The Black Lives Matter Movement

Justice and Health Equity

By MICHAEL P. JAYCOX, MDiv, PhD

Sooner or later, the members of any organization with an interest in ethics will ask themselves a critical question: Whose voices, experiences and concerns usually occupy the center, and whose have been relegated to the periphery?

Examining the relative distribution of power in the group typically helps in answering this question. For example, my work as a white participant in the Black Lives Matter movement has instructed me regarding the importance of placing in the center the voices, experiences and concerns of black persons, women and black women in particular, even when members of these groups represent a majority of the people in the room.

The sheer amount of power our racist and patriarchal society confers upon white, educated men like me underlines the fact that I must cultivate a deliberate habit of "de-centering" my own voice, experiences and concerns in order to make myself less likely to dismiss and more able to hear those of black persons and women.

Practically speaking, the de-centering habit does not require silence so much as a willingness to cede the floor. This is not a contrived self-effacement, but, rather, an appropriate humility about whether or not I am able to know what is true and good solely by consulting my own standpoint. Although this may seem like one more exercise in postmodern moral equivocation or political correctness, the reality is that patterns of systemic oppression and privilege at the societal level make such habits ethically necessary at the interpersonal level, especially, but not exclusively, in the context of grassroots political organizing.

Catholic health care in the United States obviously is a large system with a distinctive institutional culture. Perhaps less obviously, its context is similar to that of grassroots organizations because it has a center and a periphery. Even with its noble mission and its purpose to heal suffering, Catholic health care's status as an inescapably human institution means it, too, is morally implicated in the patterns of privilege and oppression that characterize the society it serves.

Health care professionals, whether in Catholic or in secular facilities, frequently have been guilty of relegating to the periphery the voices, experiences and concerns of patients who have endured terrible suffering — even while aiming to help them.

ON THE COMMON GOOD

Our societal challenges have never been greater. It will take every mind, body, and the spirit of good will to solve them. Working together, it can be done.

Darryl Robinson, Dignity Health

SYSTEMIC AND STRUCTURAL CAUSES

Such instances of well-intentioned but ultimately harmful paternalism are not attributable to a few bad apples in the profession; rather, the causes are systemic and structural. For example, we have institutional protections requiring the informed consent of human subjects participating in medical research because we know that researchers, left to their own devices, tend to prioritize interests other than those of the frequently vulnerable populations participating in the research.

Governed by the *Ethical and Religious Directives for Catholic Health Care Services*, the Catholic health care ministry "is rooted in a commitment to promote and defend human dignity."[1]

Basic human dignity is imperiled when members of vulnerable social groups are exploited by those with more power and excluded from participating in their fair share of society's benefits. Catholic health care prioritizes "by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination: the poor; the uninsured and the underinsured; children and the unborn; single parents; the elderly; those with incurable diseases and chemical dependencies; racial minorities; immigrants and refugees."[2]

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That being said, an ethical and political question remains: How should health care professionals working in Catholic facilities respond to the challenge of the Black Lives Matter movement? How can the vast institutional structure of Catholic health care serve the cause of racial justice?

HEALTH CARE EQUITY

Being a "bottom-up" grassroots coalition of many smaller groups rather than a "top-down" hierarchical organization, the Black Lives Matter movement has no official leadership structure. Political positions and policies are established at the local level and at national conferences by consensus. In addition to proposed reforms of the criminal justice system and policing methods, the movement has expressed concern about health care equity, or, to be more precise, outrage about the persistent threats to the health of black individuals and communities struggling to survive and thrive in U.S. society.

One branch of the movement, The Movement for Black Lives, calls attention in its extensive policy platform to the following health-related challenges: Lack of access to quality health care in a prison system that disproportionately jails black inmates; lack of access due to discrimination against black persons who are transgender, queer or gender nonconforming; lack of proximity to comprehensive health care facilities for black communities in racially and economically segregated neighborhoods; lack of culturally competent health care professionals; lack of access to mental health resources for black communities living with social instability, constant police surveillance, literal and structural forms of violence and the resulting trauma; persistent racial disparities in insurance coverage, even in the midst of the expansion of Medicaid under the Affordable Care Act; and the political elusiveness of a public, single-payer system as the most realistic path to guaranteeing universal access to health care.[3]

Members of another branch of the movement, the student-led coalition WeTheProtesters, also express outrage that colleges and universities generally are not prepared to address the distinctive mental health struggles of black students,

ON THE COMMON GOOD

The silence in America is deafening as poor, vulnerable and underserved communities, who feel locked out of a prosperous society, repeatedly ask the question "is anybody listening .... does anybody care?" Human flourishing and interdependence languish if we fail to raise our voices in the public square to proclaim the inviolable dignity of black lives. As we promote the common good, God's love must be demonstrated in how we care for our neighbor.

