-conceptualizing medical teaching about race and racism.

B. REFORM AT ALPERT MEDICAL SCHOOL OF BROWN UNIVERSITY

Curricular reform around questions of race and racism began at Brown in 2012, when three first-year medical students requested time in the formal medical curriculum to introduce topics related to racial disparities in disease.⁵⁷ Building on a student-led elective titled “Healthcare for the Underserved,”⁵⁸ the students focused their sessions on the social nature of race, social determinants of health, and community-based advocacy. After conversations with students, in 2013, I developed an elective for second- and fourth-year students titled “Race, Health, and Structural Inequality” to support their initiative. The elective has run continuously for four years.

Situating medicine in the context of racial capitalism, this interdisciplinary elective links questions of political economy and critical theories about race to the material practices by which race and racism have become embedded in scientific research, health policy, and clinical practice. In “Race, Health, and Structural Inequality,” we read key papers on the debate over race, genomics, and health as well as selections from *Fatal Invention: How Science, Politics, and Big Business Re-create Race in the Twenty-first Century* by legal scholar Dorothy Roberts,⁵⁹ *Fresh Fruit, Broken Bodies: Migrant Farmworkers in the United States* books by anthropologist Seth Holmes,⁶⁰ *Body and Soul: The Black Panther Party and the Fight Against Medical Discrimination* by sociologist Alondra Nelson,⁶¹ and *Blood Sugar: Racial Pharmacology and Food Justice in America* by Anthony Hatch.⁶²

This elective, however, is a reading-intensive “extra” for medical students who already carry a full course load. It thus attracts a small number of student activists who have long been deeply committed to addressing inequality and acknowledge the importance of critically historicizing and theorizing about race in science and medicine. Despite their small number, however, the students have had an important effect on the curriculum. For the final assignment in Structural Inequality in 2014, for example, three second year students wrote a letter to the Office of Medical Education critiquing the heavy emphasis on biological explanations for racial difference.⁶³ They later gathered a large number of signatories and presented the letter officially to the administration. In pointing out the deficiencies in the pre-clinical curriculum with respect to racial essentialism, students triggered a re-examination of the curriculum. Other students have published articles.⁶⁴

⁵⁷ Lucinda B. Leung et al., *A Five-Year Evolution of a Student-led Elective on Health Disparities at the Alpert Medical School*, R.I. MED. J. 43, 44 (2016).

⁵⁸ *Id.* at 43.

⁵⁹ ROBERTS, *FATAL INVENTION*, *supra* note 7.

⁶⁰ SETH M. HOLMES, *FRESH FRUIT, BROKEN BODIES: MIGRANT FARMWORKERS IN THE UNITED STATES* (2013).

⁶¹ ALONDRA NELSON, *BODY AND SOUL: THE BLACK PANTHER PARTY AND THE FIGHT AGAINST MEDICAL DISCRIMINATION* (2013).

⁶² HATCH, *supra* note 7.

⁶³ Angela Zhang et al., *Race in Medical Education*, BROWN MED., <http://www.brownmedicine.org/blog/race-in-medical-education/> [<https://perma.cc/RC7E-NMQ3>].

⁶⁴ *See, e.g.*, Brooks, *supra* note 44; Tsai et al., *supra* note 42.

In spring 2017, I taught a new elective “Medicine, Knowledge, and Social Justice: Theory and Practice” for first-year students. Drawing on radical social medicine scholarship and liberation theory in the 1960s and 1970s and critical race theorists such as Fanon, Stuart Hall, and the Black Panthers, this course addresses the dialectical relationship between theory, practice, and knowledge production.

In addition to several small group sessions, the Brown curriculum also contains several lectures on race in medicine, including an overview of race, racism, and knowledge production in medicine for first-year students and a lecture on the history of race correction of lung capacity measurements in the second-year pulmonary block. For the most part, however, the race curriculum at this point, focuses on implicit bias.

V. CHALLENGES AND POSSIBILITIES FOR ENGAGING WITH RACE AND RACISM IN MEDICAL EDUCATION

The broader political context in the United States together with ongoing and widespread student activism has made this an opportune moment for substantive rethinking of the health inequality curriculum. While the theoretical framework of the biomedical model of disease and the structure of medical education sets severe limits on possibilities for critical interdisciplinary thinking about race, racism, health, and institutions of the state, acknowledging the materiality of these constraints is a necessary first step to re-imagining the curriculum. Below I offer some thoughts on key conceptual issues to consider when re-thinking race and racism in the medical curriculum.

