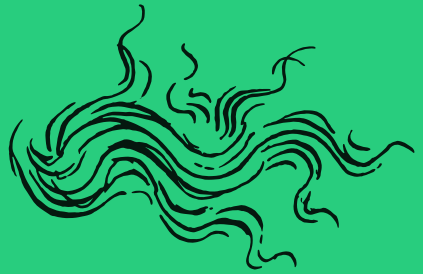


CULTURE AND POLITICS

Liberties



SALLY SATEL

Do No Harm: Critical Race Theory and Medicine

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In the winter of 1848, an epidemic of typhus ravaged Upper Silesia, a largely Polish mining and agricultural enclave in the Prussian Empire. Months earlier, heavy floods had destroyed large swaths of cropland, leaving the peasants to subsist on a paltry diet of clover, grass, and rotten potatoes. Weakened by starvation, they readily succumbed to infection. The Prussian authorities tapped a precocious twenty-six-year-old junior physician named Rudolf Ludwig Karl Virchow, at Berlin's Charité Hospital, to perform the routine task of surveying the outbreak. For three weeks, Virchow travelled from town to town, observing that families of six or more often shared single

room dwellings, turning homes into hotbeds of contagion. He noted the stigmata of the typhus rash — angry red spots that mysteriously spared the face and soles of the hands and feet — documented the nature of fevers, coughs, and diarrhea, and performed a few autopsies.

Virchow's report to the Prussian Minister for Religion, Education, and Medicine contained mortality statistics and clinical descriptions. He also dispensed predictable recommendations for flood control and drainage systems. But what exercised Virchow the most — and what his sponsors least wanted to confront — were the deeper causes of the epidemic. "The nouveaux riches" who extracted wealth in metals and minerals from the mines treated their Silesian workers "not as human beings but as machines," he wrote. He blamed the Catholic Church for keeping "the people bigoted, stupid and dependent." "If these conditions were removed," the bold young doctor offered the minister, "I am sure that epidemic typhus would not recur."

Even before he left for Upper Silesia, Virchow was primed to see the threads between social conditions and disease. In Friedrich Engels' treatise on the working class in Manchester and the deathtrap factories in which they toiled, which appeared in 1845, he read about the cramped conditions and the poor ventilation, the gruesome machine accidents, the toxic fumes and the woolen fibers they inhaled with every breath. From Edwin Chadwick's *Report into the Sanitary Conditions of the Labouring Population of Great Britain*, from 1842, Virchow learned that workers in the North rarely passed their thirtieth birthdays. He read of families crammed into half-lit quarters, choking on the stench of human and animal waste, grinding away their years under a sky so thick with soot that it blocked the sun and caused their children's legs to

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bow from rickets. In a letter to his father, Virchow said that his immersion in the Silesian typhus epidemic had turned him from “half a man [to] a whole one, whose medical beliefs fuse with his political and social ones.”

Ten days after Virchow returned to Berlin in mid-March, the spring riots erupted, one of many protests against monarchy spreading across Europe. He flung himself into the short-lived revolution, brandishing a pistol at the barricades — a feat of activism followed by months of local political involvement that led Charité to suspend him. Fortunately, the University of Würzburg was eager to attract the medical prodigy and offered Virchow a position on the condition that he not use it as “a playground for radical tendencies.” He accepted the demand for his depoliticization, and used his new position instead as a proving ground for wondrous advances in medical science. He perfected new microscopic techniques that helped him discover how tumors form, how tissues proliferate, and how blood clots. Virchow was among the first to correctly link the origin of cancers from otherwise normal cells, the first to describe leukemia, and the first to use hair analysis in a criminal investigation. He discovered the life cycle of the parasite *Trichinella spiralis*, or “pork worm,” which established the importance of meat inspection in Germany.

Yet the laboratory could not contain him. The experience in Upper Silesia had convinced him that doctors, knowing as they did the true conditions of humanity, made the best statesmen. Thus, after completing in 1858 his magisterial text *Cellular Pathology as Based upon Physiological and Pathological Histology*, a work that is regarded as the foundation of modern pathology, Virchow moved back into politics, this time as a professional. He became a member of the Berlin City Council beginning in 1859 and planned the city’s sewage system. He

next entered the Prussian House of Representatives and in 1880, at the age of fifty-nine, the German Reichstag. Virchow’s well-justified faith that social reform was necessary to combat disease never left him. When he celebrated his eightieth birthday in 1901, he was hailed by physicians all over the world as the “father of social medicine,” or *medecine sociale*. The term was coined by Jules Guerin, a French physician — doing so, coincidentally yet auspiciously, one day after Virchow’s return from Upper Silesia — to indicate “the numerous relations which exist between medicine and public affairs.”

