

Toward Abolition Medicine

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FROM THE EDITOR

Toward Abolitionist Approaches in Medicine

Osagie K. Obasogie, JD, PhD

Abolition has been part of the American democratic experiment since the founding of this nation—a founding premised in large part upon the violent exploitation of Black labor that shaped many aspects of American society in ways that endure to this very day, science and medicine included.^{1,2} Slavery, Jim Crow, and other forms of state-sponsored systems of violence have given rise to social and legal movements dedicated to abolishing these practices. Contemporary social movements have made connections between this history and modern instruments of anti-Black state violence—namely, policing and prisons—to continue abolitionist efforts that speak to existing struggles. What has come out of these discussions is a realization that anti-Blackness as articulated by law enforcement and other state institutions does not happen on its own or in isolation but is often given life and legitimacy through partnerships with other professionals—whether with architects who design prisons and execution chambers³ or paramedics who inject ketamine or other drugs into persons detained by the police to subdue them, often with deadly effect.⁴ This cross-professional complicity in anti-Blackness gives rise to an important question that is the focus of this special issue: To the extent that medicine is often closely connected to sites of anti-Black racial oppression, what would an abolitionist approach to the profession look like? To channel legal scholar Amna A. Akbar, *How can we imagine and foster an abolitionist horizon for medicine that is committed to eradicating structural inequalities that disproportionately impact the health and well-being of minority communities?*⁵ How might this be an important standpoint from which to train the next generation of physicians so that medicine can be a prominent factor in not only eliminating health inequities but also freeing communities?

Abolitionist standpoints in medicine are not new. They emerge out of a long history in which medicine, public health, and the health sciences often serve as mechanisms of racial oppression that, with appropriate advocacy and reframing, might turn into opportunities for human liberation.^{6,7,8} At the Othering and Belonging Institute at the University of California (UC), Berkeley, we began our work in this area by collaborating with 4 medical students in the UC San Francisco-UC Berkeley Joint Medical Program to develop a policy brief on abolishing the use of biological race in medicine.⁹ This work highlights how the faulty assumption that social categories of race reflect **inherent biological differences** often obscures the extent to which racial disparities are a function of how certain people and populations are treated, not the color of their skin. As Joia Crear-Perry, Dorothy Roberts, and others have noted, racism, not race, is the cause of these inequities.^{10,11,12}

Abolitionist praxis in medicine must begin with this point. But it also must continue to explore the many ways that race and racism have **become foundational** to how we understand human differences and health disparities. This understanding might lead to new approaches that recalibrate the terms in which we think about and engage with the practice of healing by centering the values of equity, inclusion, and belonging. This issue of the *AMA Journal of Ethics* provides an opportunity to continue the conversation on this important intervention and move us one step closer to making abolitionism central to what it means to practice medicine.

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

Why Add “Abolition” to the National Academies of Sciences, Engineering, and Medicine’s Social Care Framework?

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Abstract

Abundant evidence demonstrates that enduring, endemic racism plays an important role in determining patient health. This commentary reviews a patient case about disease self-management and subsequent health outcomes that are shaped by social and economic circumstances. We analyze the case using a framework for social care developed in 2019 by the National Academies of Sciences, Engineering, and Medicine (NASEM). We then propose that the NASEM framework be adapted by adding the category *abolition*, which could make the other social care practices transformative for historically marginalized populations.

Case

Mr W is a 59-year-old man with type II diabetes mellitus. Mr W takes oral medication for diabetes and uses a glucometer when he has access to lancets and strips. Mr W has a primary care physician, Dr PCP, but rarely attends clinic appointments since he does not have transportation. He eats mostly food he finds in trash cans or food donated to him; occasionally, he can purchase fast food. He is currently unsheltered, living in a tent encampment.

A few days after his last lancet finger stick, Mr W’s index finger became swollen, red, and painful. He went to a nearby emergency department (ED), where Dr ED drained a felon abscess and prescribed antibiotics. Mr W’s diet and limited hygiene opportunities have contributed to his ill health, so Dr ED prescribes agency food assistance and offers alcohol wipes so Mr W can clean his fingers before and after finger sticks. An ED social worker offered Mr W a shelter bed, but he declines, preferring to return to his tent and belongings.