Roslyn Brock, NAACP National Board of Directors

particularly on predominantly white campuses.[4]

Even this brief perusal of the health-related concerns of the Black Lives Matter movement is enough to warrant some caution on the part of health care professionals eager to respond. The temptation to propose premature answers, without first placing the voices, experiences and concerns of black persons at the center, should be avoided. It is tempting, for example, to propose, fund and implement new programs or initiatives that focus on increasing awareness of the adverse health effects of trauma or on improving the accessibility of health care resources in black communities. Such programs will indeed continue to be necessary and good, but they ultimately are insufficient for addressing the underlying structural causes of inequity, which are the focus of the movement's outrage.

STRUCTURAL RACISM AS A CAUSE

The 2004 book *Aquinas, Feminism, and the Common Good* (Georgetown University Press) by Susanne DeCrane, PhD, addresses the structural causes of health inequity specifically from the standpoint of black women's health and the Catholic principle of the common good. In it, she called attention to the gaping racial disparity in breast cancer morbidity between white women and black women and diagnosed the structural causes of this disparity as lack of equitable access to preventive care and insurance coverage.

Her common-good approach to addressing the problem prescribed substantial reforms of the U.S. health care system as a whole, some of which have been partially attained by the Affordable Care Act since the time of her writing.[5] A most surprising omission in her analysis, however, is the absence of any speculation about whether racism itself might be a cause of higher breast cancer morbidity in black women and a threat to the common good, whereas she does discuss at length the intersection of patriarchy and capitalism as causes for the disparity.[6]

A similar pattern of omission can be found in an article by Fred Rottnek, MD, published in the July-August 2016 issue of *Health Progress*. Writing in response to the systemic health disparities in the St. Louis region, he references the medical fact that "persistent, toxic stress creates poor health outcomes," particularly when the pattern of allostatic overload begins in childhood and affects early neurological development.[7]

Moreover, he highlights the reality that the presence of violence is a prime cause of chronically elevated stress responses and, thus, is a social determinant of negative health outcomes. His essentially colorblind approach to violence, however, fails to identify clearly structural racism as a root cause of the violence affecting the St. Louis region, inasmuch as this racism is embed-

ded in an economic system, housing system, education system, criminal justice system and policing system that systematically target, exploit and marginalize black communities, leaving them with not only very few legal opportunities for employment, but also worse health.[8]

From a structural standpoint, violence is primarily something white communities have done to black communities, not something black communities have done to themselves (a frequent misperception). In other words, the deepest threat to public health is not merely violence but, more profoundly, white dominance. To his credit, Rottnek is aware of the generations of racial and economic segregation in the St. Louis region, but his moral prescription to prevent violence and reduce the impact of trauma through the "Alive and Well STL" program does not reflect his having identified segregation as a root structural cause of the violence and trauma. Surely if the goal is to prevent the violence that traumatizes black communities, then the strategy should be to correct the root causes of violence in the unjust economic and political structures that benefit white communities and constitute the more fundamental threat to the common good.