A. LACK OF MEDICAL FACULTY DIVERSITY

While the student body is becoming more diverse in medical schools, (although not for all historically under-represented groups), the faculty at most medical schools remain predominantly white.⁶⁵ This creates a context where white faculty are teaching students of color about race, often with little exposure to the complexity of the issues. At best, this can promote narrow perspectives on racism; at worst, it can foster deeply stigmatizing and offensive narratives about patients and other providers of color. Of course, faculty of color do not all share a singular worldview on questions of race and racism but the lack of diversity hampers learning and professional development and deforms well-intentioned reform initiatives.

B. SCIENCE AND BIOMEDICINE AS POLITICALLY DISINTERESTED.

While it is too much to expect any medical school to incorporate a critique of global racialized capitalism into their mission statements, medical schools in general lack a space for serious examination of how the political economy and cultural history of health shapes the clinic. Medicine locates its claim to authority in its reliance on the value-neutrality and “objectivity” of science. Not only is quantitative knowledge privileged in medical education but it also defines what students consider to be legitimate “evidence”. Humanities and social science disciplines, on the other hand, problematize the assumptions embedded in quantitative knowledge and the objectivity

⁶⁵ ASS’N AM. MED. COLLS., AAMC FACTS AND FIGURES: DIVERSITY IN MEDICAL EDUCATION, tbl.38a (2016), <http://www.aamcdiversityfactsandfigures2016.org/report-section/section-5/u-s-medical-school-faculty/#tablepress-38a> [<https://perma.cc/A4A9-2WC7>] (finding that almost eighty percent of medical school professors are white, while 63.1% of all professors, associate professors, assistant professors, and instructors are white).

of such truth claims. The epistemological issues raised by scientific claims to neutrality are also found in biomedical journals whose reviewers, readers, and editors are unfamiliar with other epistemological frameworks.

C. THE HISTORY OF WHITE SUPREMACY IN MEDICINE.

Physicians and biomedical scientists tend to view the more horrific expressions of white supremacy, such as eugenics, Tuskegee, and sterilization campaigns, as misguided science, not as products of mainstream or “normal” science.⁶⁶ The many tensions and contradictions in medical education over race and racism can best be addressed by engaging educators in the study of the connections between the long history of whiteness and white supremacy in medicine, how this history persists, and how it privileges genetic accounts of racial difference in disease.

D. DOMINANCE OF U.S. NOTIONS OF RACE.

Racial categories change over time and place.⁶⁷ As Ann Morning has documented, the United States is only one country of the fifteen percent of countries worldwide who use racial classification in their census.⁶⁸ Integrating transnational and historical perspectives on how race and racism work in different geographic contexts is essential to developing more nuanced accounts of race and racism in the curriculum and to break the stranglehold of U.S. ideas of innate racial difference. One highly relevant consequence of this U.S.-centric lens is a geneticized explanatory model for higher rates of hypertension, despite extensive evidence to the contrary.⁶⁹

E. HIERARCHICAL NATURE OF MEDICINE.

Medicine is a profoundly hierarchical enterprise. This includes the structuring of labor among healthcare providers as well as the hierarchical disciplinary divides between MDs and PhDs. Basic PhD scientist researchers are integral to medical education but their relationship with physicians and medical students has long been fraught, if not sometimes hostile. Working in a different epistemological framework, humanities, social scientists, and certainly critical theorists of race face additional challenges to their credibility both with physician colleagues and with students.⁷⁰ Humanities and social science faculty who work in the area of critical theories of race and racism are few in medical schools nationwide at the moment. Consequently, most research and teaching on the racialization of medicine is taking place in arenas outside medical schools with minimal impact on medical student training.

F. RELATIONSHIP TO MARGINALIZED COMMUNITIES.

The relationship of mainstream medicine to marginalized communities is deeply problematic. While medical education emphasizes patient experience as important to

⁶⁶ See REVERBY, *supra* note 7 (discussing the Tuskegee experiments).

⁶⁷ NOBLES, *supra* note 7; Ann Morning, *Ethnic Classification in Global Perspective: A Cross-National Survey of the 2000 Census Round*, 27 *POPULATION RES. POL'Y REV.* 239 (2008).

⁶⁸ Morning, *supra* note 67, at 248.

⁶⁹ See Richard S. Cooper et al., *An International Comparative Study of Blood Pressure in Populations of European vs. African Descent*, 3 *BMC MED.* 2 (2005) (testing the genetic predisposition for hypertension among African-origin populations in the United States.).

