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Abolitionist Reimaginings of Health

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Abstract
In 2020, the authors of this article published "Abolition Medicine" as one contribution to international abolitionist conversations responding to widespread anti-Black police violence and inequity laid bare by the COVID-19 pandemic. Over the past year, there has been a surge of efforts to abolish deeply embedded patterns of race-based oppression in policing and incarceration in the United States. In this essay, the authors continue to explore how health care can join these conversations and move toward a praxis of health justice. Using the framework of Ruth Wilson Gilmore's *organized abandonment*, the article revisits grassroots organizations and efforts that have been engaging in abolitionist health care all along. It also looks to current and emerging abolitionist policies and practices operating at the margins of status quo health care for models of abolition in medicine.

There's nothing new
under the sun,
but there are new suns.
Octavia Butler[1]

Abolition Medicine

Racial violence is a public health crisis. Several organizations, including the American Medical Association (AMA) and the American Public Health Association (APHA), have recognized that police violence has devastating health consequences[2,3]; the AMA has "denounced racism as an urgent threat to public health, pledging action to confront systemic racism, racial injustice and police brutality."[2] Both organizations' policy statements indicate that medicine and public health must work to dismantle racism not only at a societal level but also within the health professions. In other words, we can choose to continue practices that perpetuate structural racism, or we can dismantle them and rebuild more just systems of care. The question then becomes: What tools and models do medicine and public health have at their disposal to accomplish the latter goal?

When we published "Abolition Medicine" in the *Lancet* in the summer of 2020,[4] we joined nationwide conversations about abolition against the backdrop of racist police violence, a devastating pandemic, and a powerful resurgence in the movement for Black lives. We drew upon the work of abolitionist practices in numerous areas—

incarceration,[5] policing,[6] law,[7] and more—to imagine what abolitionist practices in health care might look like. We invoked W.E.B. Du Bois' 1935 idea of "abolition democracy"[8] and built upon the work of abolitionists like Angela Davis[9] and Mariame Kaba,[10] who have argued that abolishing slavery was the first in a series of abolitionist practices to address racialized policing and incarceration. We included medicine as one more field in deep need of abolitionist reimagining.

We begin with a quotation by science fiction novelist Octavia Butler because we recognize that discussing abolition medicine is inherently an act of speculation. It is an act of imagining an antiracist tomorrow that is not here yet but that is possible to both envision and work toward. One year after publishing our original essay, we seek to honor the ways that abolitionist health care has already been enacted at the margins of what can be labeled *traditional medicine*. If medicine as an institution is to truly commit to an antiracist, abolitionist future, it must draw inspiration, as bell hooks would say, "from margin to center."[11]

Why Abolition Medicine

We imagine an abolitionist future for health care through the lens of our common disciplinary home: narrative medicine. Narrative medicine is the scholarly and academic endeavor to honor the role of story in the health care encounter.[12] However, in addition to eliciting, attending to, and engaging with narratives of illness and disability on the interpersonal level, narrative medicine is also concerned with understanding the framing of these stories and the structural contexts in which they are received and told. Narrative medicine recognizes that not all stories are equal and not all stories are just.[13] Dismantling racist health care practices is, in many ways, about dismantling the comfortable stories we have told ourselves about ourselves and our work—it is about entering a "pedagogy of discomfort" and examining how our actions, motives, and perspectives are shaped by social structures.[14]

In its 2020 statement, the AMA not only recognized "racism as a public health threat" but also committed to "actively work on dismantling racist policies and practices across all of health care," recognizing the detrimental effects of "racism in its systemic, cultural, [and] interpersonal … forms."[2] To understand the implications of this statement, particularly for systemic racism, it is useful to turn to structural competency, a framework offered by Jonathan Metzl and Helena Hansen.[15] Structural competency is an approach to medical education wherein medical trainees are taught to recognize barriers to care and factors that lead to or perpetuate poor health outcomes.[15] This approach requires recognizing the "upstream" sources, such as water, food, and housing, of "downstream" adverse medical outcomes, such as diabetes, heart disease, and lead poisoning. In our *Lancet* essay, we used this pedagogical framing to argue that the structure and ethos of policing in the United States must be recognized as an upstream cause of a severe downstream consequence: racialized police violence. Our contention was not just that medicine must deal with the medical consequences of upstream policing systems but that medicine can and must have a role in reimagining and creating new visions of violence prevention itself.