These “numerous relations between medicine and public affairs” formed the philosophical heart of public health in Europe. In America, however, the field organized itself around technical strategies aimed at the leading causes of death at the turn of the century, which were influenza, pneumonia, diphtheria, tuberculosis, and cholera. It was a time when physicians had little to offer in the way of medical treatment. Opium, laxatives, sleeping powders, bloodletting, and leeches were the mainstays of care. In a speech in 1860, Oliver Wendell Holmes Sr. famously told his colleagues in the Massachusetts Medical Society that “opium, which the Creator himself seems to prescribe, wine which is a food, and the vapors which produce the miracle of anesthesia... I firmly believe that if the whole material medica, as now used, could be sunk to the bottom of the sea, it would be all the better for mankind — and all the worse for the fishes.”

Public health experts and doctors worked together closely to contain epidemics, but as drug discoveries mounted — among them penicillin for a broad swath of infections in 1928 (though it was not used until 1942) and the sulfa drugs in the 1930s — the power and prestige of the medical profession grew, and it separated from public health. Boundaries

were established: public health cared for populations while medicine cared for individuals. Within American public health, an occasional champion of European-style social medicine would emerge. Charles-Edward Winslow, head of Yale's department of public health, was one. As he told his colleagues in 1948, "You and I have determined that men should not sicken and die from polluted water, from malaria-breeding swamps, from epidemics of diphtheria, from tuberculosis. Those battles have been, in large measure, won. We must now determine that men shall not be physically and emotionally crippled by malnutrition, by slum dwellings, by lack of medical care, by social insecurity."

Winslow's eloquent plea to address "social insecurity" went unheeded. The field took the opposite route, dedicating itself to individual-level risks for injury and chronic illness. Surgeons General and public service advertisements exhorted Americans to stop smoking, eat more vegetables, exercise, wear seatbelts, and so on. To protect consumers, health warnings appeared on cigarette packs. Within the academy, however, theoretical developments inspired by social medicine were underway. Sociologists and epidemiologists found common interest, for example, in 1950, in a study of the relationship of fetal and infant mortality to residential segregation. The study evoked Virchow's commitment to quantification. "Medical statistics will be our standard of measurement: we will weigh life for life and see where the dead lie thicker: among the workers or among the privileged," he vowed.

By the 1970s, a cadre of epidemiologists were studying the psychological, social, and cultural forces that make people more vulnerable to disease and that shape their choices regarding health. The term "social determinants of health," which came into general usage in the 1990s, captured that

formidable notion. Its more abstract cousin, "the social production of health," examined how social inequalities affected health, and often did so with a nakedly ideological slant that implied no limit to the profession. Consider some sample quotations from faculty: "The practice of public health is, to a large degree, the process of redesigning society"; "Every problem is a public health problem"; "A school of public health is like a school of justice." The latter dictum was issued by a former dean of the Harvard School of Public Health.

Interpreting these trends, the medical economist R.G. Evans and the health policy experts Morris L. Barer, and Theodore Marmor wrote in their book *Why Are Some People Healthy and Others Not?*, in 1994, that "for those on the left, health differentials are markers for social inequality and injustice more generally and are further evidence of the need to redistribute wealth and power and restructure or overturn existing social order." Yet not everyone welcomed the infusion of progressive norms into public health academy. "We have nearly converted the school of public health from an institution committed to developing the scientific bases for disease prevention into one of many arenas for advancing social justice," Philip Cole of the University of Alabama at Birmingham and his colleagues sternly observed in 2000. "Broadly speaking, public health is aligned with the left," said the dean of the Boston University School of Public Health, "and there is no sense dancing around this." He appealed to his colleagues to be "a fully inclusive left," to "let go of always taking sides," and to "abandon the hectoring tone [that] radicalism can entail."