⁷⁰ Warwick Anderson, *Teaching 'Race' at Medical School: Social Scientists on the Margin*, 38 *SOC. STUD. SCI.* 785, 795–96 (2008).

the best care, it generally does not take the perspective that patients, especially poor patients, have knowledge. This situates marginalized communities at best as passive recipients of philanthropically-informed care or at worst as morally culpable for poor health. The theoretical contributions of the Black Panther Party's health programs to seeing ordinary people as knowledge producers, not passive recipients of expertise, provide an important model for rethinking advocacy initiatives.⁷¹

G. PROFESSIONAL GOALS, INTERDISCIPLINARY ENGAGEMENT, CORPORATIZATION OF MEDICINE.

Physicians and medical students are action-oriented. They quite understandably want to solve problems, heal, and treat patients. Yet, as the corporatization of medicine has reshaped the structure of labor in medicine, including academic medicine, physicians are becoming increasingly constrained in their ability to define what counts as good care for patients. Business models such as “lean” medicine, based on the Toyota model of manufacturing, are gaining adherents, including at prestigious academic medical centers.⁷² But the equitable distribution of medical resources is not a problem amenable to simple “tools,” or quick technical fixes, iPhone apps, or telemedicine, especially those tools that are market-based. The fundamental causes of health inequality are social, not narrowly scientific, medical, or even public health issues. Addressing inequality requires interdisciplinary theorizing that centers the perspectives, experiences, and knowledge of the oppressed,⁷³ rather than the perspectives and goals of the experts. Collaborations between medical and humanities/social science faculty with training in critical theories of race and political economy will be necessary to bridge this divide, begin the process of addressing broader questions of race, knowledge production, and the structures of labor in the academy, and keep the issue focuses on the fundamental causes of inequality.

H. PEDAGOGY IN MEDICINE.

Accrediting and licensing bodies shape the structure of pre-clinical, clinical, and residency education. The curriculum is packed with lectures, small groups, and rotations in physician clinics, all of which allow students little time to engage in interdisciplinary study of the historical, social, cultural, and political contexts of biomedicine. Despite the long history of problem-based learning in medicine, didactic instruction still dominates medical education. Both basic science and clinical instruction commonly take the form of hours and hours of PowerPoint-based lectures, with extensive memorization and assessment comprised of board-like, multiple-choice examinations. Indeed, the majority of assessment in the pre-clinical curriculum relies on multiple-choice evaluative methods. It is not surprising then that the routinized use of race is common in medical school teaching—and in the question banks that students use for board preparation. How race is actually used in the licensing examinations cannot be systematically studied for reasons of confidentiality—but anecdotal

⁷¹ NELSON, *supra* note 61; Keisha-Khan Y. Perry & Joanne Rappaport, *Making a Case for Collaborative Research with Black and Indigenous Social Movements in Latin America*, in OTROS SABERES: COLLABORATIVE RESEARCH ON INDIGENOUS AND AFRO-DESCENDANT CULTURAL POLITICS 30 (Charles R. Hale & Lynn Stephen eds., 2013).

⁷² Sorin T. Teich & Fady F. Faddoul, *Lean Management – The Journey from Toyota to Healthcare*, 2 RAMBAM MAIMONIDES MED. J. 1, 3-4 (2013).

⁷³ BENJAMIN, *supra* note 22; FARMER, *supra* note 16; Bonilla-Silva, *supra* note 50; Ford & Airhihenbuwa, *supra* note 53; Hardeman et al., *supra* note 55; Perry & Rappaport, *supra* note 71.

evidence from students suggest that, like the question banks, the licensing examinations perpetuate racial stereotypes, albeit unintentionally.⁷⁴ Centralized oversight of the curriculum by an often-overburdened office of medical education can (though not necessarily) undermine the autonomy of faculty who have little control over the structure and the content of the curriculum, limiting incentives or opportunities for interdisciplinary pedagogical experimentation.

Despite these challenges, there are important spaces in medicine with the potential for anti-racist theorizing and practice. At Mount Sinai School of Medicine, medical students organized an elective that engaged critical theory and activism, crystalizing broad-based curricular reform.⁷⁵ Dartmouth School of Medicine is about to roll out a social justice curriculum,⁷⁶ although the theoretical framework that guides social justice advocacy is unclear. Some medical schools, such as the University of North Carolina School of Medicine, have social medicine departments with full departmental status and a regularized space in the curriculum during the first two years that is coordinated with the basic sciences.⁷⁷ This arrangement is ideal for introducing critical theories of race but it is an unusual set-up. In other medical schools, there are departments of medical humanities or history of medicine.⁷⁸ Faculty in such departments can be called on to teach electives or give lectures, but full epistemological integration is rare. A recent initiative, termed “structural competency,” calls for the integration of “a structural focus” in clinical education, drawing on insights from social scientists.⁷⁹

Without a robust theoretical framework that engages the political economy of racial capitalism, however, medical practitioners are poised to act but oftentimes with only individualized theoretical commitments at best—or at worst, highly reductionist notions of “interventions” or “outreach” to “vulnerable populations.” Even under the best of circumstances, there is a certain cognitive dissonance between the type of thinking fostered in humanities and social science fields, the pedagogical approaches and mode of assessment in the pre-clinical and clinical curriculum,⁸⁰ and the material practices of medicine that need to be engaged if meaningful social change is going to happen.