Racialized police violence is a ubiquitous presence in the United States. Even as the murder trial of Derek Chauvin, the former Minneapolis police officer who killed George Floyd, was adjudicated 10 miles away from where Daunte Wright was killed by police, another fatal police shooting occurred—this time of 16-year-old Ma'Khia Bryant.[16] The policing system—like the carceral system—does not keep everyone safe. These

institutions keep some people safe, often at the expense of Black people, Indigenous people, immigrants, people with disabilities, and queer and trans people of color who are frequently subject to a downstream outcome of policing structures that abolitionist scholar Ruth Wilson Gilmore calls *organized abandonment*.[6] Organized abandonment by capital and the state refers to the loss of protection from vulnerability that communities experience when safe housing, clean water, reliable jobs, healthy food, and social service provisions gradually disappear from towns and increased police presence and criminalization fill the cracks of a compromised social infrastructure.[17]

Health care is hardly immune to the impacts of organized abandonment. Consider day-to-day impediments to receiving health care, such as lack of transportation, difficulty in taking time off from work, lack of affordability, and lack of or inadequate insurance, and add to these the presence of police and, often, immigration and customs enforcement officials in urban emergency departments.[18] The criminal legal system puts up additional impediments to receiving health care, including the practice of executing warrants and making arrests in hospitals[19] and restraining elderly patients who are terminally ill[20] and even those giving birth.[21] Moreover, we must bear in mind the impact of individual and systemic racism on patients' receipt of health care and health outcomes, including beliefs on the part of some health care practitioners that Black patients feel less pain and therefore need less pain medication,[22] the Black maternal mortality crisis,[23] and the disproportionate rates of COVID-19-associated deaths in communities of color.[24]

These health care practices and disparities are arguably downstream outcomes of decades of upstream police and carceral racial violence that have their parallel in the historical formation of medicine in the United States. Modern policing is rooted in antebellum slave patrols that did violence to Black people in much the same way that medicine did through its practices of unethical medical experimentation on Black communities, both during and long after slavery.[4,25] What becomes clear to us is that our health care system and the carceral system are linked through histories of policing, surveillance, and exploitation. If abolition is the framework that confronts the carceral system by deconstructing oppressive systems and envisioning new ways of addressing harm without reproducing oppression, then abolition medicine is the organizing tool and response to the structural and historical violence reproduced by the US health care system that envisions care delivery without oppression.[4,5,7]

Practicing Abolition Medicine

If the emphasis of medicine is to "first, do no harm," then we must contend with medicine's history of systemic racism and redefine how we understand health and safety. Drawing on decades of abolitionist work, including policy visions by the organizers of #8toAbolition,[7] abolition medicine calls for deconstructing and divesting from practices within health care that perpetuate systemic racism[22] and criminalize the lives of marginalized people[19] and for reinvesting in life-affirming systems that address structural harm.[7] Abolition medicine means linking medicine to public safety by redirecting resources away from policing structures and towards services that invest in the welfare of all people, supporting movements for universal health care coverage, and establishing reparations for communities of color devastated not only by histories of unethical medical experimentation but also by institutions that have profited from policing and mass incarceration.[4] It also means removing police presence in places like the emergency room and safeguarding health care settings as sanctuaries.[19] By placing abolition in conversation with medicine, we ask: What healthier possibilities can emerge when social systems reduce violence and reimagine collective care?

In her discussion of organized abandonment, Gilmore speaks of the ways that public agencies (eg, schools, health care) absorb policing functions, while structures of organized violence (eg, jails, prisons, police) absorb social work functions, such as mental health care, which they are not trained for. By learning from care structures that have historically operated at the margins, health care can reclaim the care functions that policing agencies have appropriated.

Throughout history, communities have found ways to heal and care for one another outside of institutional structures through mobilizing resistance, mutual aid, and collective care networks that came about in response to organized abandonment. We see this lineage of community care and health activism in the Black Panther Party's free breakfast program of the 1960s, which fed thousands of children across the country, and its national sickle cell screening program.[26] The Black Panthers' health activism was a public health effort created to meet the needs of a community, and it falls on the same spectrum as the work of the Young Lords in the late 1960s and early 1970s, a Puerto Rican liberation organization that offered door-to-door testing for lead poisoning and tuberculosis and used acupuncture to aid in recovery from opioid use disorder in the South Bronx.[27] Rather than relying upon grassroots and community-based efforts to address all of these needs, we believe that medicine can learn from these examples and expand its vision of what counts as good health care.