During the protests triggered by the killing of George Floyd, many health professionals allowed their personal politics to bleed into their professional advice. A much-retweeted message from a senior epidemiologist at the Johns Hopkins School of Public Health instructed that “in this moment the public health risks of not protesting to demand an end to systemic racism greatly exceed the harms of the virus.” Three days later, 1,200 health professionals signed an open letter. “We do not condemn these gatherings as risky,” they wrote. They are “vital to ...the threatened health specifically of Black people.” Speaking to the *New York Times*, one epidemiologist who marched remarked that “I certainly condemned the anti-lockdown protests at the time, and I’m not condemning the protests now, and I struggle with that... I have a hard time articulating why that is okay.” His honesty was refreshing, but the answer to his dilemma is that it is not okay. The job of epidemiologists is to inform the public about risks. It is absolutely not to tell them which risks are worth taking and what their moral prerogatives should be.

Months later, when it came time to distribute the coronavirus vaccine, an assortment of authorities, including legal scholars, public health experts, and state officials argued for giving high priority to black citizens in the name of “historical injustice.” About that historical injustice there can be no doubt, but the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or CDC, concluded that race should supersede age as a prioritization category because the oldest cohort in America is whiter than the general population. Elevating “health equity,” the task force said, took precedence. The CDC itself told the committee that its allocation plan would result in up to 6 percent more deaths, many of whom would be black senior citizens — the

highest risk group; but the advisers remained loyal to it. Their loyalties, in other words, were to an ideal, not primarily to protecting health.

While the CDC was developing its equity approach, the National Academies, non-governmental institutions that offer independent advice on science policy, proposed an allocation plan that would give priority to communities that rate high on the CDC’s Social Vulnerability Index. Using U.S. Census data, the index factors in poverty, unemployment, and health-insurance rates, among other socioeconomic vulnerabilities. Since minorities are more likely to meet criteria for social vulnerability, they would receive the vaccine early under that approach. Weeks later, public outcry forced the CDC committee to reverse itself. Still, on April 1, the governor of Vermont allowed anyone aged sixteen or older who identified as black, indigenous, or a person of color, or anyone who lives in a household with someone who does, to be vaccinated. Whites under fifty, unless they qualified for a vaccine by virtue of being a health care or public safety worker, of having a high-risk health condition, or being a parent or caregiver of someone at medical risk, had to wait.

Across campus at the medical school, the academic tradition was less politicized. Doctor-led activist groups have long existed, most notably Physicians for Social Responsibility, fifty years old this year, which shared the Nobel Prize in 1985 for alerting the world to the consequences of nuclear war, but physicians have mostly confined their advocacy, if they engaged at all, to healthcare financing and delivery. Doctors who specialized in caring for homeless people or pediatricians who treated poor children could not ignore poverty and decrepit housing, and they often collaborated with local social service agencies in keeping with their medical calling.

But by oath and inclination, doctors' eyes are, or should be, on treating the patients before them, not on reforming society.

I certainly acknowledge that the culture of American medicine has been changing over the last decade or so, at least among a vocal contingent. A dramatic validation of the shift took place on December 10, 2014, International Human Rights Day, when 3,000 medical students “died” on the lawns and walkways of medical school campuses across the country. The “national white coat die-in” was the brainchild of medical students who were moved to demonstrate for racial justice in the wake of the police killings of Michael Brown and Eric Garner. At the “die-in,” students wearing surgical scrubs and white jackets lay silent for four and a half minutes, symbolic of the four and a half hours that Michael Brown’s body remained on the street in Ferguson, Missouri after a white police officer shot him. A group called WhiteCoats4 BlackLives, WC4BL, emerged from the event. Its mission is to “prepare future physicians to be advocates for racial justice,” and one of its core convictions is that “policing is incompatible with health.”



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After George Floyd’s murder, WC4BL organized gatherings in medical centers across the country. These took place only a few months into the pandemic. Reeling from a triple tragedy — another black victim of police brutality, a viral death toll that unduly savaged black Americans, and their own bone-weariness from toiling in the plague-infested trenches — trainees and doctors took action. They persuaded almost two hundred state and local governments to declare racism as a public health crisis. The dual premise was that racially motivated police violence is bad for the health of blacks and that systemic

racism is the pre-eminent driver of the overall poorer health of the black population. The American College of Physicians pledged a “commitment to being an anti-racist organization;” the American Psychiatric Association (my trade organization) vowed it “would not stand for racism against Black Americans”; and the American Academy of Pediatrics implored its members to “dismantle racism at every level” of society.

