



Perspective

Beyond a Moment — Reckoning with Our History and Embracing Antiracism in Medicine

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Medicine has reached a new consciousness of the depth and devastation of racism in the United States. Amid a national-turned-global reckoning on racism in the spring of 2020,

medical institutions and associations have declared en masse that structural racism and police violence are critical public health issues. But to go beyond declarations and move forward with fighting racism in medicine, we must understand the racial biases in our responses to past and present public health issues and plot an ethically and structurally different path to a new future.

Although the American Public Health Association and individual advocates have identified police violence and racism as public health issues for decades, medicine as a whole is painfully late in its awakening. The morbidity, mortality, and racial disparities associated with police violence are longstanding. The health and health

care disparities that plague the United States are ubiquitous and well studied. Structural racism has been described and identified as a root cause of health inequities.¹ To cite but one example: the history of medicine and public health in the United States reveals a pattern of medicalizing the suffering of White communities while ignoring or criminalizing the similar suffering of minority communities, especially Black communities. This dichotomy is particularly stark with regard to issues at the intersection of health, politics, and law. That our collective awareness comes only in the wake of a global protest movement for racial justice highlights the pervasiveness of our collective biases and willful ignorance.

Two modern-era instances of this phenomenon illustrate the way in which it perpetuates racism, health inequities, and social injustice. Among the most flagrant examples of racially biased approaches to public health issues in U.S. history are the policies enacted in response to substance use epidemics.² In the 1970s, as an epidemic of cocaine use spread across the country, a racial divergence emerged in both how cocaine was used and how it was policed. The powdered cocaine that became more prevalent in White communities was treated much as alcohol use is — largely socially accepted despite its health harms. In contrast, the crack cocaine use that was more prevalent in Black communities was often falsely attributed to personal and familial dysfunction. Ultimately, cocaine use was met with a multi-million-dollar War on Drugs and legal penalties that were up to 100 times as harsh for “crack” as

for powdered cocaine. This racially biased response was a driver of the racial disparities in incarceration that persist today³ — disparities that beget additional disparities in employment, housing, and other opportunities that, in turn, compound the adverse impact of these racially biased policies on Black lives.

The different responses in the United States to use of the same drug in Black and White communities recurred in recent decades, as the opioid overdose crisis was met with racialized public responses that echoed those of the cocaine crisis.² Opioid use in urban, often Black, communities causing substantial morbidity and mortality was met with a doubling down on the War on Drugs. But in the 2010s, when the U.S. opioid overdose crisis reached suburban and rural White communities, politicians, the media, and public health experts began to reframe the issue: substance use was no longer evidence of personal failure, but a public health crisis warranting funding and care.

Today, people suffering from opioid addiction are more often, and rightly, understood to have substance use disorder. The medical establishment now puts substantial resources toward research, education, prevention, and treatment of this health issue. While criminalization of substance use and people who use substances is ongoing, the Department of Health and Human Services reports that it has awarded more than \$9 billion to promote opioid treatment and prevention in the states. These shifts are positive and must continue, but we also must recognize that they grew in part out of an empathy that is routinely extended to suffering

White communities and traditionally denied to communities of color.

Over the past decade, this legitimization of public health challenges in White communities and diminishment of analogous public health challenges in Black communities has played out prominently in medicine's responses to police violence and gun violence. In 2013, young Black Americans formed Black Lives Matter, a national movement against anti-Black racism and the unjust killing of Black people by police. Police violence is one of the leading causes of death among young Black American men: the lifetime risk of death at the hands of police for Black men is estimated to be 1 in 1000.⁴ Police violence against unarmed Black Americans has been shown to cause serious psychological suffering among Black Americans generally,⁵ and racism-related stress adversely affects Black Americans' health regardless of their socioeconomic circumstances or geographic location. Yet with rare exceptions, including the American Public Health Association and the medical student-led White Coats for Black Lives organization, medical societies and public health organizations have until recently remained silent on the issue of protecting Black lives from police violence.

This enduring lack of a collective public health stance on protecting Black lives contrasts with the medical community's response to a contemporaneous youth-led movement against gun violence and mass shootings. In 2018, the brave students of Marjory Stoneman Douglas High School in Parkland, Florida, worked to translate the senseless deaths of their

classmates and teachers into societal change on the issue of gun violence. Almost immediately, health professionals added their voices and influence to the cause, using the battle cry "This Is Our Lane." Health care clinicians, educators, and researchers became advocates; they pressured major medical associations to declare mass shootings and gun violence a public health issue. This health crisis framing and medical community support reinforced the youth-led activism efforts that resulted in the passage of an unprecedented 67 gun laws in 26 states. Equitable and evidence-based support from the medical community was not extended to the similarly inspired movement to protect Black lives.

We — a Black medical student, a White medical anthropologist, a Black trauma surgeon, and a White clinician educator — acknowledge that we are a part of medical institutions that have too often failed minority communities, and we wish for this moment of reckoning to be an inflection point in that history. We believe our health professions colleagues, societies, and systems need to go beyond declarations — that each must review its own history, structures, workforces, and policies in an approach dedicated to truth and reconciliation and that we must all proactively engage in the battle against structural racism and health inequities to bring about a new era of antiracism in medicine.

Specifically, we urge individuals and institutions throughout the health professions to follow and support the recommendations of the American Public Health Association and others who call for a reimagining and reallocation of

police and policing resources. Without this action, the tragedies that sparked this time of reflection will continue.

More broadly, we believe a new understanding and embrace of diversity are needed, up to the highest levels of medicine and public health — diversity that goes beyond representation to empowerment of the identities, ideas, and lived experiences that can deepen our collective consciousness and prevent the willful ignorance of the past.

National and institutional funding is needed for efforts aimed at actively ending health inequities — funding that matches support for traditional disciplines and consistently embeds consideration of the perpetuation or creation of

inequities into all health care, education, and research.

The health professions must continue to engage with the complex social and structural determinants of health that intersect with politics and law. Addressing the health effects of structural racism cannot be accomplished through clinical, educational, or research activities alone; social advocacy and activism are required to employ antiracist policies targeting specific health inequities. For this reckoning to be more than a moment, we must confront our history, embrace discomfort, evolve, transform, and commit to a new era of antiracism in medicine.

Disclosure forms provided by the authors are available at NEJM.org.

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