October 5, 2020

Dear Participants,

The Julius Alexander Isaac Moot for the 2020/2021 school year generally concerns a fictitious decision (*Williams v Canada (Minister of Health)*), the failure to collect race-based health information relating to the COVID-19 pandemic, and whether that failure unjustifiably infringes either ss. 7 or 15 of the *Charter*. Details regarding the procedure and substance of the moot follow.

1. Procedure

a) Overview

The Moot will consist of a further appeal from the Supreme Court of Canada (SCC) to the Diversity High Court of Canada (DHCC). The nature of argumentation, issues, and deadlines relating to that further appeal are described below.

b) Nature of Argumentation

At the DHCC, all Canadian doctrine is only persuasive, not binding (though the established hierarchy of precedents in Canadian law still inform how persuasive that doctrine is, e.g., higher court decisions are more persuasive than lower court decisions). Further, the DHCC places equal weight on arguments rooted in doctrine and theory. To this end, parties to the appeal **must** include at least one argument based in doctrine (e.g., jurisprudence and statutes) and one argument based in theory (e.g., critical race scholarship) in their written and oral submissions. **Failure to follow this rule will lead to disqualification from the final rounds of the moot.** With this in mind, parties should be clear—in both written and oral argument—regarding the classification of their various arguments as either doctrine or theory arguments. The easiest way to do this will be to label arguments in their overview (oral) and table of contents (written) as "Theory Argument 1: …" and "Doctrine Argument 1: …". Subject to the requirement of at least one doctrine and one theory argument above, parties can have as few or as many arguments as they consider most persuasive to advance their client's position.

Whereas "doctrine arguments" typically operate from inside the current legal system, "theory arguments" typically operate from outside the current legal system, question its underlying assumptions, and seek to reveal deeper insights into the ways in which the existing legal structure may sustain and perpetuate racial hierarchy (e.g., white supremacy, and relatedly, anti-Black racism). In this way, theory arguments have substantial flexibility in terms of their potential for innovative and creative reasoning. Should the *Charter* be reworded? Can the collection of race-based data, perversely, reinforce racist stereotypes leading to discrimination? Might good faith efforts at gathering race-based data unintentionally expand state surveillance, thereby potentially threatening other *Charter* rights, e.g., privacy? Will applying a racial lens to public health distract from the social determinants of health? The sky's the limit!

To be clear, a doctrine argument need not be entirely divorced from theory, and vice versa—indeed, doctrine and theory are inseverable. However, the thrust of a doctrine argument must be rooted in reference to traditional legal authorities, whereas the thrust of a theory argument is normative (i.e., concerns what Canadian law should be, not what it is) and, to the extent such arguments are rooted in reference to authority, that authority is principally theoretical scholarship.

c) Issues on Appeal

The issues on appeal include both doctrinal and theoretical issues. The doctrinal issues are listed below, whereas the theoretical issues are up to the participants.

The doctrinal issues on appeal are as follows:

- Whether Canada's failure to collect race-based data pertaining to COVID-19 infringes the right to life, liberty, and security of the person under s. 7 of the *Charter*;

- Whether Canada's failure to collect race-based data pertaining to COVID-19 infringes the right to equality under s. 15 of the *Charter*; and

- If either infringement is found, whether such an infringement is justified under s. 1 of the *Charter*.

For maximum clarity: **No doctrinal arguments concerning standing will be entertained in the moot**.

In contrast, the theoretical issues that may be raised are not pre-ordained. Rather, it is up to participants—both Appellants and Respondents—to think creatively about how the existing legal system can be critiqued (positively or negatively) in a manner favourable to their client. For example, a theoretical issue on appeal could be any of the following:

- Whether the principles of fundamental justice should be removed from s. 7 because infringements of rights to "life, liberty and security of the person" should be justified under s. 1 like other rights, not subject to a more onerous and internal justificatory standard;
- Whether the rights under ss. 7 and 15 should not be phrased as belonging to "everyone" or "[e]very individual" because such individualistic phrasing artificially atomizes legal rights in a manner that obscures how superficially neutral policy decisions systemically harm marginalized communities;
- Whether the onus for s. 15 claims, as an especially pernicious form of government action, should, like justification under s. 1, fall on the state, rather than the rights claimant;
- Whether s. 15 rights should be excluded from the scope of s. 1 because discrimination is categorically unacceptable in a free and democratic society;
- Whether the *Charter* should include an interpretive provision clearly indicating that its rights contemplate both negative and positive obligations on the state; and
- Whether the notion of "political" questions beyond the Court's jurisdiction—a barrier often raised in the context of positive state obligations—should be jettisoned for relying on an unsustainable dichotomy between law and politics.

