



Against the Turn to Critical Race Theory and “Anti-racism” in Academic Medicine

Thomas S. Huddle¹

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Abstract

Medical academics are increasingly bringing critical race theory (CRT) or its corollaries to their discourse, to their curricula, and to their analyses of health and medical treatment disparities. The author argues that this is an error. The author considers the history of CRT, its claims, and its current presence in the medical literature. He contends that CRT is inimical to usual academic modes of inquiry and has obscured rather than aided the analysis of social and medical treatment disparities. Remedies for racism suggested by CRT advocates will not work and some of them will make things worse. Academic medicine should avoid the embrace of CRT and should maintain an allegiance to rigorous empirical inquiry and to treating patients not as essentialized ethnic group members but as individual human beings in need of care.

Keywords Critical race theory · Postmodernism · Medical education · Health disparities

In the aftermath of George Floyd’s death on May 25, 2020, America has undergone a great awakening to racism in our society. The inferior socioeconomic position of the African American community, from being a regrettable legacy of past mistreatment, is now seen by many as the product of ongoing oppression by the white majority, oppression that demands resistance, here and now. The catalyst for this change in perception has been widely publicized police killings of unarmed African-Americans, of which the video of George Floyd with a policeman’s knee on his neck was a particularly searing example that, overnight, changed the conversation over race in America.

George Floyd’s death was followed by widespread protests of police brutality and of racism in American society. In a variety of institutional settings, race and racism became the predominant topic of conversation. Academic medicine was one such

✉ Thomas S. Huddle
thuddle@uabmc.edu

¹ Department of Medicine, University of Alabama at Birmingham School of Medicine, 1534 3rd Avenue South, Birmingham, AL 35294, USA

setting. The leadership of prominent academic medical centers announced initiatives to fight racism and determinations to make antiracism a core value for themselves and their institutions (Olayiwola et al., 2020). Academic medical organizations issued statements condemning societal racism (Serchen et al., 2020). Prominent medical journals enjoined physicians to recognize harm from discrimination as a vital sign in their assessment of patients (Evans et al., 2020). The flagship American journal for medical education has published a series of articles suggesting that medical schools exhibit systemic racism (Frye et al., 2020), that efforts to encourage professionalism have perhaps amounted to socialization into white supremacy (Frye et al., 2020); that postmodernism is a useful perspective for understanding medicine and medical education (Ellaway, 2020); and that we should adopt critical theory as a useful paradigm for our conduct of health professions and education research (Paradis et al., 2020).

That we all should have awakened to the scandal of the continuing disadvantage of the African American community in our society is a welcome, indeed, a necessary development. But, it will bear fruit in more equality, less racism, and a better American society only if we see the scandal in an accurate light. The answer to the question of what measures will lead to improvement will turn on an accurate assessment of the role of racism and other factors in engendering continuing disadvantage among African Americans; on whether systemic racism is the exhaustive or primary explanation of police killings of African Americans; and on whether such racism pervades other “systems” of our society: such as housing, education, the justice system, and medical care. Much current discussion, including that in the recent medical literature, takes as given particular answers to these questions. The contention is that systemic racism is indeed the culprit for African American disadvantage in all of its myriad aspects; that is, that our various systems, including the medical system, are indeed rife with racism and that this racism explains the many disparities that negatively distinguish African Americans from other racial and ethnic groups doing better in American society.

The sudden focus on systemic racism has not emerged in a vacuum. It is largely associated with a particular body of theory and scholarship: critical race theory (CRT) and its fellow travelers, “antiracism” and postmodernism. I put antiracism in scare quotes to distinguish it from traditional understandings of racism and antiracism.¹ The usual definition of racism is a belief in racial superiority manifested in discrimination, antagonism or both toward members of other races (Oxford English Dictionary). For critical race theorists, racism is not manifested in individual incidents of discrimination or in racial animus; these reveal “racial prejudice.” According to critical race theory, racism is the broader system of collective social and institutional power in American society that serves to elevate whites and subjugate people of color (Sensoy & DiAngelo, 2017, 123). Previous definitions of racism, according to this perspective, are in fact devices of dominant white society calculated to perpetuate racial domination by whites. Older definitions implied an

¹ In the rest of this article I shall use “anti-racism” for the traditional understanding and “antiracism” for the critical race theory concept, both without quotation marks.

account of racism and its absence as a binary (racist or non-racist) and limited racism to the acts or expressions of individual people (Sensoy & DiAngelo, 2017, 125). This distracted attention from the broader societal system and its impersonal racist effects, which is the real racism we need to confront. Critical race theory popularizers, such as Ibram X. Kendi and Robin DiAngelo, contend that “non-racism”, that is, the absence of racism as traditionally defined, is in fact actually racism in a passive form. The only acceptable antiracism, in their view, is ongoing commitment to and participation in efforts to dismantle the systemic racism pervading our society and its systems.

The ideas of critical race theory and antiracism have been sounded in the medical education literature for some years (e.g. Acosta & Ackerman-Barger, 2017; Kumagai & Lipson, 2009; Wear et al., 2017). But recent events appear to have catalyzed urgent and widespread calls for action grounded in these ideas in medical academic institutions, as they have in universities more generally (Bindon et al., 2020, Faculty, Graduate Students and Staff for an Anti-Racist Cornell University, 2020; Smith et al., 2021). The kinds of demands made are far reaching. In medical schools, faculty and students have contended that the present medical curriculum is “race based” and must be reformed, in fact transformed, to be much more self-consciously antiracist. It has been urged that faculty undergo mandatory antiracist training aimed at unconscious bias and microaggressions. Other suggestions have included anonymous reporting systems aimed at detecting racism, reform of honor society selection procedures to correct their racism, and correction of the lack of diversity among medical faculty. Medical schools are presently grappling with demands such as these and determining how best to respond.