When we recognize that our well-being is contingent on one another and that health and survival rely on solidarity and collectivizing care on a local level, communities can thrive. Abolition medicine resembles actions in Oakland today by the Anti Police-Terror Project with its MH First Program, a mobile mental health first responder team comprising mental health professionals, doctors, nurses, and community members. The MH First Program disrupts the need for law enforcement in response to mental health crises by providing de-escalation assistance and life-affirming treatment.[28] This is just one example of abolition medicine in action outside the central structures of traditional medical institutions. Some examples of grassroot efforts reach beyond traditional imaginings of health care to include nutrition in movements for health justice. For instance, in response to food deserts in South Central Los Angeles, community members planted vegetable gardens in unused public spaces throughout inner-city areas. Ron Finley calls this "guerilla gardening," and, with his team of volunteers, he plants as protest, creating healthier, more sustainable food and health models for his city.[29] Similar movements have emerged at health clinics and medical school campuses, like Cooper Sprouts' Community Garden in Camden, New Jersey, and Vanderbilt's Educational Garden Initiative, which provides fresh food to Nashville community members who visit Vanderbilt's student-run health clinic.[30,31] Community gardens affiliated with health care institutions can reduce public health disparities by increasing food security and promoting physical well-being.[32]

These are a few historical and current-day examples of community care as health care, and they are critical lessons from the margins for medicine as an institution to consider. Abolition medicine may seem like a new framing, but it has been happening all along and will continue to happen in communities invested in each other's mutual aid and in creating systemic change. Emphasizing and amplifying the experiences of marginalization is crucial; it compels us to consider what new conversations and collaborations medicine can foster to nurture the public health and safety of our communities. The key is for health care and medical education to be willing to recognize these movements as central—not peripheral—to any broader vision of health justice.

Moving Health Care

By using an abolitionist framework to move towards an ethic of mutual aid, health care has the potential to transform. Abolition is already permeating necessary conversations in public health,[33] medicine,[4] and social work,[34] reshaping the way we think about health care. The time is right, and the potential for new possibilities for health justice is tremendous. As Gilmore states: "Abolition is not *absence*; it is *presence*.... So those who feel in their gut deep anxiety that abolition means knock it all down, scorch the earth and start something new, let that go. Abolition is building the future from the present in all the ways that we can."[35]

Abolition medicine is neither a prescription nor a shortcut because, as political scientist Naomi Murakawa reminds us: "There are no life hacks to revolution … abolition requires dismantling the oppressive systems that live out there—and within us."[10] Abolition medicine is looking to the neighborhood leaders and community activists who have been advocating for patient populations for decades. It is working with these experts to address upstream realities and to collectivize structurally competent care. Abolition medicine is a practice of inward and outward speculation, of dreaming of a more racially just future and acting to bring that vision to fruition. It is asking ourselves, *What is the healing work we aspire to?*, and then making that work a reality in the world.

References

1. Canavan G. "There's nothing new/under the sun,/but there are new suns": recovering Octavia E. Butler's *Lost Parables*. *Los Angeles Review of Books.* June 9, 2014. Accessed October 26, 2021. https://lareviewofbooks.org/article/theres-nothing-new-sun-new-suns-recovering-octavia-e-butlers-lost-parables/
2. New AMA policy recognizes racism as a public health threat. News release. American Medical Association; November 16, 2020. Accessed August 10, 2021. https://www.ama-assn.org/press-center/press-releases/new-ama-policy-recognizes-racism-public-health-threat
3. Structural racism is a public health crisis: impact on the Black community. Policy no. LB20-04. American Public Health Association. October 24, 2020. Accessed August 10, 2021. https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2021/01/13/structural-racism-is-a-public-health-crisis
4. Iwai Y, Khan ZH, DasGupta S. Abolition medicine. *Lancet*. 2020;397(10245):158-159.
5. What is the PIC? What is abolition? Critical Resistance. Accessed November 29, 2021. http://criticalresistance.org/about/not-so-common-language/
6. Kumanyika C. Ruth Wilson Gilmore makes the case for abolition. *Intercept*. June 10, 2020. Accessed April 22, 2021. https://theintercept.com/2020/06/10/ruth-wilson-gilmore-makes-the-case-for-abolition/
7. Abolitionist policy changes to demand from your city officials. 8 to Abolition. Accessed January 21, 2022. https://static1.squarespace.com/static/5edbf321b6026b073fef97d4/t/5ee0817c955eaa484011b8fe/1591771519433/8toAbolition_V2.pdf
8. Du Bois WEB. *Black Reconstruction in America, 1860-1880.* Atheneum; 1935.
9. Davis AY. *Are Prisons Obsolete?* Seven Stories Press; 2003.
10. Kaba M. *We Do This 'Til We Free Us: Abolitionist Organizing and Transforming Justice*. Haymarket Books; 2021.