Ultimately, as long as an argument seeks to overturn the majority decision below, it is properly advanced by the Appellant, whereas Respondents may advance any arguments seeking to uphold the majority decision below.

Since the doctrinal issues are the same for all parties, arguments on those issues will be aligned. The theoretical issues, however, will be chosen by the parties. In consequence, arguments on the theoretical issues may not be aligned in any particular moot. Do not worry about this! There will be no requirement for a Respondent's factum or oral submissions to engage with the theoretical issues that happen to be raised by the Appellants they moot against (and vice versa), though they are welcome to incorporate such a response into their oral submissions.

d) Deadlines

The following deadlines will be strictly enforced by the Moot Coordinators:

- Appellants and Respondents Factums due: January 4th, 2021
- Moot competition: February 5th and 6th 2021

e) Format

All factums should conform with the following formatting requirements:

- 20 page maximum
- Times New Roman
- 12-point font
- 1-inch margins
- 1½ line spacing (except indented quotes)
- Numbered paragraphs
- 8.5" x 11" pages
- **Bold** headings and sub-headings
- The cover should be in the same form as factums at the SCC except:
    - use 12-point font
    - "Supreme Court of Canada" should be changed to "Diversity High Court of Canada"
    - there is no need to make any references to the Supreme Court *Act* or *Rules*

Citations should conform with the latest edition of the McGill Guide.

These form requirements are primarily for consistency. Thus, minor deviations from these requirements will not result in any penalization. Participants should not be inordinately stressed about complying with every minute detail, and should instead focus on their arguments.

2. Substance

The doctrinal foundation for the moot is *Williams v Canada (Minister of Health)*, which is attached to these materials. However, the theoretical foundation for the appeal is briefly summarized here. I first discuss Critical Race Theory (CRT) generally, and then medical racism specifically.

For clarity, though, theory arguments need not cite extensive scholarship. Rather, they should be framed in line with the intellectual traditions summarized below. Some CRT scholarship is cited in the footnotes below, which may be helpful. In addition, there is plenty scholarship—much of which I would consider drawing from the CRT tradition—specifically exploring the issue of medical racism,[1] as well as the racial effects of state data collection and surveillance.[2] Reference

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[1] See e.g. Khiara M Bridges, *Critical Race Theory: A Primer* (St Paul, MN: Foundation Press, 2019) at 319-342; Harriet A Washington, *Medical Apartheid: The Dark History of Medical Experimentation on Black America from Colonial Times to the Present* (New York: Doubleday, 2006); Dorothy E Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* (New York: Pantheon Books, 1997); Dorothy Roberts, "Debating the Cause of Health Disparities: Implications for Bioethics and Racial Equality" (2012) 21:3 Cambridge Q of Healthcare Ethics 332; Dorothy Roberts, "What's Wrong with Race-Based Medicine: Genes, Drugs, and Health Disparities" (2011) 12:1 Minn J L Sci & Tech 1; Harriet A Washington et al, "Segregation, Civil Rights, and Health Disparities: The Legacy of African American Physicians and Organized Medicine, 1910-1968" (2009) 101:6 J of the National Medical Association 513; Harriet A Washington, "How environmental racism is fuelling the coronavirus pandemic", *Nature* 581 (21 My 2020), online: <https://www-nature-com.proxy3.library.mcgill.ca/articles/d41586-020-01453-y>; John Hoberman, *Black and Blue: The Origins and Consequences of Medical Racism* (Berkeley: University of California Press, 2012); W Michael Byrd & Linda A Clayton, *An American Health Dilemma, Volume 1: A Medical History of African Americans and the Problem of Race* (New York: Routledge, 2000); "Blackest Fish", *As it Happens*, CBC (21 July 2020), online: https://www.cbc.ca/radio/asithappens/as-it-happens-tuesday-edition-1.5657448/july-21-2020-episode-transcript-1.5659163; Lisa C Ikemoto, "In the Shadow of Race: Women of Color in Health Disparities Policy" (2006) 39:3 UC Davis L Rev 1023; Chandra L. Ford, Collins O. Airhihenbuwa, *Critical Race Theory, Race Equity, and Public Health: Toward Antiracism Praxis* (April 2010), online: Am J Public Health < 100(Suppl 1): S30–S35. doi: 10.2105/AJPH.2009.171058>; Butler J 3rd, Fryer CS, Garza MA, Quinn SC, Thomas SB, *Commentary: Critical Race Theory Training to Eliminate Racial and Ethnic Health Disparities: The Public Health Critical Race* (2018), online: Praxis Institute < Ethn Dis.; 28(Suppl 1):279-284. Epub 2018 Aug 9>; Hardeman RR, Burgess D, Murphy K, et al, (August 2018) *Developing a Medical School Curriculum on Racism: Multidisciplinary, Multiracial Conversations Informed by Public Health Critical Race Praxis (PHCRP)*, online: Ethn Dis. 2018; 28(Suppl 1):271-278. <doi:10.18865/ed.28.S1.271>; Richard Matthews, *The cultural erosion of Indigenous people in health care*, (January 2017), online: CMAJ.; 189(2): E78–E79 <doi: 10.1503/cmaj.160167>; Brown TN, *Critical race theory speaks to the sociology of mental health: mental health problems produced by racial stratification*, (2003), online: <J Health Soc Behav. 2003;44(3):292-301>; Williams DR, *Race, socioeconomic status, and health. The added effects of racism and discrimination*, (1999), online: Ann N Y Acad Sci. 1999;896:173-188. <doi:10.1111/j.1749-6632.1999.tb08114.x>; Sheryl Nester, *Colour Coded Health Care The impact of race and racism on Canadians' Health*,(2012),online*:* <https://www.wellesleyinstitute.com/wp-content/uploads/2012/02/Colour-Coded-Health-Care.pdf>.

