

EDITORIAL: CRITICAL RACE THEORY: WHY SHOULD WE CARE ABOUT APPLYING IT IN OUR RESEARCH?

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RACE AND RACISM TODAY

While race has been always with us in the United States, the concept of race has been shaped by the political and scientific beliefs of the social fabric of our society throughout history. Thus, the past two years have provided a unique context for race, racism and race relationships in the United States. Indeed, President Donald J. Trump and his administration have brought race into our everyday life at alarming levels - whether through rhetoric against football players calling attention to social justice,¹ the suggestion that White supremacists at the Unite the Right rally in Charlottesville, Virginia were “very fine people,”² or the name calling

of Mexican Americans – bad hombres, rapists, drug dealers or animals³ – just a few of the everyday examples the nation endures through the now-famous tweets of the day. Evidence suggests that the divisiveness characterizing Donald Trump’s 2016 presidential campaign and the constancy of his disparaging remarks about anyone who disagrees with his agenda or discourse is already having adverse mental health effects.⁴ All of these add up to direct and indirect tolls on the nation’s health, especially for those of us for whom race is part of our ascribed and/or self-identity.⁴ As scientists, we must be responsibly conscious of finding ways to design research studies and produce solid evidence within the context of the societal structure where race, racialization and racial relationships take place.

RESEARCH DEDICATED TO CRITICAL RACE THEORY

En hora buena! I commend and congratulate the guest editors of this supplement of *Ethnicity & Disease*, Drs. Chandra L. Ford and Collins O. Airhihenbuwa, for providing a public health framework, based on Critical Race Theory (CRT), that could contribute

to achieving health equity by informing research design, development, implementation and translation of findings into policy changes. This supplement includes a collection of 10 articles including qualitative and quantitative empirical research as well as a few

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commentaries applying CRT to current issues or public health education. We present these articles in three domains: Defining CRT, Applying CRT and Training the Next Generation.

Defining Critical Race Theory

In this section, the guest editors, Ford & Airhihenbuwa,⁵ provide a concise but comprehensive summary and introduction to CRT: definition; distinction from public health; its application to health equity research; and most importantly, the presentation of a tool that could help translate CRT for use in health equity research, the Public Health Critical Race Praxis (PHCRP). While CRT refers to the social scientific approach to study race and racism in the society, PHCRP uses CRT concepts and methods for racial/ethnic health equity research. Specifically, and as one of the PHCRP three functional components (ie, race conscious orientation to research; four major focus areas; and CRT-derived lexicon), the four major focus areas could easily serve as a conceptual framework for any research question addressing racial/ethnic equity research. For instance, if I were to examine the association between race/ethnicity and hypertension in US adults, the premise is that African Americans or Blacks (40.3%) have a higher prevalence of hypertension than Whites (27.8%).⁶ Using the four major focus areas, I will link: 1) hypertension in African Americans to the embodiment of the psychosocial stress associated with the racism they have and continue to experience nowadays⁷ (Focus 1: Contemporary Racialization); 2) the previous hypothesis would unpack and challenge any biases around biological or genetic factors associated with the findings (Focus 2: Knowledge Production); 3) the findings would be explained in the context of the multidimensional social construction of race and the history

of oppression for African Americans throughout the years (Focus 3: Conceptualization and Measurements); and 4) rather than using the findings to state the well-known and established disparities, I would use them to call attention to interpersonal and structural racism African Americans face day in and day out, which could inform interventions to prevent the onset of hypertension and help control the condition among those who have it (Focus 4: Action). Thus, PHCRP could help to: 1) inform translation of findings from research; and 2) design meaningful research studies that contribute to our understanding of racial/ethnic equity inquiry beyond the findings. Specifically, and using a PHCRP framework, the study findings could be contextualized in a society where race/ethnicity, as part of the social fabric, manifests in disproportionate negative health outcomes in minority groups such as African Americans and Hispanics relative to the majority group.

Applying Critical Race Theory

This section comprises six articles including a commentary on setting the anti-racism agenda and five studies using qualitative and quantitative methodology, applying PHCRP to big data⁸ and to an existing hypothesis on the thrifty gene among Canadian aboriginal populations.⁹ The articles use qualitative methodology through semi-structured interviews, focus groups and community forums and are focused on two important and distinct issues: health care disparities, a persistent problem even when access to care is not an issue¹⁰; and the Flint water contamination due to a change in water supplier from Detroit's Wa-

ter Department to the Flint River in Michigan in 2014. Through semi-structured interviews and focus groups with personnel at a large Minnesota health care system, Cunningham & Scarlato¹¹ show how colorblindness, a way of not seeing or acknowledging race when thinking of racial/ethnic inequity or differences, among participants could evade race to inform their beliefs that all patients are treated equally by providers and staff while refuting suggestions of racial inequality. As the authors conclude, this way of thinking helps to maintain the racial status quo and may preclude efforts to promote health equity. Muhammad and colleagues,¹² on the other hand, using community forums of mostly Black adolescents aged 13 to 17 years in Flint, aimed to understand how participants conceptualize, interpret and respond to the racism they perceive as part of the administrative process that led to the Flint water contamination. The youth clearly connected the racial composition of the city (ie, a Black city) and its historical and persistent racial stratification with the water contamination crisis, seeing it as a type of genocide targeting Blacks. Thus, they saw the water contamination problem as yet another form of racism against the city residents.