In the wake of George Floyd’s death, major journals published numerous essays on racism in medicine, often lifting the paywall for them. In the *New England Journal of Medicine*, for example, a psychiatrist called for “majority taxes” on white colleagues defined by the author as a mandate to “acknowledge your White privilege, no matter how uncomfortable; leverage privilege to highlight medical racism; and humbly and actively implement antiracist policies.” In the *Journal of the American Medical Association*, authors insisted that “researchers must name and interrogate structural racism and its sociopolitical consequences as a root cause of the racial health disparities we observe.” Writing in *Health Affairs*, six doctors, all closely affiliated with the American Medical Association, the AMA, cautioned that “while naming racism as a fundamental cause of health inequity is a crucial first step, our patients, colleagues, and communities will not reap the benefits of such declarations until racism is exposed, confronted, and dismantled.”

Some of these articles specifically cited Critical Race Theory, or CRT, a worldview that interprets social existence for minorities as a perpetual power struggle waged every day and in every aspect of their lives against a dominant group. Differences of any kind — in income, education, school performance, and, of course, health — are manifestations of racism and racism alone. Within the domain of medicine, the critical race perspective casts key institutions — the training apparatus

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(medical schools), the knowledge base (medical journals and funders of research) and the treatment enterprise (the delivery of healthcare) — as engines of oppression and exploitation. The practice of “equity,” the enactment of critical race theory, permits, if not endorses, unequal treatment of the dominant group in order to arrive at equal group outcomes, even if it is to the detriment of ailing individuals.

Despite the radical nature of critical race therapeutics, its proponents mean to deploy it in the service of a most conventional project: the reduction and elimination of health disparities, that is, the white-black gap in health status and in access to care. This is a fine goal and a decades-old campaign, put forth most prominently by the federal government, notably in a landmark report in 1985, and by foundations such as the Kaiser Family Foundations and the Robert Wood Johnson Foundation. But can approaches informed by critical race theory help to narrow the health gap? And can they do so in ways that do not create a zero-sum scenario in which the health of other groups is compromised?

That question will be tested on a small scale at Brigham and Women’s Hospital in Boston in the form of a pilot study designed to give preferences to black and Hispanic patients with heart failure, a condition in which the heart muscle can no longer pump enough blood to meet the body’s needs. Minority patients will receive priority for admission to the cardiac specialty unit. According to two Brigham physicians writing earlier this year in the *Boston Review*, a review of medical records going back ten years showed that minority patients were less likely to be admitted to the specialty cardiac unit (with its private rooms and, presumably, more attentive care) than whites. Instead, they were more likely to be admitted to the general medical unit.

Three percent of black patients hospitalized on the general unit died within a month of discharge, compared to under one percent who were cared for on the specialty unit. Retrospective studies such as this one are inherently limited, as the authors themselves admit, because they are conducted in hindsight and thus miss important variables. Even so, the data showed that the strongest predictor of where a patient would be admitted was whether or not they were being cared for by an outpatient cardiologist, making physician advocacy the most likely, though not the sole, explanation for unit of admission.

Non-controversial remedies for differences in the quality of care include strengthening standardized admission guidelines or using decision tools to upgrade physicians’ care for heart failure care on the general medical unit. The doctors at Brigham who devised the pilot openly considered these options in a paper in a cardiology journal two years ago, yet still they chose to pursue a pilot that followed a “reparations framework,” no matter the legal ramifications. As Bram Wispelwey and Michelle Morse explained in their *Boston Review* article, entitled “An Anti-Racist Agenda for Medicine”:

Offering preferential care based on race or ethnicity may elicit legal challenges from our system of color-blind law. But given the ample current evidence that our health, judicial, and other systems already unfairly preference people who are white, we believe—following the ethical framework of [applicative justice] and others—that our approach is corrective and therefore mandated. We encourage other institutions to proceed confidently on behalf of equity and racial justice, with backing provided by recent White House executive orders.

The physicians who designed the Brigham pilot justified it as “redress [for] the outstanding debt from the harm caused by our institutions.”

Similar developments are occurring in medical education. Last summer, the Association of American Medical Colleges informed the medical community and its 155 medical schools that they “must employ anti-racist and unconscious bias training and engage in interracial dialogues.” This spring, the AMA advocated “mandatory anti-racism [training]” as part of its vision that all physicians “confront inequities and dismantle white supremacy, racism, and other forms of exclusion and structured oppression.” The data on effectiveness of such training initiatives, however, are dismal, with study after study showing that such efforts often backfire by reinforcing racial and ethnic stereotypes while failing to improve morale, collaboration, or diverse hiring within a workplace. Still, Michigan now requires implicit bias training for health professionals and Maryland has made it a condition of obtaining a medical license. Such training often includes the wildly popular Implicit Association Test, or IAT, a computer-administered reaction time test purported to measure unconscious prejudice and thus foretell whether an individual will engage in discrimination. The problem, according to several teams of research psychologists, is that the race IAT has no predictive value.