[2] See e.g. Beverly Bain, OmiSoore Dryden & Rinaldo Walcott, "Coronavirus discriminates against Black lives through surveillance, policing and the absence of health data" (20 April 2020), online: *The Conversation* <https://theconversation.com/coronavirus-discriminates-against-black-lives-through-surveillance-policing-and-the-absence-of-health-data-135906>; Sachil Singh, "Collecting race-based data during coronavirus pandemic may fuel dangerous prejudices" (27 May 2020), online: *The Conversation* <https://theconversation.com/collecting-race-based-data-during-coronavirus-pandemic-may-fuel-dangerous-prejudices-137284>; Allen Fremont & Nicole Lurie, "Appendix D : The Role of Racial and Ethnic Data Collection in Eliminating Disparities in Health Care" in M Ver Ploeg & E Perrin, eds, *Eliminating Health Disparities: Measurement and Data Needs* (Washington, DC: National Academies Press, 2004); Sidney D Watson, "Health Care Divided: Race and Healing a Nation" (2000) 21:4 J Leg Med 601; Ver Ploeg M, Perrin E, *The Role of Racial and Ethnic Data Collection in Eliminating Disparities in Health Care* (2004),online: National Research Council (US) Panel on DHHS Collection of Race and Ethnic Data; Eliminating Health Disparities: Measurement and Data Needs. Washington (DC): National Academies Press (US); Appendix D, < https://www.ncbi.nlm.nih.gov/books/NBK215740/>; Bierman AS, Lurie N, Collins KS, Eisenberg JM., *Addressing racial and ethnic barriers to effective health care: the need for better data*. (2002), online: Health Aff (Millwood).21(3):91-102. <doi:10.1377/hlthaff.21.3.91>; Zaslavsky AM, Ayanian JZ, Zaborski LB., *The validity of race and ethnicity in enrollment data for Medicare beneficiaries* (2012), online: Health Serv Res. 47(3 Pt 2):1300-1321.< doi:10.1111/j.1475-6773.2012.01411.x>; 12. R.S. Cooper, *A case study in the use of race and*

to some of this scholarship is sufficient for competition in the moot, but additional research is always encouraged. That said, the scrutiny of theory arguments will rest principally on the extent to which they raise thoughtful insights about race and law, while also furthering your client's case, not on a tally of how many different scholars or articles happen to be cited.

a) What is CRT?