To enroll in the food assistance program, Mr W must attend a nutrition consultation, but he has no way to get there and no address to which food can be delivered. Mr W’s phone is stolen, so he misses a reminder call from Dr PCP’s office, can’t access his calendar, and misses a follow-up appointment. The alcohol wipes run out and Mr W stops checking his blood sugar. Soon feeling ill again, Mr W goes to the ED. Mr W is admitted, diagnosed him with hyperglycemia and a urinary tract infection, and

prescribed antibiotics and access to a private bathroom. The ED social worker has long been asking the city to supply water and bathroom access for residents of the encampment. Permanent housing requests are placed and pending. Mr W returns to his tent.

Commentary

A popular public health parable describes the dual urgency of pulling drowning children from a river and looking upstream to prevent more children from entering the water.¹ Over decades of telling, the story has taken many forms. A second version of the story casts poisoned fish in the role of the drowning children.² In health care settings, Mr W's finger abscess is more commonplace than children drowning in a river or poisoned fish, but the moral of the story is similar. Consistent and convincing evidence shows that social and environmental deprivation—including insufficient or unsafe food, housing, water, and transportation—contribute to poor health.^{3,4,5,6,7,8,9} In the United States, however, we are less attentive to addressing adverse **social conditions** than to immediate injuries.¹⁰

In this case, Mr W's medical condition and social circumstances are inextricably linked; their synergies lead to his acute illnesses, diminish the effectiveness of his medical treatment, and impede his opportunity to flourish. In formulating a plan for treatment, Dr ED reasonably looked upstream. In addition to draining Mr W's abscess and prescribing antibiotics, the physician made referrals to help him obtain nutritious food, safe housing, and clean water. Since emerging evidence suggests that, in cases like Mr W's, interventions to address social needs and disease self-management may yield health improvements and cost savings,^{11,12,13,14,15,16} it may be surprising that after multiple well-intentioned attempts by Dr ED to address Mr W's social needs, neither Mr W's circumstances nor his health improved. Why?

To answer this question, we first turn to a 2019 National Academies of Sciences, Engineering, and Medicine (NASEM) report on medical and social care integration, which focused explicitly on articulating roles for health care stakeholders in responding to the rapidly growing evidence that health is powerfully shaped by social circumstances.¹⁷ The NASEM report defined 5 broad "social care" categories—awareness, assistance, adjustment, alignment, and advocacy—each of which describes different types of activities in which health care systems might participate to influence patients' social determinants of health.¹⁷ The 5 categories encompass patient-level, health care delivery-targeted interventions, and also more **community-directed initiatives**; all are relevant to Mr W's case. In this paper, we explore ways that the NASEM report's recommendations might be used to spur more intentional and coordinated actions by the health care system to improve outcomes for patients like Mr W. We then consider how the NASEM social care categories also might be interrogated and reenvisioned to more deliberately dismantle the inequity in opportunities to achieve health and well-being that more fundamentally shapes Mr W's story. This reenvisioning process leads us to suggest that the NASEM report's original social care categories be viewed through the frame of a sixth *A: abolition*, which would make health care's social care activities more impactful and enduring.

NASEM Social Care Framework Is Necessary but Insufficient

The NASEM framework begins by underscoring the relevance of efforts to understand patients' socioeconomic environments (awareness), including patient- and community-level social needs and assets, as a core element of integrated care approaches. It also

defines 2 categories of patient care interventions that might stem from increased awareness about social conditions. These include activities to tailor the delivery of medical care based on **identified social barriers** (adjustment) and to more directly intervene on social risk (assistance). Finally, alongside patient-level activities, the framework recommends work at the community and policy level. In these areas, health care systems might assume roles to better align their own efforts with community needs and priorities (alignment) and to advocate for deeper social and structural investments (advocacy) (see Table).

Table. Social Care Framework^a

Social Care Category	Definition
Awareness	“Activities that identify the social risks and assets of defined patients and populations”
Adjustment	Activities that alter “clinical care to accommodate identified social barriers”
Assistance	Activities that reduce “social risk by assistance in connecting patients with relevant social care resources”
Alignment	Activities “undertaken by health care systems to understand existing social care assets in the community” and then organize and invest in health care activities to facilitate synergies that positively affect health outcomes.
Advocacy	Activities in which “health care organizations work with partner social care organizations to promote policies that facilitate the creation and (re)deployment of assets or resources” to address health and social needs.