In what follows, I will examine the origins and important claims of critical race theory; discuss what I regard as its most important flaws; scrutinize the claims and rhetoric of medical academics writing from the vantage point of critical race theory and antiracism; and conclude by suggesting that academic medicine would do well to avoid embracing these ways of thinking about race in society. Furthermore, society is not the proper sphere of action for academic medicine. While racism is of course to be deplored wherever we find it, it is enough for we medical professionals to first clean our own house before setting our sights on the houses of our neighbors. We should focus our attention on our own institutions and work. We should rely on traditional definitions of racism and take due care to identify it in ourselves and our work as physicians. Properly accomplishing that task, through introspection and the use of sound methods of academic inquiry, will go far toward expunging racism from academic medicine and medical work.

Critical Theory and Critical Race Theory; Origins and the Attack Upon Conventional Academic Inquiry

Critical race theory and postmodernism are important sources of the ideas now percolating among medical educators. It is important to understand these ways of thinking about the world and the ways in which they are foreign to the conduct (up to now) of most university disciplinary work. Not only science, but also the humanities

and social sciences have traditionally been conducted as empirical disciplines in the American university. That is, the presumption is that the natural world we discover and the human worlds that we jointly create are realities that we can come to understand through disciplinary inquiry. Truthful understanding is the end in view, attained through inquiry meeting the standards of disciplinary communities. Those standards are impersonal and offer the means of objective assessment of knowledge claims. In seeking objectivity, we seek to transcend our limited personal perspectives; we aspire to know the world beyond us through impersonal methods of inquiry that will yield, not an absolutely true picture but a better picture of the world than our own unaided perspectives can achieve.

This is not to say that scholars in either the humanities or the social sciences eschew normative judgments; but they generally regard their primary task as understanding; judgment may come into the picture once the phenomena under study have been illuminated by disciplinary inquiry.

The ideas we are now considering attack traditional disciplinary work by denying its claims to objectivity and to truth as aims. From a critical perspective, the methods and assumptions of traditional historians or sociologists are not useful tools for getting at the truths of history or of how society works. They are instead reflections of societal power relationships and serve to perpetuate the domination of the oppressed by the powerful (DiAngelo, 2011, 59; Sensoy & DiAngelo, 2017, 26). From a critical perspective, empirical disciplinary work in its usual form is a rationalization of domination by the powerful; as such, it invites and requires critique—that is, an unveiling of the ways in which it achieves its purposes and bamboozles both its practitioners and their audience. Critique may then open the way to societal change. This was the mission of early “critical theory,” as promulgated by the Frankfurt School of social theorists of the 1930s. In a seminal article of 1937, Max Horkheimer argued that science and its progress in the bourgeois era could best be understood as an outworking of the social processes of that era; that is, the science of a given time and place is “an instance(s) of the way in which society comes to grips with nature and maintains its own inherited form” (Horkheimer, 2002, 197). Scientific thought served to perpetuate an economic order. Critical theory could expose this dependence of academic methods on social hierarchy through “an investigation into the social conditioning of facts and theories.” In so doing, it could become a form of political action aimed at subverting oppressive hierarchy (Horkheimer, 2002, 209–210).

Critical theory for many years had little influence in the American university, unsurprisingly, as university disciplines rejected its skepticism of truth and objectivity. It first found a beachhead in the American academy in law schools. Perhaps law was more vulnerable to critical theory than history or sociology because law had fewer pretensions to objectivity and was enmeshed with politics in more obvious ways than other disciplines. The other road into the academy for critical theory was to become the various ethnic and gender studies programs that were formed in the wake of the political unrest of the 1960s and early 1970s. These programs were notable for an important aspect of mission that they shared with other academic groupings influenced by critical theory: a commitment to scholarship as an arm of politics aiming at social change (Turner & McGann, 1980, 59).

The form in which critical theory first appeared in law was “critical legal studies”. This movement arose in the 1970s among legal academics inspired by the protest movements of the recent past and inclined to be skeptical of traditional liberal claims that the law was (or aspired to be) an impartial instrument for administering justice. Instead, as the slogan of the movement asserted, “law is politics”.

Critical legal studies drew together feminists, postmodernists, Marxists, and the early proponents of what was to become “critical race theory”. The common commitments of the movement included a conviction that social context was critical in determining legal decisions; that the law was in some important sense indeterminate, and that legal claims were best understood as attempts to advance the interests of political groupings (Crenshaw, 2011, 1288–1289; Tushnet, 1991, 1517–1518).