CRT is an academic field of inquiry interested in the intersection of law and racial inequality.[3] It defies narrow definition. But one could say it interrogates racial truth, i.e., that it challenges established conservative—and even liberal[4]—interpretations of law and society. As Derrick Bell, the "intellectual forefather of CRT",[5] explains: "critical race theory recognizes that revolutionizing a culture begins with the radical assessment of it."[6]

However, it would be incomplete to claim that critical race theory—or, perhaps more precisely, critical race theories[7]—does not reflect any ideological leaning (indeed, every movement does). And CRT is a generally "progressive" ideological movement—in the words of one of its founding theorists, Kimberlé Crenshaw, CRT represents a "left intervention into race discourse and a race intervention into left discourse."[8]

More precisely, CRT can be understood in opposition with "post-racialism"—whereas post-racialism claims that race does not play an explanatory role in our current society, CRT counterclaims that race not only plays such a role in society, but further, that powerful forces (like law) assist race in playing that role.[9] For example, in the United States, mass shootings by white men are typically characterized by initial media reporting as relating to mental health, whereas mass shootings by Arab-Americans are quickly characterized as relating to terrorism.[10] A post-racial lens would say that race simply describes the demographics of terrorist actors; CRT, in contrast, would say that race explains how we conceptualize terrorism.

Simply put, if you are critically thinking about race and law, then you are doing critical race theory.[11] And that is the intent of the Isaac Moot: to encourage participants to dig deeper into how our legal structures maintain and perpetuate racial hierarchy in society. The ultimate goal is to

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ethnicity in public health surveillance (Jan-Feb 1994), online: Public Health Rep. 1994 Jan-Feb; 109(1): 46–52. PMCID: PMC1402241 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1402241/>; 13. Bliss Kaneshiro, Olga Geling, Kapuaola Gellert, Lynnae Millar, *The Challenges of Collecting Data on Race and Ethnicity in a Diverse, Multiethnic State* (August 2011), online: Hawaii Med J. 2011 Aug; 70(8): 168–171.PMCID: PMC3158379 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3158379/; Vickie M. Mays, Ninez A. Ponce, Donna L. Washington, and Susan D. Cochran, *Classification of Race and Ethnicity: Implications for Public Health (October 2002), online:* Annu Rev Public Health. 2003; 24: 83–110.< doi: 10.1146/annurev.publhealth.24.100901.140927>.

[3] Bridges, *supra* at 7.

[4] *Ibid*, at 12-13.

[5] *Ibid*.

[6] Derrick A. Bell, "Who's Afraid of Critical Race Theory" (1995) 1995 U. Ill. L. Rev. 893 at 893.

[7] I say this because CRT is not a *scientific* theory, but rather, a *social* theory best described as "many theories" roughly united around a core "belief in an opposition to oppression." See Jerome McCristal Culp, Jr. "To the Bone: Race and White Privilege" (1999) 83 Minn. L. Rev. 1637 at 1638.

[8] Crenshaw, Gotanda, Peller and Thomas, eds., *Critical Race Theory* (1995) at xix.

[9] Bridges, *supra* at 5-7.

[10] Bridges, *supra* at 1-2.

[11] Bridges, *supra* at 9.

encourage creativity and imagination, hallmarks of CRT. With that in mind, participants should not feel pressured to follow any particular "methodology" or reach any particular "conclusion" in their arguments to remain faithful to CRT—indeed, CRT prescribes neither.[12]

Some dismiss CRT as fringe and misguided. It is anything but. To be sure, American equality jurisprudence adopts the post-racial view that historic examples of legally sanctioned racism (e.g., racially segregated public institutions) and contemporary efforts at race-conscious anti-racist policy (e.g., affirmative action) should be subject to similar constitutional scrutiny,[13] a view perhaps most famously articulated by Roberts C.J.'s concurring opinion in *Parents Involved in Community Schools v Seattle*: "The way to stop discrimination on the basis of race is to stop discriminating on the basis of race."[14] However, the Canadian *Charter of Rights and Freedoms*, in stark contrast, specifically permits affirmative action.[15] Indeed, when the Supreme Court in *R v Le* held that a proper s. 9 detention analysis must consider "the larger, historic and social context of race relations between the police and the various racial groups and individuals in our society",[16] the highest court in our country is doing CRT (well, our highest court other than the Diversity High Court of Canada…).

Some also critique CRT for its malleability, but this simply corresponds with the malleability of its subject. Racial logic is agile; it evolves overtime to evade detection. Whereas state-sanctioned racism was predominantly overt historically, changing etiquettes now redesign the modalities of racism into more subtle forms. Before, society was explicitly anti-Black. Now, the claim is, we are simply pro-merit[17] and pro-patriotism.[18] Decoding these forms of racism is central to contemporary anti-racist projects.