^a Adapted from National Academies of Sciences, Engineering, and Medicine.¹⁷

A robust social care program would involve complementary work at both the patient and the community level. In Mr W’s case, the ED physician learns about Mr W’s housing instability (awareness) and provides cleaning supplies and referrals for food and housing (assistance), and the ED social worker advocates for improved hygiene resources for the tent encampment (advocacy).

In the NASEM report, a strong emphasis is placed on health care systems that can ensure that social care activities in each of the 5 categories are not only feasible but also impactful for both individuals and populations. Feasible and impactful social care in this case would eliminate reliance on the good-hearted Dr ED and instead embed social care practices in Dr ED’s workflow to help him identify and intervene on the socioeconomic adversities faced by Mr W and many other patients like him. Yet it is not clear from the case presentation that the health care system responsible for Mr W’s care has committed to systematically engaging in high-quality activities in any of the NASEM categories. Dedicated social care staff and staff training, modified clinical workflows, and health information technology tools embedded in those core workflows are needed to provide high-quality social care and to ensure that data generated from individual patient care can be used in real time both to improve care and to guide investments at the population level.¹⁸ For instance, is a standardized social risk/asset screening systematically conducted in settings with well-trained, culturally competent

staff who sensitively approach patients with an understanding of their lived experience? Are data about socioeconomic risks documented and protected in electronic health records? What informatics tools and processes are available to generate and, as appropriate, track relevant referrals to community-based services and disease management support? How are data from patients like Mr W aggregated and applied to inform future care as well as community-level alignment and advocacy decisions?

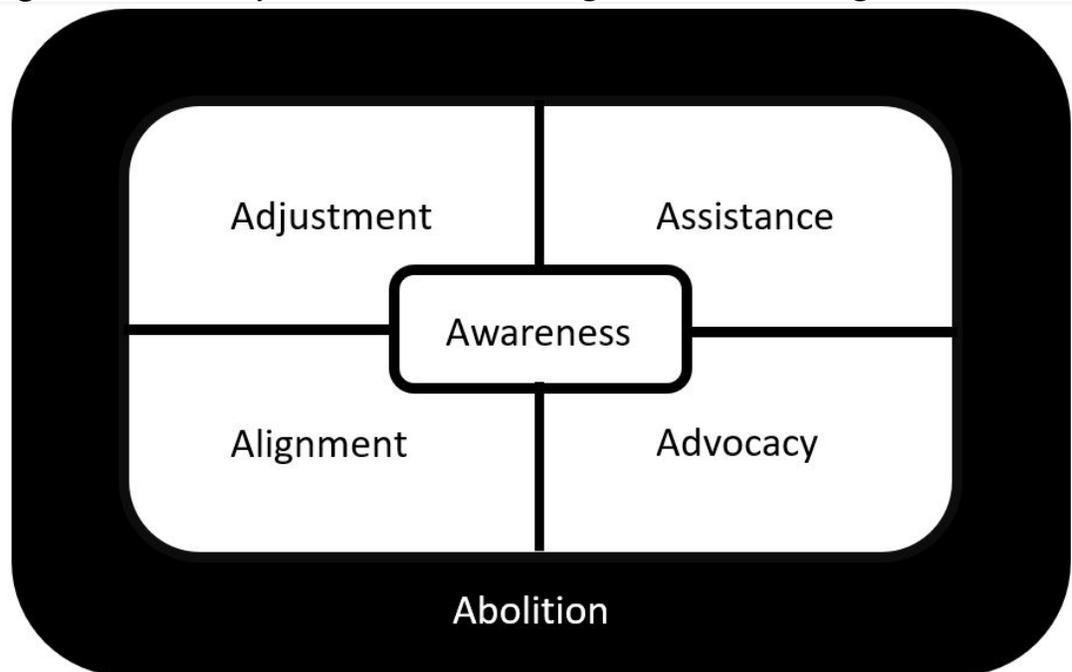
Unfortunately, Mr W's health outcomes might not improve even in a health care system investing in the high-quality practices defined in the NASEM report. Although the framework provides a useful organizing tool to operationalize health care sector actions related to social adversity, these social care activities—whether focused on patient care or at the community level—are often implemented absent an awareness of the **racialized systems and structures** that have led to and perpetuate health inequities. Inattention to structural and systemic racism as fundamental causes of individuals' socioeconomic risks means that health care's social care practices will prove insufficient for improving health outcomes for marginalized patients. Although the case does not provide information about Mr W's racial or ethnic identity, in the United States, Black, Indigenous, and other persons of color are disproportionately homeless.¹⁹ Black Americans constitute 13.4% of the US population²⁰ but make up 39% of the US homeless population¹⁹ as a result of structural inequities in housing, education, employment, and policing and carceral systems that discriminate against Black people.²¹ These same structures also limit opportunities for other socially marginalized groups.²²

It is therefore not surprising that we must do more, do it differently, and do it better in order to improve health and health equity. Overcoming health inequity demands more than adding social care practices to health care. It also requires addressing the inequities in other sectors and institutions (eg, education, criminal justice, housing) that influence the physical health and well-being of Black and other marginalized populations.