Curricular reform in medical schools is also underway. At Stanford University School of Medicine, for example, a new “anti-racist” curriculum will instruct students in “confronting white supremacy.” Students at Brown University will take a four-week course on Racial Justice and Health Inequity to “gain a deep understanding of topic areas, such as Critical Race Theory, intersectionality, and the inequities that

pervade the U.S. healthcare system.” At Kaiser Permanente Bernard J. Tyson School of Medicine, topics covered will include social identity, intersectionality, power, and privilege; history of race and racism in medicine and science; and media bias and literacy. Staple readings of the new curricula are *White Fragility* by Robin DiAngelo and *How to Be an Antiracist* by Ibram X. Kendi.

The integrity of the medical profession has certainly been compromised by a terrible history of racism. Physicians performed medical experiments on male and female slaves, trying to improve surgical techniques and better understand anatomy and physiology. In the Jim Crow era, many Southern hospitals, clinics, and doctors’ offices were completely segregated by race, and many more maintained separate wings or staff that were legally banned from mixing with both black and white patients. Even donated blood was kept in separate blood banks. As Vann R. Newkirk II put it, “Within the confines of a segregated health-care system, these factors became poor health outcomes that shaped black America as if they were its genetic material.” In 1997, President Clinton apologized for the Tuskegee syphilis study.

Students should also know that the AMA apologized to black physicians in 2008 for more than a century of policies that excluded them from the association, in addition to policies that barred them from some state and local medical societies. As late as 1966, black and white demonstrators picketed the AMA annual meeting to integrate all county and state medical societies. The association also failed to speak against federal funding of segregated hospitals and was silent in the face of pending civil rights legislation. Those transgressions are an important part of the record — but will they and other examples of racial injustice in medicine be taught as part

of the encompassing social history of the field, or as a defeatist narrative that glosses over the moral progress that medicine, though still imperfect in many ways, has made?

The fundamental problem with social justice in public health is that there are no limiting principles to it. And so the new pedagogy prompts other questions. Will coursework in basic medical science, early clinical skills, epidemiology, bioethics, or exposure to the medical humanities be displaced to accommodate the anti-racist curriculum? How will deans respond to students who do not regard the medical classroom as a suitable venue in which to interrogate their social conscience, be told they must “accept America’s racist roots,” or informed that “we live in a country [with] a political economy predicated on devaluing Black labor, demeaning Black bodies, and denying Black humanity” (as a group of medical educators writing in the *New England Journal of Medicine* would have them do)? Will the moral fitness of such future doctors be called into question?

If health is completely at the mercy of social forces, as critical theory insists, will the importance of self-care be given adequate attention? It is hard to imagine that physicians will desist in discussing with patients matters such as diet, exercise, smoking, and so on — in short, actions they can and should take to improve their health. And yet, following a lecture I gave earlier this year, I was castigated by some psychiatric residents for drawing attention to the dimensions of personal agency in addiction. I was not “blaming the victim,” as charged. Quite the contrary. I was drawing attention to their potential, to the remnants of their agency.

Will the anti-racist medical classroom accommodate controversy? Judging from the censorious milieu in some medical schools, I am not optimistic. One of my colleagues

— here is one example among many — lost a departmental leadership position after trainees accused him of making them feel “unsafe.” The accusation came on a Zoom call during which my colleague objected to a fellow faculty member questioning his “support” for diversity. Surprised, he asked to know what he had said to give such a false impression, but he was never told. In an ethos in which an allegation is a conviction, an insinuation was enough. Another colleague told me that she stifled complaints when her school jettisoned lectures in bioethics to “make room for the anti-racist curriculum. Which is ironic, because that was where students were taught about subjects like the Tuskegee syphilis experiment.” A third colleague told me that during a group discussion of stress and suicide in black youth, the tacit rule was that only fear of police aggression and subjection to discrimination were allowable explanations, not the psychological torture of bullying by classmates or the quotidian terror of neighborhood gun violence.

One florid instance of the intolerance for controversy is the case of Dr. Norman C. Wang, a University of Pittsburgh cardiologist. Last March, he published an article in the *Journal of the American Heart Association* titled “Diversity, Inclusion, and Equity: Evolution of Race and Ethnicity Considerations for the Cardiology Workforce in the United States of America from 1969 to 2019.” Wang’s interpretation of the data on performance persuaded him that affirmative action in medicine was not working. “Excellence should not be sacrificed for short-term demographic optics,” he concluded. When news of Wang’s peer-reviewed paper hit social media last August (its initial appearance in March 2020 garnered little notice because it coincided with the onset of the pandemic), the reaction was swift.