Conventionally, we think of race as a concept related to identity, e.g., Black people and white people. But race is more a process (verb) than a person (noun). As Kendall Thomas, another founding CRT thinker, writes: "we are 'raced' through a constellation of practices that construct and control racial subjectivities."[19] With this in mind, participants are encouraged to reflect on the subtle ways in which race is mobilized to sort—and ultimately, subjugate—certain groups within society.

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[12] Bridges, *supra* at 11.
[13] See e.g. *Adarand Constructors, Inc. v. Peña*, 515 U.S. 200 (1995). There is extensive CRT scholarship critiquing race-neutral (or, "colorblind") conceptualizations of equality. See e.g. Neil Gotanda, "A Critique of `Our Constitution is Color Blind'," in *Critical Race Theory*, *supra* and Lani Guinier and Gerald Torres, "A Critique of Colorblindness," in *The Miner's Canary* 32-66 (2002).
[14] 551 U.S. 701 (2007) at 748.
[15] *Charter*, s. 15(2).
[16] *R. v. Le*, 2019 SCC 34 at para 76.
[17] Bret Stephens, "Diversity, Inclusion and Anti-Excellence" (Aug. 2, 2019) *New York Times*, online: https://www.nytimes.com/2019/08/02/opinion/university-campus-diveristy-inclusion-free-speech.html.
[18] Sally Jenkins, "Colin Kaepernick reminds us that dissent is a form of patriotism too" (Sept. 8, 2016) *Washington Post*, online: https://www.washingtonpost.com/sports/redskins/colin-kaepernick-reminds-us-that-dissent-is-a-form-of-patriotism-too/2016/09/08/053830aa-75e4-11e6-8149-b8d05321db62_story.html.
[19] Kendall Thomas, *The Eclipse of Reason: A Rhetorical Reading of Bowers v. Hardwick*, (1993) 79 Va. L. Rev. 1805 at 1806-07.

As one example, consider the pernicious feedback loop that can arise for marginalized people in medical care. Given a complex combination of factors (e.g., medical racism, medical paternalism, and distinct health traditions) it is understandable for Black and Indigenous people to be distrustful of medical systems, especially when, for example, implicit bias continues to impair medical services. But this distrust may, in turn, exacerbate health disparities, especially when paired with other structural factors disproportionately impacting racialized communities, including the social determinants of health. If racialized communities are legitimately apprehensive about the medical community, but that apprehension contributes to systemic health disparities, some will simply place the blame for such disparities on racialized people themselves. This is the logic of white supremacy, a logic which can only be properly theorized with necessary historical and social context, and a logic which perniciously leads to the under-treatment of racialized people and the over-expectation that they simply look past the structural and individual factors that compromise their health. Racialized communities are not innately unhealthy. And yet, by the logic described above, they are held principally to blame for their poor health. This "unhealthy" community did not pre-exist human intervention; rather, it was, at least partially, created by health systems that have considered them both biologically and culturally predisposed to poor health, and which then responded accordingly. With every poor health outcome resulting from structural racism embedded in our health systems, the self-fulfilling prophecy of racial logic fuels its own fire.

b) What is Medical Racism?

Medical racism refers to the ways in which racial hierarchy can manifest in systems of health. Medical systems have a long and horrific relationship with white supremacy, of which the Tuskegee Syphilis Experiment is emblematic.[20] But many argue that this toxic relationship persists to this day, both in America and Canada. Just last month, a whistleblowing nurse alleged that immigrants held by the American government were being subject to non-consensual gynecological procedures.[21] And in Canada, Indigenous women have long suffered mistreatment and abuse by health professional, including being subject to forced sterilizations, which continued as recently as 2018.[22] Indeed, just last week, Joyce Echaquan—an Indigenous woman—broadcast a Facebook live video as she lay dying in a Quebec hospital. In the background, healthcare workers can be overheard denigrating her ("you are stupid as hell"), blaming her for her ultimately fatal health crisis ("well you made some bad choices, my dear"), and even shaming her, with reference to her children ("what would your kids think of you seeing you like that?").[23]

A critical concept in medical racism is "health disparities", i.e., the "differences in health states among groups within a population."[24] In Canada, aggregated health data—e.g., statistics