Roberts et al,¹³ using intersectionality as part of CRT, examine the combined effects of gender and racial teen discrimination on dating violence among Black and Hispanic adolescents aged 13 to 19 years in Bronx, New York. Findings suggest that adolescents reporting both gender and racial discrimination were 2.5 as likely to report experiencing dating violence compared with those who did not report

gender and racial discrimination after adjusting for age and sex. Ford and colleagues⁸ provide an application of three foci of PHCRP – contemporary racial relations; knowledge production; and conceptualization and measurement – into an empirical study that uses big data (N=3,476,741) in California. The authors discuss the advantages and disadvantages of applying PHCRP to their research but emphasize the potential for the study to establish the feasibility of using PHCRP elements for social epidemiology, health services research and other studies using big data. The authors also present the next steps for the analytical phase of the study to translate their findings into action, the four foci of PHCRP.

This section includes two sole-authored commentaries by Hay and Jones. Hay⁹ uses the application of PHCRP to the thrifty gene hypothesis, a racist theory of genetic predisposition to type 2 diabetes among Indigenous populations in Canada as proposed by James V. Neel in 1962. Stressing the need to incorporate CRT and PHCRP in public health research, he discusses how, despite the thrifty gene theory being debunked in 1989 by Neel himself, it is still imprinted in the DNA of the Canadian health system as relates to their indigenous populations.

Finally, this section includes a commentary on anti-racism. Jones¹⁴ describes her experience in putting racism at the forefront during her tenure as president of American Association of Public Health (APHA) and her use of allegories such as the Gardener's Tale or the Cliff Analogy to call attention to how racism impacts our lives. During her term at APHA, she proposed the launching of a *National Campaign*

against Racism to bring attention to this foundational pillar of our history and root cause of health inequity. Focusing on the denial of racism in our society, she discusses the three main tasks of the proposed Campaign: naming racism; asking “How is racism operating here?”; and organizing and strategizing to act. While APHA did not host the Campaign, other institutions/venues are currently embracing anti-racism and campaign elements as a framework for their work.

Training the Next Generation

The three articles under this domain present a proposal to include CRT in a public health curriculum and discuss the results of conversations to develop a medical school curriculum on racism using PHCRP among a multiracial group of faculty members as well as the experiences of training professionals on CRT. Israel Cross¹⁵ not only underscores the lack of historical and contemporary instructions on race and the role it plays in shaping health but also how, to some extent, White supremacy is maintained or normalized through the public health curriculum. She proposes ways in which CRT could be embedded in the public health curriculum to inform education, methodology and practice. Hardeman et al¹⁶ discusses a 12-month, two-phased conversation process among faculty members of a medical school to develop a curriculum on racism. The conversations included only minority women in Phase I and integrated males and White colleagues in Phase II. The findings suggest that the Phase I discourse went not only well but was also described as ‘powerful’ by the participants. However, for Phase II,

participants in Phase I became quieter and the group dynamics shifted. The results call attention to the importance of conversations on racism and its roles among people of all racial/ethnic backgrounds and the need to account for gender-race intersectionality when having such conversations. Finally, Butler et al¹⁷ praise the success of a 2.5-day

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training program using CRT. The authors state that there was a wide range of participation along the career continuum and that participants were eager to examine race and racism in their research using a PHCRP framework.

CONCLUSIONS

CRT and PHCRP aim to identify and contextualize racism in the design, implementation, conduct and translation of research findings. This supplement of *Ethnicity & Disease* on CRT and PHCRP is crucial given our current

times. Interestingly, this year marks the 50th anniversary of the “Separate and Unequal” or Kerner report.¹⁸ This report’s main conclusion was that the nation was moving toward two societies, one Black and one White, and that these societies were separate and unequal due mainly to the pervasive discrimination and segregation in Blacks but unknown to Whites. While there have been some improvements for Blacks, they are still experiencing disadvantages due to race inequality. For instance, Jones et al¹⁹ compare key sociodemographic and health-related characteristics for Blacks and Whites between 1968 and 2018. This comparison underscores four Black-White disparities that have increased over the past 50 years: the percentage of college-educated (Black-White gap: 7.1% in 1968 vs 19.3% in 2018); median wealth in 2016 USD (Black-White gap: \$45,188 in 1968 vs \$153,591 in 2018); incarcerated per 100,000 population (Black-White ratio: 5.4 in 1968 vs 6.4 in 2018); and infant mortality per 1,000 live births (Black-White ratio: 1.9 in 1968 vs 2.3 in 2018).¹⁹ Moreover, we can add the re-emerging structural racism of police brutality against Black men, including killing while the Black victim is not attacking or unarmed.²⁰ The latter has a direct effect on the mental health of Black adults in the general population. These statistics suggest that we still have a long way to go to create an equal society and call attention to the tenets of CRT and PHCRP to incorporate race and racism when conducting research to reduce and eventually eliminate health inequity. Thus, we are excited to publish this supplement and commend the guest editors and contributing authors for tackling this timely issue.

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