VI. CONCLUSION

A major rethinking of how health inequality is structured into the racial state will be necessary going forward, as the existing (and profoundly inadequate) structures of healthcare and knowledge production come under further attack by a right-wing Congress in the coming years. For health care providers, this is a moment to build on and work with, not only social scientists but more importantly, the robust community-

⁷⁴ Ripp & Braun, *supra* note 31, at 4; Tsai et al., *supra* note 42, at 917-18.

⁷⁵ Charlotte Austin et al., *supra* note 53.

⁷⁶ Alexandra Coria et al., *The Design of a Medical School Social Justice Curriculum*, 88 ACAD. MED. 1442, 1442 (2013).

⁷⁷ *Education and Training*, UNC SCH. MED., <https://www.med.unc.edu/socialmed/education-training> [<https://perma.cc/N4MQ-6K7B>].

⁷⁸ See, e.g., Div. Med. Humanities, *About Us*, NYU SCH. MED., <http://www.med.nyu.edu/medicine/medhumanities/about-us> [<https://perma.cc/BP8E-XBNT>]; Dep’t Glob. Health & Soc. Med., *History of Medicine*, HARV. MED. SCH., <http://ghsm.hms.harvard.edu/research/history-of-medicine> [<https://perma.cc/7JTY-SZME>]; *Program for Humanities in Medicine*, YALE SCH. MED., <http://medicine.yale.edu/humanities/inmedicine/> [<https://perma.cc/6XQY-NZ2J>].

⁷⁹ Jonathan M. Metzl & Helena Hansen, *Structural competency: Theorizing a New Medical Engagement with Stigma and Inequality*, 103 SOC. SCI. & MED. 126, 126 (2014).

⁸⁰ Ripp & Braun, *supra* note 31, at 2.

based movements that are flourishing—and will continue to flourish no matter how challenging the times. The activism sweeping both medical campuses across the country will not easily be silenced.

Working with and pushing the structures of medicine to better prepare healthcare providers to address inequality is imperative. This will entail significant restructuring of the preclinical and clinical curriculum to allow faculty and students time to read, think, and engage with oppressed communities as equals, something that their education and life experiences has often left them ill-equipped to understand or to discuss. To do so, though, we will need more careful analyses, such as the work of Khiara Bridges⁸¹ about the subtle ways in which racism shapes clinical practice in the various clinical specialties on a daily basis.

Yet, organizing for social justice in an era of right-wing assaults and an appalling normalization of hateful discourse in the public sphere holds certain challenge for activists. “How,” as Ruth Gilmore wrote at least fifteen years ago, “does the state-in-crisis discipline surplus workers, and how do workers organize against their abandonment within and across oppositional spaces delimited by race, gender, class, region, and violence?”⁸² One danger of well-intentioned activism in medicine is a kind of philanthropic capitalism so thoughtfully analyzed by Vincanne Adams in the context of the privatization of advocacy organizations in the aftermath of hurricane Katrina in New Orleans, Louisiana.⁸³ The coming period will require not only medical education attuned to the political economic structures of inequality that shape health but also robust educational formations outside of educational institutions driven by community needs—as perceived by communities—much like those set up by the Black Panthers with political allies in the 1960s.⁸⁴ High quality patient care requires providers who understand the political nature of medicine and how the racial state shapes both the epistemology of biomedicine, the health experience of marginalized groups, and their own notions of expertise. While the structural absence of an intellectual space within the academy to theorize race, racism, and the social order is consequential, as a site where the materiality of culture and political economy collide, medicine is a lens that illuminates the contradictions of the social order.