Critical race theory (CRT) emerged in the critical legal studies milieu among law professors seeking to bring the insights of critical theory to the topic of race. Pioneering work was done by Derrick Bell at Harvard and Richard Delgado at UC Berkeley in the late 1970s and early 1980s (Bell, 1980; Delgado, 1984). Bell departed Harvard Law in 1982 over the School’s failure to hire a minority woman for a tenure track professorship. That Fall, a group of Harvard students demanded suitable replacements for Bell’s courses on race and the law from the School’s Dean. Their failure to get what they wanted led to a burgeoning interest in what was to become critical race theory among students and visiting faculty when the students themselves put a course together (Crenshaw, 2011; Harris, 2015). The heyday of critical race theory in academic discussion was the late 1980s and the 1990s. While it achieved some prominence in law and education scholarship, it had limited success in penetrating other academic disciplines (Cabrera, 2018, 210; Crenshaw, 2011, 1258; Wing, 2016, 49). Its present vogue in popular culture as evidenced by the best seller status of Robin DiAngelo’s “White Fragility” and Ibram X. Kendi’s “How to be an Antiracist” presumably owes much to the present political moment. It is notable that both of these CRT popularizers are becoming recommended reading in academic medicine.

Critical race theory is usefully considered as a set of axioms from which analysis of race and race relations in society may proceed (Delgado & Stefancic, 2017, 8–10). The most important is that racism permeates the structures and culture of everyday life in the United States. Rather than a personal quality of individuals, it is best thought of as baked into the institutions and activities in which we all necessarily participate. As Delgado and Stefancic put it: “racism is ordinary, not aberrational—“normal science,” the usual way society does business, the common, everyday experience of most people of color in this country” (Delgado and Stefancic, 2017, 8). Secondly, the forces maintaining the regime of racism are sufficiently powerful that the interests of blacks will be furthered only when it is in the interests of whites to do so: the thesis of “interest convergence.” Thirdly, race as it operates in the thinking of Americans is a social construction rather than a matter of biology. Our ideas of whiteness or blackness are culturally resonant and as such a product of social conditioning. Hence, “anti-essentialism” about race: there is no social or cultural essence of whiteness or blackness or of any other race. Fourthly, people of color have privileged access to the reality of racial relations and racism. Black experience and narrative conveys truth about black-white race relations in ways inaccessible to

whites. As Delgado and Stefancic note, this “voice-of-color” thesis exists “in somewhat uneasy tension with anti-essentialism” (Delgado & Stefancic, 2017, 10). The claim is not merely that voices of color ought to be listened to; it is that such voices have a privileged access to truth. Yet, if racial identity and sensibility are social artifacts, it is unclear how voices having race in common gain privileged access to truth that those of other races do not possess.

From these basic tenets, a range of positions follow. Perhaps, the most important idea directly downstream from critical race theory is a presumption that racial disparities of all sorts exhibiting black disadvantage signify no more or less than past and present racism. Rather than invitations to empirical investigation, disparities are viewed as occasions for identification of the racist arrangements that cause and explain them and for the dismantling of those arrangements. The latter is an urgent moral imperative; and CRT advocates seek converts to the righteous cause of immediate social transformation to end systemic racism.

These ideas are now being held out to the medical community for adoption. Until now mostly the preoccupation of diversity and inclusion officials, a smattering of academics and ethnic studies departments, critical race theory and calls for action grounded upon it seem poised on the threshold of reshaping academic medical curricula and institutions. Ought we to permit it to do so? Will we gain in more truthful teaching, less racist institutional proceedings, and a more diverse and harmonious academic medical community if we do?

Difficulties with Critical Race Theory

To answer these questions, it will be helpful to explore two core aspects of critical theory that have kept it from mainstream acceptance in the broader academic community: what I will call (1) its “ideology critique” of traditional academic inquiry and (2) the “voice of color” as a means to truth thesis about race relations.

Critical (and Critical Race) Theory’s “Ideology Critique” of Academic Inquiry

To medical academics uninitiated into these ideas, their most jarring aspect is likely to be their distance from the stance of usual academic inquiry. Whether studying the past, the present human world, or the natural world, traditional academics like to think of themselves as constructing understandings of the raw material of historical, sociological or scientific data in ways that are faithful to its character and undistorted by the perspectives that they bring to it. That is, they aspire to honor the epistemic norms of objectivity and impartiality as they seek to understand the world. Objectivity is especially compelling an ideal in scientific disciplines, in which most medical faculty are trained. From the perspective of science, it might seem plausible that an ideal of seeing the world from an objective, impersonal standpoint has less application in disciplines concerned with the social world than in science or medicine. If our perspectives are necessarily more intrusive in conceiving of the social

world than the natural world, then perhaps critical theory has a point in impugning the supposed objectivity of historical or sociological inquiry.

As it happens, the issue of objectivity and the possibility of an impersonal authoritative rationality in science, the humanities and the human sciences was hotly debated from the late 1980s through the early 2000s among historians, social scientists, and philosophers. It was perhaps during the early 1990s that attacks by post-modernists, deconstructionists, and “crits” on ideals of impersonal rationality and objectivity in these disciplines reached a peak. Public figures such as Michel Foucault, Richard Rorty, Stanley Fish, and others argued powerfully that objective truth was unattainable; that knowledge of any kind was always relative to a discourse and therefore to a community; that how we see the world is inevitably determined by our interests and pre-existing perspective. This attack was pressed against natural science as well as other disciplines, but it was the “softer” disciplines of literature, history and sociology that were more vulnerable to it.

The debate proved useful to historians and sociologists who were challenged to think beyond the positivist pretensions of their nineteenth century ancestors who had modeled these disciplines on natural science and who had hoped to find laws governing history and society of a kind analogous to the regularities of the natural world. The upshot of the debate in these disciplines was that if an ideal of objectivity and impersonal rationality was to be defended, it must be distinguished from the kind of impersonal view of the natural world attainable in biology or physics. The human world of the past or the present did not admit of the kind of austere and unified description that consensus scientific theory could attain. It did not follow however, that a form of objectivity and impersonal rational standards could not obtain in history and sociology. The useful insight brought to the social sciences by the crits was the importance of perspective and of interests in determining what topics are studied, what questions are asked, and what methods are applied in interrogating the human world. The further contention that our interests and perspectives (rather than our object of study, the human world beyond us) are decisive in determining the conclusions we come to in history or sociology proved a bridge too far (Goldman & O’Connor, 2019).