CHRONIC STRESS, DISPARITIES

By focusing on racism as a social determinant of a variety of negative health outcomes for persons of color, we can see that the available evidence confirms the health-related concerns of the Black Lives Matter movement and reveals the magnitude of the problem to be truly staggering. For example, a 2007 study based on data from the ongoing Black Women's Health Study at Boston University's Slone Epidemiology Center found that black women who perceive themselves to be impacted by racial discrimination have a higher risk for breast cancer than black women who do not, and by comparison with white women before age 40 (DeCrane did not have this information at the time of her writing).[9]

We have known since 1997 that the biological fact of lower (on average) birth weight for the children of black mothers is caused by the system of social subordination that is racism, and not putative genetic differences associated with race.[10] Both in the case of higher breast cancer risk and in the case of lower birth weight for their infants, black women are experiencing the biological effects of a chronically elevated stress response to racism (combined with patriarchy) over the entire course of their lives, and not merely during pregnancy or at the time of cellular mutation.[11]

Moreover, because of epigenetic mechanisms we are just beginning to understand, the trauma associated with a chronic stress response to racism can be inherited intergenerationally at the level of phenotypical expression of genes.[12] Black children literally are being born with the effects of racism already in their bodies.

The skeptic might respond by noting that there is some ambiguity in the public health community as to whether being black in the U.S. is, in itself, a significant social determinant of negative health outcomes, regardless of income level. Paul Farmer, the medical anthropologist and co-founder of Partners in Health, who articulated one of the first comprehensive, social-justice-oriented, international health agendas, has written that "where the major causes of death ... are concerned, class standing is a clearer indicator than racial classification." Yet when faced with the available data, he says that "race differentials persist even among the [economically] privileged."[13]

In order to speak meaningfully about oppression on the basis of race in the context of U.S. society, one also must speak about oppression on the basis of economic class and vice versa, given that the white domination of black communities has been accomplished historically through the systematic extraction of economic resources and deliberate disinvestment by private and public institutions. Sociologist and Harvard University public health professor David R. Williams, PhD, in examining the effects of this historical (and contemporary) pattern, observes that "although the majority of poor persons in the United States are white, poor white families are not concentrated in contexts of social and economic disadvantage

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and with the absence of an infrastructure that promotes opportunity in the ways that poor blacks, Latinos, and Native Americans are."[14]

If the goal is to eliminate health disparities determined by the interlocking oppressions of racism and economic class stratification, then reliance on a public health approach that aims only to increase incomes for all households living in poverty will not reduce racial disparities and may even make them worse.[15] Instead, more research and more input from communities struggling on the ground are both necessary for crafting adequate public health strategies that take into account the distinctive barriers to health that different black communities face, whether lower, middle or higher income.[16]

POLITICAL INTERVENTION

Despite the depth and complexity of the problems, they are not so overwhelming that positive steps are impossible; indeed, the Black Lives Matter movement requires political solidarity from those who have the power to influence the functioning of large social systems. If the vast institutional structure of Catholic health care, in particular, is going to make an impact for the cause of racial justice, what is demanded is not primarily a medical intervention, but rather a political intervention.

Health care professionals working in Catholic facilities have in their box of resources not only the fact that the system in which they participate has a stated commitment to making services more accessible to those who are oppressed, but they also have the considerable amount of educational and professional privilege they exercise as individuals. From a grassroots organizing standpoint, that privilege is an invaluable asset, because it gives one political access to powerful people and the capacity to be an advocate for those who do not have such access. Just as white people are needed to challenge other white people to resist racism and take the claims of black organizations seriously, so doctors and nurses are needed to pressure elected officials to support progressive laws and policies capable of changing the economic and criminal-justice status quo which is so harmful to the health of black citizens.

A fine example of such advocacy work can be found in the WhiteCoats4BlackLives movement, which in 2014 was started by medical students at Icahn School of Medicine at Mount Sinai in New York City, Perelman School of Medicine at the University of Pennsylvania, and the University of California San Francisco School of Medicine. These students called upon health professionals everywhere to confront institutionalized violence against people of color in the policing system as a public health crisis.[17]

Moreover, they have offered a four-point agenda for pursuing racial justice in health care that includes increasing the number of physicians of color, eliminating implicit racial bias toward patients, advocating for a single-payer health care system in the U.S. and working to address structural racism embedded in social, political and economic institutions.[18]

What if even more clinicians working in the Catholic health care system were to join this movement, and what if they couched their reasoning in terms of participating in a Catholic institutional commitment to racial justice and advocating on behalf of those who are oppressed? The organization already has chapters at the medical schools of Loyola University Chicago and Saint Louis University. Consider the difference that could be made if every Catholic medical school and hospital in the U.S. had a chapter.

