Perspective

#BlackLivesMatter — A Challenge to the Medical and Public Health Communities

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Two weeks after a Staten Island grand jury decided not to indict the police officer involved in the death of a black man, Eric Garner, I delivered a lecture on the potential for partnership between academia and health departments to advance health equity. Afterward, a group of medical students approached me to ask what they could do in response to what they saw as an unjust decision and in support of the larger social movement spreading across the United States under the banner #BlackLivesMatter. They had staged "white coat die-ins" (see photo) but felt that they should do more. I wondered whether others in the medical community would agree that we have a particular responsibility to engage with this agenda.

Should health professionals be accountable not only for caring for individual black patients but also for fighting the racism — both institutional and interpersonal — that contributes to poor health in the first place? Should we work harder to ensure that black lives matter?

As New York City's health commissioner, I feel a strong moral and professional obligation to encourage critical dialogue and action on issues of racism and health. Ongoing exclusion of and discrimination against people of African descent throughout their life course, along with the legacy of bad past policies, continue to shape patterns of disease distribution and mortality.[1] There is great injustice in the daily violence experienced by young black men. But the tragedy of lives cut short is not accounted for entirely, or even mostly, by violence. In New York City, the rate of premature death is 50% higher among black men than among white men, according to my department's vital statistics data, and this gap reflects dramatic disparities in many health outcomes, including cardiovascular disease, cancer, and HIV. These common medical conditions take lives slowly and quietly — but just as unfairly. True, the black–white gap in life expectancy has been decreasing,[2] and the gap is smaller among women than among men. But black women in New York City are still more than 10 times as likely as white women to die in childbirth, according to our 2012 data.

Physicians, nurses, and public health professionals witness such inequities daily: certain groups consistently have much higher rates of premature, preventable death and poorer health throughout their lives. Yet even as research on health disparities has helped

University of Vermont Medical Students during a "Die-In" Protest.

to document persistent gaps in morbidity and mortality between racial and ethnic groups, there is often a reluctance to address the role of racism in driving these gaps. A search for articles published in the *Journal* over the past decade, for example, reveals that although more than 300 focused on health disparities, only 14 contained the word "racism" (and half of those were book reviews). I believe that the dearth of critical thinking and writing on racism and health in mainstream medical journals represents a disservice to the medical students who approached me — and to all of us.

The World Health Organization proclaimed in 1948 that "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[3] Today, both individual and social well-being in communities of color are threatened. If our role is to promote health in this broader sense, what should we do, both individually and collectively? Many health professionals who consider that challenge stumble toward inaction — tackling racism is daunting and often viewed as divisive and requiring action

outside our purview. I would like to believe that there are at least three types of action through which we can make a difference: critical research, internal reform, and public advocacy. In reflecting on these possibilities, I add to nearly two centuries of calls for critical thinking and action advanced by black U.S. physicians and their allies.

First, it's essential to acknowledge the legacy of injustice in medical experimentation and the fact that progress has often been made at the expense of certain communities. Researchers exploited black Americans long before and after the infamous Tuskegee syphilis study.[4] But there is room for optimism. Over the past two decades, for example, we've seen a welcome resurgence in social epidemiology and research documenting health disparities. Whereas stark racial differences in health outcomes have sometimes inappropriately been attributed to biologic or genetic differences in susceptibility to disease or bad individual choices, new methods and theories are allowing for more critical, nuanced analyses, including those examining effects of racism. By studying ways in which racial inequality, alone and in

combination with other forms of social inequality (such as those based on class, gender, or sexual preference), harms health, researchers can spur discussions about responsibility and accountability. Who is responsible for poor health outcomes, and how can we change those outcomes? More critical research on racism can help us identify and act on long-standing barriers to health equity.

There is also much we can do by looking internally at our institutional structures. Though the U.S. physician workforce is more diverse than it was in the past, and some efforts have been made to draw attention to the value of diversity for improving health outcomes, only 4% of U.S. physicians are black, as compared with 13% of the population, and the number of black medical school graduates hasn't increased noticeably in the past decade.[5] Renewed efforts are needed to hire, promote, train, and retain staff of color to fully represent the diversity of the populations we serve. Equally important, we should explicitly discuss how we engage with communities of color to build trust and improve health outcomes. Our target "high-risk" communities, often communities of color, have assets and knowledge; by heeding their beliefs and perspectives and hiring staff from within those communities, we can be more confident that we are promoting the right policies. The converse is also true. If we fail to explicitly examine our policies and fail to engage our staff in discussions of racism and health, especially at this time of public dialogue about race relations, we may unintentionally bolster the status quo even as society is calling for reform.

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In terms of broader advocacy, some physicians and trainees may choose to participate in peaceful demonstrations; some may write editorials or lead "teach-ins"; others may engage their representatives to demand change in law, policy, and practice. Rightfully or not, medical professionals often have a societal status that gives our voices greater credibility. After the grand-jury decision last November not to indict the police officer who shot a black teenager in Ferguson, Missouri, I wrote to my staff noting that in this time of public outcry, it is important to assert our unwavering commitment to reducing health disparities. We can all do at least that.

As a mother of black children, I feel a personal urgency for society to acknowledge racism's impact on the everyday lives of millions of people in the United States and elsewhere and to act to end discrimination. As a doctor and New York City's health commissioner, I believe that health professionals have much to contribute to that debate and process. Let's not sit on the sidelines.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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