Critical theory makes use of the Marxist idea that one’s thinking is going to be decisively determined by one’s interests and position in a social structure. On such a view, conclusions drawn about the world and the standards governing inquiry leading to such conclusions are determined not by how the world is as revealed by objective inquiry but by the social position of the inquirer (Elster, 1986, Ch. 8). In the case of critical race theory, the contention is that usual academic inquiry and academic standards, including objectivity and impartiality, are a product of white supremacy and are directed at keeping minorities subjugated (Crenshaw, 2011, 1309–1310; Diangelo, 2011, 59). While adherents of critical race theory have continued to defend this position, it has not gotten much purchase in traditional academic disciplines, for good reason.

The difficulty with the crits’ pejorative analysis of academic knowledge as ideology determined by interests is that any such analysis undermines the crits’ own position. If purported knowledge about the world is inevitably determined by the interests and social position of inquirers, then crit claims to knowledge are vulnerable to

the same debunking analysis they apply to their opponents. By their own lights, the critics' claim that academic knowledge is in fact a rationalization of white supremacy has its origins in the social position and interests of critical race theorists; those interests must be determining in the forming of the claim, which, then, is sufficiently accounted for by the situation of the claimants, rather than by any correspondence of the claim to how the world is.

Critical theorists are making truth claims about the world; presumably they believe they have overcome any blind spots they might possess on account of their interests and social position; if so, how can they maintain that there is no possibility that academics engaged in traditional inquiry may not have done the same? A functional analysis of any body of academic (or other) knowledge is inadequate for debunking it; to do that, the body of knowledge must be shown to be false; that is, an argument must be made not about the situation of inquirers but about the merits of their positions. If the positions at issue are axioms of critical race theory, that American society in its totality, and the edifice of academic inquiry in particular, subjugates minorities to whites, then that position must be argued for rather than merely asserted. Such argument cannot merely gesture toward an inferior minority social position and conclude that said position is caused by ongoing subjugation by the white majority. Other possible causal factors must be considered; lines of causation must be established; mechanisms from inputs to outputs must be delineated. We must assay the world around us using valid methods of inquiry and draw conclusions when the dust has settled, not before we have begun. So traditional academics have argued against critical race theory; such arguments have been frequently made and have not been rebutted by critical race theorists (Farber & Sherry, 1997, 7; Posner, 1997; Goldman, 1999, *passim*, especially Ch. 1.8 and Ch. 1.9).

The “Voice of Color” Thesis

Critical theory's skepticism of traditional modes of academic inquiry was and is viewed by most academics as going too far; any wholesale dismissal of such modes as pejoratively ideological ensnared the critical theorists just as surely as their opponents. The other fatal difficulty with critical theory had to do with its positive program; with what Delgado and Stefancic call its “voice of color” thesis. The contention is that minority scholars, by virtue of their experience of oppression, have privileged insight into the character of race relations in any minority-oppressive society to which they belong. The “voice of color” thesis is closely connected to the ideology critique of usual academic inquiry; if academic inquiry is generally contaminated by false consciousness, those who can lead the way forward are those who are unaffected by such ideology: minority scholars, whose experience of oppression opens their eyes to its true character and to the failure of usual academic inquiry to appreciate its nature and extent. And their conclusions, including those of critical race theory, are validated not by usual academic criteria of logic, accuracy and rigor but instead by the identity and experiences of the inquiring minority scholar.

The grain of truth in the voice of color thesis is that differing experiences and perspectives may indeed expose the shortcomings of inquiry limited by the common

perspectives and experiences of previous inquirers if such a group of inquirers (say, predominantly white men) had cultural or intellectual blind spots. Thus it can only be salutary for academic inquiry if academia draws from a wide variety of cultural and class perspectives. So far, so good. The error, however, in the voice of color thesis is to suppose that one such perspective (that of the putatively oppressed) has privileged access to truth simply by virtue of the identity of its members being that of an oppressed group. Once again, the critical race theorists risk being hoist by their own petard in making such a claim.

They might have chosen to remain on the playing field of usual academic inquiry; in that case their claims, such as that American society as a totality subjugates minorities, would be subject to empirical investigation and verification. The various aspects of our societal “system” (if that word’s implication of interlocking and reciprocal mechanisms could possibly be appropriate for the freewheeling polity in which we live) would then have to be subject to investigation and mechanisms of subjugation of blacks by whites would have to be unveiled in many or all of those aspects for the claim to go through.

Minority identity would give its possessor investigators a head start on others as their experiences would point the way toward useful avenues of research; but the case for assertions about American society would still have to use accepted disciplinary methods and meet the usual academic standards for publication in good disciplinary journals for general acceptance. In actual fact, however, the critical race theorists have (at least until recently) rejected usual academic inquiry on the grounds that objectivity is a false ideal and that traditional academic standards including logic, accuracy, fidelity to data, and rigor in argument are parochial tools of an oppressor class.