Abolition as a Sixth A for Social Care

In this particular case, we are specifically tasked with improving the design and delivery of social care practices in the health care sector to better meet the needs of patients like Mr W. To achieve this goal, we follow the lead of a recent *Lancet* article describing *abolition medicine*.²³ The Thirteenth Amendment to the US Constitution, which abolished slavery as we currently understand it, nonetheless allowed slavery and “involuntary servitude” to continue for those convicted of crimes.²⁴ As a result, the abolition movement has predominantly focused on eradicating racialized policing, surveillance, and carceral systems.²⁵ The *Lancet* article authors advocate for similarly challenging **racialized practices** in medicine,²³ which also have worked to diminish the health and well-being of Black people. We now extend their argument to propose *abolition* as a sixth category through which to frame health care's other social care activities (see Figure), appreciating that this framing will influence outcomes for all racial/ethnic minorities and other socially marginalized populations.

Figure. Health Care System Activities That Strengthen Social Care Integration^a



^a Adapted with permission of the National Academies Press from National Academy of Sciences, Engineering, and Medicine.¹⁷ Permission conveyed through Copyright Clearance Center, Inc.

Applying an abolition frame involves redefining the goals, methods, and activities associated with each of the 5 social care categories originally articulated by NASEM. As described below, doing so would require more explicitly designing and implementing social care integration practices that are antiracist to help health care teams both to understand and to reverse racial inequity and opportunity gaps for patients like Mr W.

Awareness. Abolition-influenced awareness activities would be designed in collaboration with patients from marginalized backgrounds, whose input on framing, content, and implementation could improve these patients' experiences with social risk and asset screening.^{26,27} Health care teams would also protect against the potential harms of such screening—including the possibility that collected data could increase opportunities for police surveillance and discrimination and exacerbate distrust—instead ensuring that **data collection** is paired with data use and distribution safeguards as well as meaningful interventions.^{28,29} Awareness activities would not end at patient-directed socioeconomic risk and asset assessments; health care teams would be required simultaneously to increase their own awareness about racism, including current and historical institutional racism and antiracist practices.^{30,31,32,33}

Adjustment. Looking at adjustment strategies through an abolition frame would proactively involve patients in treatment planning (eg, using shared decision-making tools) with the intent of improving both the experience of social care and outcomes for historically marginalized patients.^{34,35} In Mr W's case, a shared decision-making discussion might explore the comparative advantages of his transition to a temporary shelter bed vs staying close to his worldly possessions and familiar community. Shared decision making is a particularly powerful abolition strategy because shared decision making is fundamentally about supporting patients' agency, which can affect both their experience of health care and their health outcomes. Although the practice has been

used less frequently in care provided to racial and ethnic minorities and other socially marginalized patients than in care provided to White patients,³⁵ if implemented both well and routinely, it would support abolition's goals of sharing power, increasing patient agency, and building clinician humility. If achieved, these types of changes would counter some forms of institutional racism and help to decrease health inequities.

Assistance. Abolition also would involve ensuring that assistance activities are designed in ways that maximize patient dignity. For instance, health systems might develop ways in which people can simultaneously give and receive. Three studies of CommunityRx, a community resource referral intervention, show that half the patients who received social care information shared it with others.^{27,36,37} At the University of Chicago, the Feed1st program has provided emergency food relief to thousands of patients over 10 years via self-serve, no barriers, hospital-based food pantries. Over time, many patients and family members who have obtained services from the pantries have also contributed back (eg, donating food, stocking shelves, participating in advocacy, creating their own food security initiatives.^{38,39}) Providing these kinds of opportunities can simultaneously strengthen patients' self-respect and build community, both of which are foundational to abolition.