While this is a frightening historical moment with potentially profound implications for housing, education, police violence, immigration, and health, it is also a moment when the contradictions of the racial state are abundantly clear, even to those who do not bear the full burden of its daily violence. Vibrant critical traditions, such as CRT and the long Black radical tradition, which have at certain historical moments intersected directly with medical activism, can deepen our analyses of the structures of society, health inequality, and knowledge production. Social justice movements fighting racial inequality in health have much to gain by engaging the insights of traditions that integrate race, class, gender, and disability: W. E. B. Du Bois’s broad interdisciplinary studies of race and social conditions,⁸⁵ Frantz Fanon’s

⁸¹ See, e.g., BRIDGES, *supra* note 7.

⁸² Ruth Wilson Gilmore, *Fatal Couplings of Power and Difference: Notes on Racism and Geography*, 54 PROF. GEOGRAPHER 15, 15 (2002).

⁸³ VINCANNE ADAMS, *MARKETS OF SORROW, LABORS OF FAITH: NEW ORLEANS IN THE WAKE OF KATRINA* (2013).

⁸⁴ NELSON, *supra* note 62.

⁸⁵ See, e.g., W. E. B. DU BOIS, *THE SOULS OF BLACK FOLK* (1903); W. E. B. Du Bois, *Social Planning for the Negro, Past and Present*, 5 J. NEGRO EDUC. 110 (1936); W. E. Burghardt Du Bois, *Race Relations in the United States*, 140 ANNALS AM. ACAD. POL. SOC. SCI. 6 (1928).

insightful critiques of colonial medicine;⁸⁶ Cedric Robinson's inspiring work on racial capitalism;⁸⁷ Stuart Hall's analysis of societies structured in dominance;⁸⁸ Angela Davis' theorizing of race, class, and gender;⁸⁹ the Black Panther's theorizing of communities as knowledge producers;⁹⁰ Kimberle Crenshaw's intersectionality;⁹¹ Sylvia Wynter's reconceptualization of the human;⁹² Ruth Gilmore's interrogation of the "fatal couplings of power and difference,"⁹³ or Keenanga-Yamahtta Taylor's notion of black liberation⁹⁴ and many, many others. Abigail Bakan and Enakshi Dua have recently brought together a range of scholars to begin a re-theorizing of anti-racism by linking Marxism and critical race and postcolonial theories.⁹⁵ In so doing, they offer new analytic strategies that can be brought to bear on the history of scientific knowledge production and health.

As we try "to make sense of the present,"⁹⁶ it is crucial to push the structures of academic medicine as much as possible. Yet, social change will not come from the academy or from the experts alone. The academy can enable or it can—and does—obstruct social justice. The most productive spaces for rethinking medicine as simultaneously a healing profession, a complex structure of power, and a racialized knowledge-producing system will be in joint action and theoretical work with the rich variety of community-based groups, unions, and other groups to re-imagine what Ruha Benjamin has termed "a people's science," a science that engages how power shapes knowledge, a science rooted in "principles of participatory science-making."⁹⁷ Such spaces, in which engaged scholars could participate, would demand an end to racially-based state violence and the redistribution of wealth as a starting point for social justice. With joint action, it will be possible to begin the process of re-envisioning the social order to construct a just society where it is possible for all to live lives of dignity with health and well-being.

⁸⁶ FRANTZ FANON, *A DYING COLONIALISM* (Haakon Chevalier trans., Monthly Review Press 1965) (1959).

⁸⁷ CEDRIC J. ROBINSON, *BLACK MARXISM: THE MAKING OF THE BLACK RADICAL TRADITION* (1983).

⁸⁸ Hall, *supra* note 3.

⁸⁹ ANGELA Y. DAVIS, *VIOLENCE AGAINST WOMEN AND THE ONGOING CHALLENGE TO RACISM* (1985).

⁹⁰ NELSON, *supra* note 61.

⁹¹ Kimberle Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics*, 1989 U. CHI. LEGAL F. 139 (1989).

⁹² SYLVIA WYNTER, *ON BEING HUMAN AS PRAXIS* (Katherine McKittrick ed., 2015); Sylvia Wynter, *Unsettling the Coloniality of Being/Power/Truth/Freedom: Towards the Human, After Man, Its Overrepresentation – An Argument*, 3 NEW CENTENNIAL REV. 257 (2003).

⁹³ Gilmore, *supra* note 82, at 16.

⁹⁴ KEEANGA-YAMAHTTA TAYLOR, *FROM #BLACKLIVESMATTER TO BLACK LIBERATION* (2016).

⁹⁵ *THEORIZING ANTI-RACISM: LINKAGES IN MARXISM AND CRITICAL RACE THEORIES* (Abigail B. Bakan & Enakshi Dua eds., 2014).

⁹⁶ Caplan, *supra* note 1.

⁹⁷ BENJAMIN, *supra* note 22, at 172.