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[20] Vann R. Newkirk II, "A Generation of Bad Blood" (2016) *The Atlantic*, online: https://www.theatlantic.com/politics/archive/2016/06/tuskegee-study-medical-distrust-research/487439/.
[21] Caitlin Dickerson, "Inquiry Ordered Into Claims Immigrants Had Unwanted Gynecology Procedures" (2020 Sept 16) *NY Times*, online: https://www.nytimes.com/2020/09/16/us/ICE-hysterectomies-whistleblower-georgia.html.
[22] "Forced Sterilization of Indigenous Women in Canada", *International Justice Resource Centre*, online: https://ijrcenter.org/forced-sterilization-of-indigenous-women-in-canada/.
[23] Benjamin Shingler, "Investigations launched after Atikamekw woman records Quebec hospital staff uttering slurs before her death" (29 Sept 2020) *CBC News*, online: https://www.cbc.ca/news/canada/montreal/quebec-atikamekw-joliette-1.5743449.
[24] Bridges, *supra* at 320.

concerning broad categories, like "visible minorities"—may conceal race-based health disparities[25] (hence, the topic for this moot). In contrast, in America, where disaggregated data is more often collected, a stark landscape of racial inequity is more easily ascertainable. For example, in the last forty years, "black women have been dying during pregnancy, childbirth, or shortly thereafter at three to four times the rate of their white counterparts."[26] CRT asks: why?

Class is undeniably relevant. Racialized communities are, in general, poorer than white communities. And it is well-established that social factors—i.e., the "social determinants of health"—influence health outcomes. It follows that poorer racialized communities would likely have worse health outcomes, especially in America's privatized health care system, where wealthier people have particularly greater access not only to quality health care, but health services at all.

But does class tell the whole story? Two responses from CRT scholars are especially important in this regard.

First, some argue that class does not completely explain racial health disparities. Indeed, several studies show that, when the variable of class is accounted for, racial health disparities remain.[27] This is true, for example, with respect to maternal mortality rates,[28] a concern recently discussed by Hadiya Roderique in *The Globe and Mail*.[29] Notably, some racial health disparities actually increase across income levels, such that it is wealthy Black people who experience the greatest disparities in health with respect to peers in the same class bracket.[30] Such studies cast doubt on the extent to which class explains racial health disparities.

Second, thinking even more critically, some CRT scholars argue that, while class is often the immediate cause for racial disparities in health, race is nevertheless the ultimate cause for those disparities—in other words, that "race and racism may explain the U.S.'s status as the sickest among the wealthiest nations."[31] Perhaps the political will for universal health care in America has lagged so far behind other peer countries precisely because—whether subconscious or otherwise—Americans know that many of the people lacking health care in the United States are Black and Indigenous.

Given the above, it seems clear that race affects health systems, and in turn, health outcomes. But what is the mechanism through which these racial effects occur? Some conservatives claim that

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[25] Patricia Rodney & Esker Copeland, "The health status of black Canadians: do aggregated racial and ethnic variables hide health disparities?" J Health Care Poor Underserved 2009 Aug;20(3):817-23. doi: 10.1353/hpu.0.0179, online: https://pubmed.ncbi.nlm.nih.gov/19648707/.
[26] Bridges, *supra* at 320.
[27] Bridges, *supra* at 322.
[28] Christopher T. Lang & Jeffrey C. King, "Maternal Mortality in the United States" (2008) 22 Best Prac. & Res. Clinical Obstetrics & Gynaecology 517, 522-23.
[29] Hadiya Roderique, "Can I be a Black mother in a world so dangerous to Black children?" (2020) *The Globe and Mail*, online: https://www.theglobeandmail.com/opinion/article-can-i-be-a-black-mother-in-a-world-so-dangerous-to-black-children/.
[30] Marsha Lillie-Blanton et al., "Racial Differences in Health: Not Just Black and White, But Shades of Gray" (1996) 17 Ann. Rev. Pub. Health 411 at 429.
[31] Bridges, *supra* at 320.

racial health disparities can be best explained by outdated—indeed, eugenic—notions of biological race predisposing Black people to negative health outcomes.[32] Others claim that Black culture, not white supremacy, best explains racial health disparities. While it is "undeniable that one's behaviour affects one's health",[33] the new discourse of "culture" can be deployed as a strategic surrogate for the old discourse of "race". Indeed, this race/culture swap is common in contemporary discourse: it was deployed by a sitting bencher in the debates surrounding the Law Society of Ontario's recent equality initiatives, where that bencher tacitly approved the idea that the underrepresentation of Black lawyers may be due to Black people lacking "a culture of learning";[34] and it has been deployed by Ontario's current "Advocate for Community Opportunities" who emphasizes the role of hip hop culture in persisting racial disparities in society.[35] As anthropologist Kamala Visweswaran astutely observes:[36]

> [B]ecause everyone 'talks culture' (that is to say, has access to the concept of culture), its relativist outlines have been increasingly filled by racist content. But does that not illustrate how culture has come to stand in for race? … [C]ulture is asked to do the work of race. This is perhaps what Walter Benn Michaels means by the title of his essay "Race as Culture." He writes, "Our sense of culture is characteristically meant to displace race, but … culture has turned out to be a way of continuing rather than repudiating racial thought."