Alignment and advocacy. As in the original NASEM framework, abolition would require pairing patient-focused social care interventions with community-directed alignment and advocacy activities. But now these community-directed investments would more specifically focus on the systems and structures that perpetuate inequities, including racist policies and practices both within and external to the health care system. Consistent with the abolition movement's original focus, health systems committing to social care would analyze and share data about the health effects of police violence and incarceration.⁴⁰ They would use those data to advocate to overcome racialized policing and carceral policies that in turn perpetuate and exacerbate homelessness.⁴⁰ They would leverage the health care system's role as an anchor institution to invest in neighborhood low-income housing,⁴¹ with special attention to eliminating racist programs and policies built into many housing assistance programs.^{42,43,44}

Conclusion

Returning to Mr W, we again pose the question of why Dr ED's well-intentioned efforts did not clearly change the course of Mr W's illness. One potential explanation might lie in the lack of institutional investment in a high-quality system that supports the integration of social and medical care for individuals and populations. But our collective failure to effectively serve patients in circumstances like Mr W's also reflects the lessons of a modern version of our public health parable. In the modern retelling, the bank of the river is three-dimensional: Black, Indigenous, and other persons of color living in the United States, people living in poverty, and others affected by structural and systemic racism are forced to stand closer to the edge of the river than other groups of people, thereby disproportionately increasing their initial risk of falling into the water. As a result of restricted access to pools, lakes, and rivers, marginalized groups also are less likely to have learned how to swim, which increases their risk of drowning.⁴⁵ The updated parable underscores how social determinants of health are closely tied to social determinants of equity.⁴⁶ In the case of Mr W, that link forces us to critically evaluate health care initiatives concerning social adversity to ensure not only that such initiatives are high quality, standardized, and systematically implemented, but also that they are designed in ways that both acknowledge and help to reduce the entrenched and inequitable threats to health levied on historically marginalized people.

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

Why Professionalism Demands Abolition of Carceral Approaches to Patients' Nonadherence Behaviors

Nhi Tran, MD, MPH, Aminta Kouyate, and Monica U. Hahn, MD, MPH, MS

Abstract

Some clinicians' and organizations' considerations of how a patient's prior adherence to health recommendations should influence that patient's candidacy for a current intervention express structural racism and carceral bias. When clinical judgment is influenced by racism and carceral logic, patients of color are at risk of having their health services delivered by clinicians in ways that are inappropriately interrogative, aggressive, or punitive. This commentary on a case suggests how an abolitionist approach can help clinicians orient themselves affectively to patients whose health behaviors express or have expressed nonadherence. This article argues that an abolitionist approach is key to facilitating clinicians' understandings of root causes of many patients' nonadherence behaviors and that an abolitionist approach is needed to express basic health professionalism and promote just, antiracist, patient-centered practice.

Case

NM is 50 years old. After developing a lower-leg blood clot after a road trip, NM was diagnosed with moderate-to-severe symptomatic mitral valve stenosis due to rheumatic heart disease and hypertension. NM has long experienced racial bias during English-language dominant health care encounters and once experienced a severe adverse reaction to a medication. NM remains dubious that benefits of hypertension and anticoagulation medications outweigh risks. Why NM needs to continue taking these medications as prescribed has not been clearly explained, so NM stopped taking them when the leg swelling went away. But NM's mitral valve stenosis progressed. A cardiologist and cardiac surgeon assessed NM, and NM's "history of nonadherence" was cited in discussions about whether NM would be offered surgery.

Commentary

One ethical question raised by this case is this: Should patients' prior nonadherence be part of a patient's candidacy assessment for surgical care? In what follows, we consider which features of a patient's social, cultural, and racial experiences should matter in surgical candidacy determinations and why. When clinicians determine treatment courses based on assumptions about patients' adherence to recommendations, they

use the authority that prosecutors and judges have when using criminal records and racial stereotyping to determine whether individuals are blameworthy, threatening, or have potential to reform.¹ In NM's case, using medication adherence history to determine qualification for surgical intervention exemplifies how clinicians use punitive approaches in medical decision making that are deeply rooted in structural racism, as are US criminal legal processes, which leads to harsher outcomes for Black and Latinx people, in particular, in relation to police encounters, sentencing, bail, and capital punishment.^{1,2,3} This case study exemplifies punitive weaponization of medication nonadherence as a means of withholding or denying potentially lifesaving interventions. Interrogating the roles of oppression and racism in NM's life is needed to ensure that clinicians are accountable, share decision-making authority, and express respect for a patient's autonomy and agency. Equity requires recognition and critique of structural, historical, and political factors contributing to nonadherence.