Physicians savaged him on Twitter. “Rise up, colleagues. The fact that this is published in ‘our’ journal should both enrage & activate all of us.” “Racism is alive, well, and publishable in medicine.” “We stand united for diversity equity and inclusion. And denounce this individual’s racist beliefs and paper.” The school fired Wang as director of the electrophysiology fellowship and banned him from having contact with medical students. The American Heart Association emphatically tweeted that Wang’s article “does NOT represent AHA values,” and it launched an “investigation to better understand how a paper that is completely incompatible with the Association’s core values was published.” Once alerted by Wang’s own medical school to allegations that his article contained “many misconceptions and misquotes” that “void ... its scientific validity,” the journal retracted it.

Diversity is one of the most pressing issues in medical schools today. Nationwide, five percent of physicians are black, under half the national demographic of 13.4 percent. Graduates are more likely to practice in underserved areas, and some evidence suggests that black patients enjoy better communication with doctors of the same race. To bolster those numbers, many medical school admissions committees employ a “holistic review framework,” created by the American Association of Medical Colleges to consider applicants’ experiences and attributes in addition to academic achievement. “Situational judgment” and emotional intelligence are taken into account at several dozen schools. Some colleges offer special programs to shore up the academic record of aspiring black pre-med students. Yet despite these robust efforts and others, progress has been exasperatingly slow.

Another delicate topic is the relationship between race and disease. Some worry that putting “genes” and “race” in the

same sentence will encourage the fiction that races are discrete entities defined by biological traits. With science literacy among the public so tenuous, the worry is not misplaced. But the fact is that studies involving genes and race are simply about population genetics: the fact that people sharing a geographical ancestry are more likely to have particular gene variants (alleles) in their genome than do people with a different heritage. These variants may code for proteins or enzymes that cause vulnerabilities to certain diseases or determine how robust a response to treatment is likely to be.

Race is thus a shorthand for ancestral descent — and the more precise the ancestral origin the better, as variations in genetic heritage exist even between groups within a geographical region. Genetic admixing, that is, when parents are of different “races” or are mixed race themselves, further complicates the picture to the point where the shorthand of race becomes irrelevant, or too crude a category to be of any help at all. Researchers and physicians agree that the science of pharmacogenomics — the elucidation of the relationship between treatment and individuals’ unique genomic fingerprint to create personalized therapies — will make the controversy obsolete. But until this gold standard is used widely, group-based genetic analysis will have some value.

Even with the caveats in mind, genetic heritage can be relevant to medicine with regard to appropriate dosing of certain drugs, more accurate prediction of responses to those drugs, clinical decision-making via algorithms (an especially controversial matter that scientists are currently debating in good faith), and heightened risk for certain conditions, such as cardiovascular and renal disease.

A recent study in the *Journal of the American Medical Association* uncovered an interesting finding correlated with race.

In a sample of about three hundred patients at a New York medical center, blacks had stronger expression of the gene that codes for Transmembrane Serine Protease 2, a protein known as TMPRSS2 than did white, Asian, Hispanic, or mixed-race patients. TMPRSS2 sits on the surface of cells lining the nose and is involved with entry of the coronavirus into those cells. Will that finding hold up on replication? Perhaps not. And if it does, the protein likely accounts for a small part of the racial variation in COVID-19 infections, the lion's share accounted for by social factors. Still, the investigation yielded potentially important findings. Science, after all, is provisional, cumulative, and, eventually, self-correcting.

Yet this study, too, provoked a swarm of angry responses from doctors and health professionals. "This is sounding way too much like blaming and rings of eugenics." "Race IS NOT genetic." "Stop ...systemic racism is why [black, indigenous, and people of color] are disproportionately harmed by COVID-19." "I think this would hold water if by 'TMPRSS2,' you meant 'racism.'" "Shame on this publication for perpetuating racism." "Biomedical racism to a T." A team writing in *Health Affairs* warned researchers who planned to publish on health disparities to "never offer genetic interpretations of race because such suppositions are not grounded in science." They also proposed that medical journals "reject articles on racial health inequities that fail to rigorously examine racism." The article-review process, they say, requires "editors who are well versed in critical race theory." But why? For genetic inquiry across groups is emphatically not "racial science" or scientific racism. The objectivity of research is not a form of complicity in structures of power; it is the very condition for the discovery of treatments that are genuinely universal.