This lets them off the hook of needing to do empirical investigation but the price paid is very high. Once we give up the premise of a common world in which we all live and to which we all have access for purposes of investigation—that is, the premise of an objective reality—we are indeed free to live within a discourse of our own creation that captures our own reality as we choose to see it. But, it is not so clear that we can draw those who may disagree with us into our ambit. The contention that there is no “Truth with a capital T” is well-taken if the point is that we cannot get outside of our perspectives to somehow see the world from a perspective-free zone. It is far more problematic if the suggestion is that we do not share reason and logic in common; and that there are therefore only “truths” relative to given communities, each with its own discourse and standards of evaluation—the postmodernist position. As the Marxist legal scholar Mark Tushnet puts the problem:

In its broadest form, the critique turned against the concept of rationality itself goes as follows: just as the proposition “Women have an essential nature as mothers” can be historicized, so can the proposition “Reason requires a stance of detached consideration of abstractly stated propositions.” Truth and reason then become entirely localized to the particular contexts in which those words are used; in the jargon, local narratives are all that anyone can offer. As Rosenau and other critics point out, the historicization of reason itself traps postmodernists. They are subject to the familiar critique of thoroughgo-

ing relativism, which asks, What is the truth-status of the claim of relativism itself? If truth is historicized, why not logic itself? If logic is historicized, what exactly is the point of postmodernism considered as (logical) argument? Or, in Rosenau's version:

We can convince those who agree with us, but we have no basis for convincing those who dissent and no criteria to employ in arguing for the superiority of any particular view... In the end the problem with post-modern social science is that you can say anything you want, but so can everyone else. Some of what is said will be interesting and fascinating, but some will also be ridiculous and absurd. Post-modernism provides no means to distinguish between the two. (Tushnet, 1995, 587)

The voice of color thesis risks tipping into this untenable position just insofar as its adherents refuse to subject minority narratives of oppression to usual methods of historical and sociological inquiry. If they so refuse, they have their community narrative but no means of persuading non-participants. If they do not refuse, they are back in the realm of scholarly debate in which the color of the debater is less important than the cogency and empirical validity of the case to be made. Oppressors may be blind to the reality of their oppressive position which may be ripe for exposure; but the putatively oppressed may be mistaken in attributing their inferior position to oppression. No one gets general assent to their preferred narrative simply by virtue of their identity. Elusive truths about the human world must be established through normative and empirical investigation of that world in which we all live and to which we all have access, situated in perspectives though we be. And, such investigation must be subject to the traditional standards of academic inquiry including accuracy, logic, choice of method suited to the problem at hand, and care about getting it right no matter who's favored narrative is threatened.

Racism, Academic Medicine and Society

An embrace of critical race theory and postmodernism would put academic medicine at odds with most of the university; indeed it would threaten our place in the university, at least in any university that chooses, in Jonathan Haidt's alternative choice scenario, to be "Truth U" rather than "Social Justice U" (Haidt, 2016). More importantly, from the standpoint of the political impulse which has propelled critical race theory into the forefront of academic medical discussion, such an embrace will not move us forward in extirpating racism from medical care or from society at large. Well meaning medical faculty, program directors, and clinical teachers have been quick to foreground CRT-inspired pedagogy in the medical school and the medical residency (Satel, 2021, 106–107). They need to rethink this decision in light of the character of CRT-inspired rhetoric and of its likely effects.

Medical academics writing in the spirit of critical race theory make a series of important errors. First, they promote a picture of the role of racism in American society and in medicine in particular that is false, or, at best, not demonstrated to be

true. Second, they propose a role for medicine in combatting racism that goes far beyond both medicine's remit and medicine's practical reach. Third, the remedies they propose for racism in medicine are at worst immoral and at best likely to be counterproductive.

Finally, the spirit and atmosphere that they bring to academic medicine is deeply subversive of the comity and unity in shared inquiry that has made American academic medicine such a success at increasing medical knowledge and at educating medical trainees.

The medical CRT-inspired critique of American society and American medicine

Those inspired by critical race theory within academic medicine argue that we are all complicit in oppressive societal structures and that we must all focus on dismantling these structures. But, they do not make the empirical case that would warrant this position. One can hardly open a general medical journal at present without seeing explications of structural racism and its remedies, as if academic physicians had suddenly become expert in the historical and sociological study of race in society. They have not, and the case they offer for the critical race theory position gains what plausibility it does through the systematic avoidance of a vast range of empirical literature, especially in economics and economic history. This is not to say that these medical academics do not echo voices in the broader discussion; but they emphasize one radical end of what is a spectrum of opinion among scholars who study race on the contemporary relevance of racism in maintaining the inferior position of the American black community.

I will consider an example, which I take to be representative of many other pieces: "How Structural Racism Works—Racist Policies as a Root Cause of U.S. Racial Health Inequities," recently published in the *New England Journal of Medicine* (Bailey et al., 2021). The authors begin by suggesting that U.S. society is a "racial hierarchy." This hierarchy, they maintain, is "produced and reproduced by laws, rules, and practices, sanctioned and even implemented by various levels of government, and embedded in the economic system as well as in cultural and societal norms" (Bailey et al., 2021, 768). That is, racism is baked into the structures and systems in which we all participate simply by living in society. What is their case for this chilling picture of ongoing systemic oppression? They specify three areas of societal life, housing, criminal justice, and health care, in which to demonstrate the pervasiveness of racist proceedings.