11. hooks b. *Feminist Theory: From Margin to Center*. South End Press; 2000.
12. Charon R. *Narrative Medicine: Honoring the Stories of Illness.* Oxford University Press; 2006.
13. Pasco JC, Anderson C, DasGupta S. Visionary medicine: speculative fiction, racial justice and Octavia Butler's "Bloodchild." *Med Humanit.* 2016;42(4):246-251.
14. Boler B. *Feeling Power: Emotions and Education*. Routledge; 1999.
15. Metzl JM, Hansen H. Structural competency: theorizing a new medical engagement with stigma and inequality. *Soc Sci Med*. 2014;103:126-133.
16. Amiri F, Welsh-Huggins A. Recordings show chaos surrounding Ma'Khia Bryant shooting. *AP News*. April 24, 2021. Accessed August 12, 2021. https://apnews.com/article/makhia-bryant-ohio-shooting-video-recordings-186abfbcfd1717a8c42a38021a83de4b
17. Gilmore RW. *Golden Gulag: Prisons, Surplus, Crisis, and Opposition in Globalizing California*. University of California Press; 2007.
18. Caballero A. ICE in the ER: how US policies are causing an immigrant health crisis. Physicians for Human Rights. December 7, 2018. Accessed August 12, 2021. https://phr.org/our-work/resources/ice-in-the-er-how-u-s-policies-are-causing-an-immigrant-health-crisis/
19. Song JS. Policing the emergency room. *Harvard Law Rev*. 2021;134(8):2646-2720. Accessed November 29, 2021. https://harvardlawreview.org/wp-content/uploads/2021/06/134-Harv.-L.-Rev.-2646.pdf
20. Thompson C. Old, sick, and dying in shackles. Marshall Project. March 7, 2018. Accessed August 12, 2021. https://www.themarshallproject.org/2018/03/07/old-sick-and-dying-in-shackles
21. Shackling of pregnant women in jails and prisons continues. Equal Justice Initiative. January 29, 2020. Accessed August 12, 2021. https://eji.org/news/shackling-of-pregnant-women-in-jails-and-prisons-continues/
22. Hoffman KM, Trawalter S, Axt JR, Oliver MN. Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proc Natl Acad Sci USA*. 2016;113(16):4296-4301.
23. Roeder A. America is failing its black mothers. *Harvard Public Health*. 2019. Accessed August 12, 2021. https://www.hsph.harvard.edu/magazine/magazine_article/america-is-failing-its-black-mothers/
24. Pilkington E. Black Americans dying of COVID-19 at three times the rate of white people. *Guardian*. May 20, 2020. Accessed August 12, 2021. https://www.theguardian.com/world/2020/may/20/black-americans-death-rate-covid-19-coronavirus
25. Washington HA. *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans From Colonial Times to the Present*. Harlem Moon; 2006.
26. Nelson A. *Body and Soul: The Black Panther Party and the Fight Against Medical Discrimination*. University of Minnesota Press; 2011.
27. Fernández J. *The Young Lords: A Radical History*. University of North Carolina Press; 2019.
28. MH First Sacramento. Accessed April 22, 2021. https://www.antipoliceterrorproject.org/mh-first-sac
29. Finley R. A guerilla gardener in South Central LA. TED. March 6, 2013. Accessed November 29, 2021. https://www.youtube.com/watch?v=EzZzZ_qpZ4w

30. Dunn P. Medical students help revive Camden Garden. *Courier Post*. December 20, 2014. Accessed August 12, 2021. https://www.courierpostonline.com/story/news/local/south-jersey/2014/12/20/medical-students-help-revive-camden-garden/20664639/
31. Vanderbilt Educational Garden Initiative (VEGI). Vanderbilt University School of Medicine. Accessed August 1, 2021. https://medschool.vanderbilt.edu/md-admissions/vanderbilt-educational-garden-initiative-vegi/
32. George DR, Rovniak LS, Kraschnewski JL, Hanson R, Sciamanna CN. A growing opportunity: community gardens affiliated with US hospitals and academic health centers. *Prev Med Rep*. 2015;2:35-39.
33. A national abolitionist victory for public health! Critical Resistance. Accessed August 12, 2021. http://criticalresistance.org/apha/
34. Rasmussen C, James KJ. Trading cops for social workers isn't the solution to police violence. *Truthout*. July 17, 2020. Accessed August 12, 2021. https://truthout.org/articles/trading-cops-for-social-workers-isnt-the-solution-to-police-violence/
35. Gilmore RW. Making abolition geography in California's Central Valley. *Funambulist*. December 20, 2018.

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