Concerned by the disavowal of such studies, experts

spoke up. "For some applications, race may continue to be the best variable to capture the influence on health," wrote John P. Ioannidis, Neil R. Powe, and Clyde Yancy in *the Journal of the American Medical Association*. "Quick dismissal," they cautioned, "may worsen outcomes, especially for the most disadvantaged populations." In the *New England Journal of Medicine*, five genetics experts, who identified themselves as black, declared that "ideally, race will be replaced with genetic ancestry as a variable in medical research and practice. But until more ancestry data are available, ignoring race and extrapolating research findings from European-ancestry populations to others is neither equitable nor safe." The authors expressed disappointment that some "curricula promote ideologies that downplay the medical achievements of genetic studies."



Several months after Rudolf Virchow returned from Upper Silesia, he started a weekly newsletter. Although *Die Medizinische Reform* lasted only a year, many of the aphorisms enshrined in its pages live on. The masthead dictum — "physicians are the natural attorneys of the poor" — is among the most famous. In Virchow's time, a physician was able to make a powerful case to politicians that the major scourges of the day — contagion, malnourishment, and starvation — required effective sanitation, adequate nutrition, and the alleviation of extreme poverty. In short, significant social policy. The connection between health and reform — civil engineering and food — was direct and obvious, "a remedy against the recurrence of famine and of great typhus epidemics," as Virchow told the Prussian minister. (This was especially the case because antibiotics did not yet exist.)

Under a regime of critical medical theory — CMT? — the mandate for change — “dismantling racism” — presents doctors with an unworkable challenge. For one, physicians are wholly ill-prepared for such a task. Their primary job is to diagnose and to treat — and to do no harm in the process. They have no expertise in the redistribution of power and money — nor can triage or surgery wait for such a redistribution. By urging reform of this kind in the name of health, good intentions aside, they risk abusing their authority, using the profession as a vehicle for politics, and, ultimately, eroding the trust of the public.

Moreover, the mission itself is too ambiguous. Even for seasoned policy analysts, teasing out a strong causal link between health and sprawling upstream economic and social factors is very difficult. With so many “intervening variables” at play, manipulating policy in the service of health may not have its intended effect, while the odds of creating unwanted repercussions elsewhere in the system are significant.

None of this is to elide the fact that much of black disadvantage in health is the cumulative product of legal, political, and social institutions that have historically discriminated against them, either explicitly or through passive disregard to the differential brunt of policies, and in certain instances still do. As a result, blacks lack comparatively fewer opportunities for better health. The neighborhoods in which they are more likely to reside attract lower levels of civic investment. This in turn leads to underfunded hospitals, fewer emergency services, pharmacy deserts, worse air and water quality, and fewer supermarkets and safe options for outdoor exercise.

There is indeed a race-based story to tell about why, in aggregate, black Americans suffer poorer health and receive less care than whites. It is a story that delivers real and painful

truths. The pandemic served as an object lesson in differential exposure to the virus, with rates of coronavirus infections that were three times as high in blacks as whites. With jobs as lower-paid essential workers (e.g., transit workers, building maintenance staff, grocery store employees), dependence upon public transportation, and residency in dense quarters, African Americans were at higher risk.

And yet “systemic racism” is not a useful medical diagnosis: it may have explanatory value but it doesn’t yield realistic prescriptions. So what are physicians supposed to do now? Only when explanations are able to bring causal dynamics into sharp focus will they reveal efficient points of entry into the healthcare apparatus for minimizing health gaps. In California, for example, too many black patients with colon cancer were falling through the cracks. When such patients in California were treated at an integrated health care system — a point of entry where all aspects of care were delivered under one roof — black patients fared much better than black patients treated in other settings. As a result, survival was the same for black and whites. Such initiatives are hard at work in cities across the country.

The totalizing narrative of race, like all totalizing narratives, dangerously simplifies things. It discounts other ways to illuminate the black-white gaps in health. Consider, for example, the constellation of disadvantages called Adverse Childhood Experiences, which bear a well-documented relationship to future health. Imagine a succession of deprivations and insults, toppling one after the other like dominoes across the lifespan. Start with mothers who receive little to no prenatal care. Their poorly thriving babies are born into an often fatherless world full of chaos, physical and emotional abuse or neglect, and domestic and community violence. These

are not hostile stereotypes; they are real-world phenomena that must be faced if their consequences are to be understood — and, optimally, prevented, buffered, or reversed.