Solidarity between Catholic health care insti-

ON THE COMMON GOOD

To me, the common good is all about building the Kingdom of God on earth, community, through the use of our collective gifts and talents. This common good obligates us to embrace the individuality and uniqueness of "the other" and ourselves so that we may see that giftedness.

Mary Paul, Ascension

tutions and the Black Lives Matter movement really isn't as simple as asking, "What are the actionable items?" Black health cannot make significant improvement in the context of the current economic and political structure of the U.S., at least not in the absence of a radically new distribution of power and resources.

And so, I invite those reading this article to share their own power and resources for the cause of social justice and health equity, which are among the deepest ethical aspirations grounding the ministry of health care.

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NOTES

1. See United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, fifth edition (issued November 17, 2009), Part One, "The Social Responsibility of Catholic Health Care Services." www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf.
2. *Ethical and Religious Directives*, Directive 3.
3. See The Movement for Black Lives, "Platform," https://policy.m4bl.org/platform/ (accessed September 6, 2016); and "Universal Health Care: One Pager," https://docs.google.com/document/d/1Ug0uwTZz5KuhoCWdlbLWh7GYin1ReGG-KNgrVG1Lr68/edit (accessed Sept. 6, 2016).
4. See WeTheProtesters, "The Demands," available at: www.thedemands.org/ (accessed Sept. 6, 2016).
5. See Susanne DeCrane, *Aquinas, Feminism, and the Common Good* (Washington, D.C.: Georgetown University Press, 2004): 149-50.
6. See DeCrane, 144-46.
7. Fred Rottnek, "How Can Our Communities Move Ahead after Ferguson?" *Health Progress* 97, no. 4 (July-August 2016): 48-52, at 50.
8. See David R. Williams and Selina A. Mohammed, "Racism and Health I: Pathways and Scientific Evidence," *American Behavioral Scientist* 57, no. 8 (August 2013): 1152-73.
9. See Teletia R. Taylor et al., "Racial Discrimination and Breast Cancer Incidence in U.S. Black Women: The Black Women's Health Study," *American Journal of Epidemiology* 166, no. 1 (2007): 46-54.
10. See Richard J. David and James W. Collins, "Differing Birth Weight among Infants of U.S.-Born Blacks, African-Born Blacks, and U.S.-Born Whites," *New England Journal of Medicine* 337, no. 17 (Oct. 23, 1997): 1209-14; and Richard J. David and James W. Collins, "Disparities in Infant Mortality: What's Genetics Got to Do with It?" *American Journal of Public Health* 97, no. 7 (July 2007): 1191-97.
11. See Michael C. Lu and Neal Halfon, "Racial and Ethnic Disparities in Birth Outcomes: A Life-Course Perspective," *Maternal and Child Health Journal* 7, no. 1 (March 2003): 13-30; and Fleda Mask Jackson et al., "Examining the Burdens of Gendered Racism: Implications for Pregnancy Outcomes among College-Educated African American Women," *Maternal and Child Health Journal* 5, no. 2 (June 2001): 95-107.
12. See Christopher W. Kuzawa and Elizabeth Sweet, "Epigenetics and the Embodiment of Race: Developmental Origins of U.S. Racial Disparities in Cardiovascular Health," *American Journal of Human Biology* 21, no. 1 (January 2009): 2-15.
13. Paul Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor* (Berkeley: University of California Press, 2005), 45-46.
14. David R. Williams, "Miles to Go before We Sleep: Racial Inequities in Health," *Journal of Health and Social Behavior* 53, no. 3 (2012): 279-95, at 284.
15. See David Mechanic, "Disadvantage, Inequality, and Social Policy," *Health Affairs* 21, no. 2 (2002): 48-59.
16. See David R. Williams, Naomi Priest and Norman B. Anderson, "Understanding Associations among Race, Socioeconomic Status, and Health: Patterns and Prospects," *Health Psychology* 35, no. 4 (2016): 407-11.
17. See WhiteCoats4BlackLives, "Origins," available at: www.whitecoats4blacklives.org/origins (accessed Sept. 11, 2016).
18. See White Coats for Black Lives National Working Group, "#Black Lives Matter: Physicians Must Stand for Racial Justice," *AMA Journal of Ethics* 17, no. 10 (2015): 978-82.

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