In housing, pervasive ongoing racism is indicated by racist New Deal housing policies of the 1930s which created widespread residential segregation of blacks into inferior neighborhoods. This state of affairs is maintained by ongoing structural racism (not further specified). The criminal justice section of the paper begins by pointing to unequal outcomes between blacks and whites involved with criminal justice and contending that these indicate "racial bias in virtually all aspects of the criminal justice system" (Bailey et al., 2021, 768). The authors go on to assert a continuity, presumably of spirit, between eighteenth century slave patrols and contemporary

police forces. The use of police in the American South as an instrument of racial oppression in the ante-and post-bellum periods is parallel, we are told, to the disproportionate involvement of blacks with criminal justice in the 1970s and 1980s under anti-crime and anti-drug policies of those years. Police now “disproportionately target Black people who enter White neighborhoods” (Bailey et al., 2021, 769). These considerations confirm pervasive structural racism in U.S. criminal justice proceedings, we are to infer. Racism in health care, we are told, begins with modern medicine’s “roots in scientific racism and eugenics movements” (Bailey et al., 2021, 770). Racism’s presence more recently is indicated by the 2003 Institute of Medicine (IOM) Report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Institute of Medicine, 2003), which found “that bias, prejudice, and stereotyping contributed to widespread differences in health care by race and ethnicity” (Bailey et al., 2021, 770). That such racism continues today is indicated by ongoing disparities in the care that minorities receive compared to whites.

Bailey et al.’s rhetorical strategy has much in common with other CRT-inspired indictments of contemporary American society. They begin by asserting an identity between present day practices and past antecedents that were contaminated with racism. They then point to ways in which racism was embedded in U.S. societal arrangements prior to 1968 and assert that nothing (or not much) really changed when laws were passed during the Civil Rights era to remove racism from government policy and business practices. That disparities favoring whites over blacks in treatment and outcome persist in various realms of social activity is then taken to be wholly explained by systemic or structural racism: invidious treatment of blacks because of their race best seen not as a sporadic result of individual moral failure (whether by racism or by not avoiding statistical discrimination (see below)) but as a simple function of how we all proceed in our various racist practices of exchanging homes, maintaining public order, or healing the sick.

U.S. society was indeed a racial hierarchy during the era of mandated unequal treatment and segregation prior to the 1970s. Critical race theorists and their allies take it as axiomatic that that is still the case; but their position rests on assertion rather than argument. For each of the social realms they consider, Bailey et al. present an account of social reality that is belied by the empirical literature relevant to their respective topics of housing, criminal justice, and health care. The first point to make is that discrimination resulting in racially disparate outcomes can happen for many reasons other than racism. White homebuyers may avoid predominantly black neighborhoods because of racism—“taste-based discrimination” in economics parlance (Guryan & Charles, 2013). But, they may instead be engaging in “statistical discrimination,” that is, using race as a signal for neighborhood characteristics important to them such as crime levels or school quality. Discrimination of this sort by consumers is likely much more important in maintaining high levels of residential segregation at present than is invidious treatment of blacks by realtors or landlords (O’Flaherty, 2015, Ch. 9).

The case for systemic racism as pressed by CRT does not go through for the criminal justice system, but it comes closest here. A wealth of data confirms that in similar circumstances minorities are more likely to be interfered with than whites by police. And minorities in at least some cities are subject to higher levels

of non-lethal force than whites, once again, in similar circumstances (Fryer, 2019; O’Flaherty & Sethi, 2019, Ch. 6).² This is deplorable and properly illegal. But while some of the disparate treatment is likely due to racism, much of it is likely, again, statistical discrimination—police operating with heuristics in part formed by accurate perceptions of race indicating the likelihood of involvement in crime as a statistical matter. We must, of course, work for the reform of police departments to avoid such racial profiling and disparate treatment. But, we slander contemporary police and criminal justice more generally when we analogize their proceedings to the racial oppression of the pre-Civil Rights era American South. It is now recognized across the political spectrum that policies from the 1970s through the 1990s aimed at crime reduction had the horrendous unintended result of disproportionate incarceration of black men, especially for non-violent drug crimes. Before labeling these policies as “The New Jim Crow” (Alexander, 2010), implying deliberate and systematic racial oppression of blacks by whites, it should be remembered that the black community, including urban politicians and members of congress, generally favored these policies and even demanded them in hope of reducing soaring levels of violence in American cities (Foreman, 2012; Fortner, 2015). In hindsight, it is clear that violent crime could have been addressed by more carefully targeted policies that would not have had such malign effects on the young black men who were unjustly incarcerated. But, the policies in question were not rooted in racism—they were rooted in efforts to aid the black community.

The CRT indictment of medicine as systemically racist is no more convincing than its indictments are for housing or criminal justice. The identification of modern medicine with the scientific racism of the Progressive Era is peculiar, to say the least. While elite early twentieth century American physicians, white and male as they were, were men of their time on matters of race, they were not the leaders of the eugenics movement, which was spearheaded by statisticians and biologists. Eugenics was, of course, established science in the early twentieth century and physicians certainly participated in eugenic policies such as compulsory sterilization of the unfit. The movement, however, did not emerge out of medicine and physicians were never of central importance to it in Great Britain or the United States (Paul, 1995). As for racism in the present day medical profession, the assertion that past or continuing racial disparities in medical treatment are wholly or best explained by racism is not substantiated by the IOM Report *Unequal Treatment* or by other empirical work. The IOM Report is considerably more tempered in its conclusions than suggested by Bailey et al. It did indeed find “evidence that stereotyping, biases, and uncertainty on the part of healthcare providers can all contribute to unequal treatment” (Institute of Medicine, 2003, 1). But, it took no position on how much racial bias as opposed to many other factors were causally important in producing disparate outcomes. As one of the Report’s authors later remarked, “clinical uncertainty and discretion,