And as Ruha Benjamin observes, "culture talk" has crept into health discourse to reproduce racist narratives, as illustrated by distinct media reporting on "Black" and "white" drug epidemics:[37]

> Whether it is drug addiction or other health behaviors, cultural explanations for disparate outcomes is an ever-ready lexicon with deeply racist roots. In fact, the intertwining of cultural and genetic traits to identify and hierarchize groups has been integral to scientific racism. Culture is typically posited as the mechanism through which genetic differences operate. As such, "culture talk" obscures the social reality of those it purports to describe and hides the positionality of those who engage in such descriptions.

Still, lifestyle does impact health consequences. And so, even those with progressive racial politics have to grapple with the multifaceted sources of health disparities, while remaining mindful of the pernicious scripts certain sources may draw from.

Instead of biology and culture—two explanations which, conveniently, omit white supremacy and state policy from racial health disparities—CRT scholars point to several alternate causes. And

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[32] Bridges, *supra* at 323-327.
[33] Bridges, *supra* at 327.
[34] Joshua Sealy-Harrington, "Twelve Angry (White) Men: The Constitutionality of the Statement of Principles" (2020) 51:1 Ottawa Law Review 195 at 226.
[35] Jamil Jivani, "Has Obama become a conservative?" (2019) *Fox News*, online: https://www.foxnews.com/opinion/has-obama-become-a-conservative.
[36] Kamala Visweswaran, "Race and the Culture of Anthropology" (1998) 100 Am. Anthropologist 70 at 76.
[37] Ruha Benjamin, "Cultura Obscura: Race, Power, and 'Culture Talk' in the Health Sciences" (2017) 43 American Journal of Law & Medicine 225 at 228 [footnotes omitted].

these causes may be helpfully divided into two categories: (1) structural causes (i.e., those which originate in societal and health systems, e.g., residential segregation and access to health insurance);[38] and (2) individualist causes (i.e., those which originate with specific patients and health care providers, e.g., stress and provider bias).[39]

Given the relationship between race and health outlined above, CRT scholars actively debate the relative merits of race-based data collection. In favour of such collection, some scholars argue that it is impossible to diagnose the specific mechanisms through which racial disparities in health emerge without access to disaggregated data. In opposition to such collection, other scholars argue that race-based data can be used to reinforce racism, both in terms of prejudicial attitudes and with respect to the construction of algorithms that exacerbate bias. No matter your position, though, it is clear that racial disparities in health are a complex problem warranting continued critical engagement.

3. A Parting Note

Khiara Bridges writes that "CRT is dedicated to the production of politically engaged scholarship."[40] This moot, relatedly, is dedicated to the production of politically engaged lawyers. And, more specifically, lawyers who are politically engaged with respect to questions regarding law and racial inequality.

The structure of this moot may make some participants uneasy, or uncomfortable. Law schools often emphasize doctrine over theory, and law over justice. But certain forms of oppression simply cannot be fully understood by the limited imagination of traditional legal discourse. The law, by its very nature, demands clear dispositions: a winner and a loser. Human thought and activity, in contrast, is anything but clear. Racism is subtle. And race is vague. While this moot is unconventional, it is our hope that participants will lean into their discomfort, and begin to think more critically—and imaginatively—about race and law. It is only through critical theoretical thought, and active creativity, that deeper insights about racial hierarchy can be generated and explored. Ultimately, the goal with this moot is for participants to work hard, think deeply, and enjoy engaging with complex questions at the forefront of Canadian political and legal discourse. So, thank you for competing in the Isaac Moot. Your mere participation is a significant commitment to driving forward Canada's racial discourse in law.

Kind regards,

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[38] Bridges, *supra* at 330-332.
[39] Bridges, *supra* at 332-337.
[40] Bridges, *supra* at 14.