The stress of sustained trauma can alter children’s neural maturation and hormonal function, predisposing them to problems such as poor emotional regulation and stunted cognitive development, including working with memory, attentional control, and cognitive flexibility. These deficits, in turn, may disrupt the formation of healthy attachment to other people, lead to weak performance in school and low educational attainment overall. As often lonely teens with a foreshortened sense of the future, they are prone to risk-taking with drugs and alcohol, reckless driving, and unprotected sex. As adults, they are often burdened by depression and despair and tend to smoke heavily, drink to excess, and abuse drugs. Next comes disease, mainly in the form of cancer, cardiovascular disease, diabetes, and renal illness. Then, premature death. The more adverse experiences, the greater the odds of these otherwise avoidable health consequences. Racial and ethnic minorities and Appalachian youth, as epidemiologists have shown, are at greater risk for more adverse experiences.

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The *medecine sociale* that Jules Guerin defined and the noble Rudolf Virchow once practiced was about the “numerous relations between medicine and public affairs.” Social medicine today, having been irradiated by critical race theory, has mutated into a belief that only one relation matters: systemic racism. From this monocausal vision, so constrained by its nature and animated by grievance as it is, has emerged a host of unhealthy developments. The worst of them is a doctrinal intol-

erance of explanations that lie outside the oppression narrative.

Add to this an intensely politicized environment that threatens academic collegiality, open inquiry, and unapologetic discourse. Round out the project with contempt for the notion of personal responsibility in health, and permission to erode the boundary between personal politics and professional obligations. Perhaps the apotheosis of the critical medical imperative is the dispensation that it grants a group of Boston doctors to miss the real question — how a hospital can deliver the best care for each patient it serves — in favor of a righteous trial of racial preferences that might harm other patients.

Whether critical medical theorists represent the tip of an iceberg or the far tail of a bell curve seems moot, given their formidable influence at elite medical schools. Many deans and chairmen are doubtless too intimidated to resist. At the same time, however, their youthful colleagues are likely to be sympathetic to the critical justice project. Over the past decade, according to an analysis at Stanford University in 2019, young physicians have been moving so “sharply to the left” and flocking so densely to urban areas — “ideological sorting,” the authors called it — that rural areas are suffering from shortages of physicians.

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The spirit of social medicine is precisely what should inspire some of those young doctors to set up practice in a rural minority town. If being anti-racist is their priority, it is probably the best gift they can give. That spirit should also prompt us to challenge the status of the black-white gap in health as the dominant measure of our wellbeing as a population. Just as a hammer is predisposed to see all problems as nails, emphasizing such gaps — now routinely called “health inequities” — leads inexorably to the quixotic conclusion that dismantling racism is the medical answer. And the tyranny

of this gap forecloses another, more universal definition of disparity: the differential between a person's current health and their optimal health, between the quality and quantity of the care that they are currently receiving and what, as a matter of right, they deserve.

The strict imperatives of clinical practice may be the best buffer against ideology. The surgical suite, the emergency department, and the examining room are the definitive, consequential spheres of clinical intervention. When applications to medical school rose steeply last year in the wake of the pandemic, a phenomenon dubbed the "Fauci effect," the young applicants were surely inspired by the extraordinary heroism of doctors and nurses and the technical prowess of medical science.

Physicians are still the natural lawyers for the disadvantaged, but in their way. In the clinic and at the bedside, they argue most eloquently through their specialized knowledge and their compassion. In medical journals, they spread knowledge through dispassionate, truth-seeking methods that speak to all. And in the realm of social medicine, they do their best work aiding those who are most vulnerable and in need, regardless of group affiliation. The best way to be an anti-racist doctor is to be a good doctor.



R. B. KITAJ

Three Tales

MONDRIAN

Mondrian's closest friend was the Dutch painter Eli Streep, a Jew who was caught in a raid in Paris in 1942 and murdered. Mondrian had escaped by then, via London to New York. Streep and Mondrian saw each other almost every day in Paris during the many years they both lived in the same shabby building on the Rue du Depart by the Montparnasse railway station. They had been schoolboy friends in Amsterdam, and they were among the first young painters to notice the death of the almost unknown Vincent van Gogh, a few of whose strange paintings had attracted them. They even visited Theo van Gogh's young widow, Jo, to see more of her brother-in-law's