² Fryer’s study found no increased likelihood that police use deadly force against blacks compared to whites, when relevant variables were accounted for. Fryer’s study does not conclusively settle the question of police discrimination in the use of deadly force; it has been cogently criticized—see the discussion by O’Flaherty and Sethi (2021). It remains, however, one of the best if not the best study on this issue to date.

race-related heuristics and attitudes, and communication failures across cultural and linguistic lines interact in complex ways to create disparity” (Bloche, 2005). The IOM Report is an invitation to begin to sort out these various factors rather than a fixing upon one of them as *the* source of treatment disparities. It is likely that some doctors engage in taste-based discrimination (racism). It is highly unlikely that racism can do all or even most of the work in explaining the complex picture of treatment and outcome disparities in medicine (O’Flaherty, 2015, Ch. 4).

Bailey et al. find “evidence of the health effects of structural racism to be convincing, and supported by more than a century of wide-ranging theoretical and empirical scholarship” (Bailey et al., 2021, 771). Yet the “evidence” to which they refer appears to be the fact of disparities favoring whites over blacks, which the authors simply then declare to be due to “structural racism”. As the eminent African American economist Glenn Loury argues, structural racism as invoked by Bailey et al. and others, “isn’t an explanation, it’s an empty category.”

The invocation of structural racism...is a bludgeon in the sense that use of the phrase is mainly a rhetorical move. Users don’t even pretend to offer evidence-based arguments beyond citing the fact of the racial disparity itself. Rather, it asserts shadowy causes that are never fully specified, let alone demonstrated. We are all just supposed to know that it’s the fault of something called “structural racism”...(Loury, 2021)

The Proper Scope of Medical Efforts to Combat Racism

George Floyd’s death focused attention on the continued inferior position of African Americans in American society now fifty years on from the civil rights era; and on the past and ongoing festering sore of racism in American society—I now refer, not to structural or systemic racism as per critical theory, but to racism as (still) usually understood: beliefs in racial inferiority or racial animus. It has, of course, always been incumbent upon academic medicine to do what it may to excise racism from medical institutions and medical work. Many have, for some time now, suggested that the physician’s remit extends further than that; as the argument goes, physicians are responsible not merely for healing but for health; they must seek to improve not merely the health of individual patients but the health of society.

Medical fellow travelers of CRT have embraced this argument, urging organized medicine to fight for policies that will right “the wrongs done by the foundational racial hierarchy that continue to shape everyday life” (Bailey et al., 2021, 771).

The argument that physicians are responsible for the health of society is mistaken at its core. The social determinants of health are various, involving both the structure and culture of society. Altering society through social policy to improve health will inevitably run up against other social priorities, including prosperity and individual freedom. Professional training and professional identity give physicians no special insight into how much freedom or prosperity should be sacrificed to gain given increments in population health. For that reason, physicians should acknowledge that any advocacy they may engage in for changing society in aid of health is

ordinary political advocacy—on the same plane as any citizen’s advocacy on behalf of a disputable vision of the good. Such advocacy is not somehow incumbent upon professionals or a signal of special professional virtue (Huddle, 2011; 2013).

What physicians can contribute to the fight against racism is to examine themselves and their institutions and ensure as best they can that their own work is not contaminated by it. Better understanding of treatment disparities will, it is to be hoped, lead to better understanding of the extent to which racism is actually present in American medicine and to practicable ways of reducing both racism and treatment disparities. For that understanding we need, not the dogmatic axioms of critical race theory but the careful empirical work performed according to usual standards of academic inquiry that critical race theory condemns as oppressive. Our teaching of trainees should be based upon our anti-racism (not antiracism) and on the vast body of good empirical work on race in American society—not on popularizations of critical race theory such as the work of Robin DiAngelo or Ibram Kendi.

On the remedies for racism in medicine suggested by CRT advocates

Racism as traditionally understood likely plays a minor role at most in generating health treatment disparities, which are most likely primarily due to a host of other factors including doctor–patient communication difficulties (O’Flaherty, 2015, 72–79), differential benefit from given treatments such as cardiac catheterization (Chandra & Staiger, 2010), differing treatment preferences, and, probably most importantly, differential access to sophisticated care. Physicians should, of course, do whatever they can to ensure that all whom they treat are getting the care best suited to their clinical condition. Judging interventions purely by their success in diminishing treatment disparities may be erroneous if the disparities track clinical benefit, as in the cardiac catheterization case.

Among the antiracist interventions often championed by CRT fellow travelers is training to reduce unconscious bias. This is a striking example of devising an intervention for a problem which has not been demonstrated to exist. It is highly plausible that we all have unconscious biases, of course. That such biases play a role in creating health care treatment disparities, however, has, to my knowledge, never been demonstrated. Nor is it plausible to suppose that they do so, given the state of the science of unconscious bias. Psychometric attempts to measure unconscious bias (“implicit bias”) have had notably little success. For the best known measurement, the implicit association test (IAT), it is not at all clear what the test is measuring as the test has low test–retest reliability and does not predict actual behavior (Jussim et al., 2021). Furthermore, efforts to alter performance on the IAT do not lead to behavior changes (Forscher et al., 2019).

