

The Population Health Impact of Racial Bias and Social Injustice: The Example of Police Brutality and Black Men

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Our country is caught in the middle of a heated discussion. At the heart of the discussion is the proper use of law enforcement and the role of government vs. the individual rights, liberty, and security of citizens. The discussion has been played out most visibly in the repeated images of black men dying under the hand of police and at the same time police being attacked and killed by wayward perpetrators. Physicians have long been witnesses to the consequences of communities suffering from disparities in health and diminished resources and opportunities. At this past SGIM annual meeting we expanded on this discussion through a symposium titled “Population Health Impact of Racial Bias on Health: The Example of Police Brutality and Black Men.”

This symposium began with narratives by several SGIM members, all of whom were black male faculty describing scenarios in which they were mistreated in some way, shape, or form by law enforcement. In their stories was a theme—a description of scenarios or an environment where their dignity was denied, leading to feelings that this experience would be repeated and reinforced through individual encounters and institutional policies.

Our speakers—Dr. Camara Phyllis Jones, Dr. Wisdom Powell, and Dr. John Rich—helped us name this phenomenon as an effect of racism. Dr. Powell described it as “similar to carbon monoxide, difficult to detect, colorless, odorless but with disastrous effects if not addressed.” Another discussion showed appreciation of our collective benevolence—a desire

to examine our institutions, uplift our communities, work with our colleagues, and serve our patients and each other. From this conference we submit four great lessons:

1. We should try to understand and recognize how everyday micro aggressions and discrimination affect patients in terms of health care seeking and self-care behavior, internalization of stresses, and eventually health outcomes. Patients may not be aware of the details behind historical events such as Tuskegee, but due to everyday experiences of discrimination they may look at health care as another institution that they may be hesitant to fully trust.
2. We should investigate how institutional and personally mediated racism affects the care we deliver. Institutional policies and structures should be re-evaluated to determine if we are systematically delivering care based on socially determined characteristics rather than purely biologic or epigenetic characteristics. Dr. Rich gave an example of black male victims of violence who frequently suffer from post-traumatic stress disorder but whom the medical system does not counsel, acknowledge, or treat appropriately, if at all. It is not only important to think about how our services are affected but also how we deliver those services. Perhaps we should ask these young men about their experiences in the health care system and adjust our processes to account

for how they receive care. Though this self-evaluation we may band together and create a more respectful environment within our institutions so that negative racial messages are not repeated.

3. Racism is a system of structuring opportunities and assigning values based on race. It is important to name, identify, and talk about racism. Racism saps the strength of our systems by failing to invest the full resources of our nation equally. Using Dr. Camara Jones’ colorful description of a gardener tilling the soil, bad soil not only causes flowers to grow in an impaired environment but also perpetuates a lack of attention by the gardener due to impaired growth. Using our positions of privilege it is important that we identify, document, question, and address systemic factors we identify as wrong.
4. We value multi-racial and multi-institutional partnerships and have many strategies that facilitate doing so. These include incorporating social justice issues in our clinical assessments and attention to social determinants of health during rounds; co-locating primary care and mental health services to remove stigma from those seeking help; and using our clinics as a safe place to transition people from the hospital to community resources. By working together in these ways we can uplift our communities and strengthen the relationships of the community to our medical institutions.

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