More worrisome than tilting against the windmill of unconscious bias are efforts to reduce treatment disparities by altering clinical decision making to favor those of one race over another. An initiative of this sort has recently been announced by Brigham and Women’s Hospital in Boston, where there is to be “a preferential admission option for Black and Latinx heart failure patients to our specialty

cardiology service” (Wispelwey & Morse, 2021). That is, individualized clinical decision making by physicians is to be replaced by race-based discrimination against whites in the treatment of severe heart failure at Brigham and Women’s. As the recently founded Foundation against Intolerance & Racism has noted, this is not anti-racism. This is neo-racism, and it appears to the direction in which CRT advocates wish to take us (Foundation Against Intolerance & Racism, 2021).

CRT and Academic Life

Among the most chilling developments in academic medicine associated with CRT are increasing attempts to silence and intimidate those who question CRT orthodoxy. Norman C. Wang was fired from his position directing a University of Pittsburgh electrophysiology fellowship after publishing an article in a peer-reviewed journal questioning the use of racial preferences in academic medicine (Harrell, 2020). Disgracefully, the *Journal of the American Heart Association* retracted the article in spite of its having undergone full peer review, claiming, unpersuasively, that the article “misrepresented facts” (Caverly, 2020; Simon et al., 2020). An editor of *JAMA* was recently placed on administrative leave for being insufficiently respectful of claims about structural racism during a podcast (Tanne, 2021). It is disturbing enough that medical journals are publishing articles on race in American society that ignore much of the extant literature on that topic. It is even more disturbing that they are now beginning to suppress legitimate dissent from CRT-associated ideas.

Those in academic medicine engaging in viewpoint suppression are, however, acting in accord with the spirit of CRT and its companion idea, antiracism, even if they have not, perhaps, worked out the connections. CRT’s illiberal stance toward its opponents follows from its underlying logic. Knowledge claims made by its opponents reflect not reality but instead the unjust social structure in which those claims (and claimants) are embedded. To oppose such claims with rational argument is to play the enemy’s game; as the norms of objectivity and rationality governing usual academic discourse are in fact a form of false consciousness. What in fact validates positions in a discourse is not success at making an argument by canons of academic inquiry; it is instead their implications for inequality, power and dominance. CRT has lifted the curtain on the roots of privilege and power differences in the United States in unjust social arrangements. Arguments against racial preferences and questioning of structural racism issue from these arrangements and are tainted by them; hence, they require, not rational rebuttal but suppression.

The concept of antiracism communicates the urgency of suppression. Antiracism denies that the absence of racism is in fact the absence of racism. Unless one is at the barricades, actively dismantling purportedly racist structures, one is at best passively racist. Antiracism thus divides humanity into sheep and goats; those that are not with CRT and its acolytes are against them—and must be excommunicated. The impulse here is to demand continuous mobilization against designated evil as a condition of moral acceptability. This is all familiar. We have the combination of a totalizing axiom casting its light upon all of reality: the universality and omnipresence of racism in society; with a demand for constant and compulsory mobilization

against that racism. This is Hannah Arendt's account of ideology, a totalizing idea impelling movement according to its inexorable logic, a weapon ready to be grasped by the would-be totalitarian (Arendt, 1973, Ch. 13). Some of Arendt's interlocutors were prone to analogize ideology of this sort in religious terms; CRT certainly has affinities to religion, even if the linguist John McWhorter is perhaps too hasty in labeling it as "religion, pure and simple," a religion in which heretics must be cast out (McWhorter, 2021).

Conclusion

Critical race theory and its accompanying ideas have had important and salutary effects on discourse in medicine since May of 2020. We can only benefit from a renewed effort to identify and extirpate racism from attitudes and institutional arrangements in medicine. Health and health care disparities, an important facet of racial inequality in the United States, rightly demand better understanding and ameliorative action. A new focus on these matters within academic medicine is to be welcomed. It is important, however, that work on eliminating racism and understanding disparities be conducted so as to bear fruit in undiscriminating respect for persons in health care and in truth and accuracy in health research. The problematic aspects of CRT, antiracism, and postmodernism threaten both of these outcomes.

Academic medicine must reject Critical Theory's pessimism as to the possibility of objectivity and accuracy in knowledge production. Our inevitable situatedness does not preclude knowledge of a shared world, even if shared from competing perspectives. Such knowledge is not inevitably vitiated by the context of its production. If objective knowledge is impossible, then indeed the political and moral perspective of academic work must be decisive in validating or invalidating it. But objectivity, in the form of methods conforming to canons of rationality, is not impossible; it is in fact necessary. Rationality cannot be relativized to social position; it is not the preserve of any particular social group, oppressed or otherwise. It is important that medical researchers, journal editors, and medical educators subject their ideas and their work to norms of disciplinary inquiry irrespective of positions taken on hot button issues of the day. The "correct" perspective on matters of race is insufficient to warrant the pursuit or publication of work that does not meet academic standards. And an incorrect perspective by the lights of CRT is not enough to warrant rejection or suppression of work that does.

To say that much is, of course, to reject the atmosphere of moral panic evident in the CRT-inspired work newly prominent in the medical literature and in efforts to suppress its opposition. That moral panic is founded upon a view of race and race relations in the United States that is axiomatic rather than a result of empirical investigation. We must return to empirical investigation, both as already conducted and as demanded by lacunae in our present knowledge if our new-found (and welcome, if properly directed) moral urgency in addressing the real problem of racism in the United States and in medicine is to succeed.

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