Carceral Logic in US Health Care

US health care intertwines with the US carceral state when clinicians use their authority and power to reinforce patterns of racial oppression. Historically, science and medicine have falsely identified **race as biological** and pathologized Black people to justify White supremacy and the captivity, mistreatment, and torture of Black people.^{4,5} Carceral logic's punitive and controlling orientation continues to express racism, for example, in the inequitable toxicology screening of Black mothers and their newborns.⁶ Black caregivers are also heavily policed by the child welfare system and preemptively placed in law enforcement custody, which reinforces racist and classist tendencies to normalize separating children of color from their families.^{7,8} Nonvoluntary hysterectomies performed on immigrant women detained by the US Immigration and Customs Enforcement at Irwin County Detention Center in Georgia, for example, is also reminiscent of a painful legacy of **forced sterilization**, driven by US eugenic policies targeting persons of color.^{9,10} Health equity cannot be realized in this country without dismantling relationships between health care and the carceral logic of detention and punishment.

Contextualizing Nonadherence

The World Health Organization defines adherence as "the extent to which a person's behaviour ... corresponds with agreed recommendations from a health care provider."¹¹ Given power differentials in patient-clinician relationships, clinicians often dictate terms of agreement. For example, if a clinician assesses a patient's health literacy, social stability, or intellectual capacity as inadequate to adhere with medical advice, that clinician's assumptions, decisions, and practices, however well-intentioned, are rooted in carceral tendencies that normalize disrespect for patients' autonomy.¹² If treatment plans are not formulated with a patient's input, we suggest that it's not reasonable to characterize a patient as nonadherent to such plans.

Recently, *adherence* has replaced *compliance* when referring to how a patient follows or does not follow long-term medication regimens in chronic disease management treatment plans. The term *adherence* is intended to draw attention to how one participates in shared decision making and follows up on plans issuing from those decisions.¹³ But this model still tips the balance of power in favor of a clinician issuing a directive, with a patient's role as subservient and subject to punishment if not obedient.¹⁴ Social and cultural factors (eg, race, age, language proficiency, mental health status)^{15,16} have been offered as supposed indicators of medication adherence and seem to encourage a kind of patient profiling based on use of such characteristics

to implicitly or explicitly form assumptions about patients and their adherence practices. These factors also contribute to a narrative of blaming patients for nonadherence.

Patients' reasons for nonadherence deserve consideration. In one study, patients veering from their statin regimens, for example, questioned the risk-benefit ratio of their medications, experienced those medications' negative iatrogenic effects, and wanted more information about why they needed their prescribed medications.¹⁷ Qualitative research on adherence among individuals living with chronic illnesses has demonstrated that patients' trust in clinicians, clear communication from clinicians about patients' condition, and access to relevant resources influenced patients' perspective on how reasonable it was to adhere to an intervention.¹⁸

In the case of liver transplantation, a history of nonadherence is a contraindication for transplant candidacy.¹⁹ Obtaining a transplant is a multistep process, which is especially challenging for patients with marginalized identities. Socioeconomic inequity in liver transplantation is common,²⁰ and such inequity is also observed in kidney transplant procedures and surgeries.²¹

Some clinicians' concerns about prescribing pre-exposure prophylaxis (PrEP) for HIV prevention reveal profiling tendencies that tend to subserve gatekeeping. In one survey, 57 of 99 clinicians reported being hesitant to prescribe PrEP to a patient based on prior nonadherence patterns, regardless of reasons for nonadherence.²² PrEP access inequity exists for Black and Latinx men, despite their levels of PrEP awareness being similar to White men.²³

An Abolitionist Understanding of “Adherence”

Using an abolitionist perspective, the concept of nonadherence is framed in a larger analysis that includes structural racism and systemic barriers to health care experienced by historically marginalized individuals. This framework requires clinicians to understand that it is their responsibility to contextualize treatment plans and protocols within the reality of patients' lived experiences. Furthermore, clinicians must acknowledge that for many who experience racism, ableism, and heteropatriarchy, the health care setting represents a site of ongoing trauma, including violation of autonomy.^{3,6,7} This institutional violence is a source of deep and ongoing **intergenerational harm**. Abolition medicine requires an interrogation of all systems and dynamics that operate in a way to monitor, surveil, and punish people and instead proposes reimagining medicine through an antiracist lens.²⁴

The worldwide challenge of medication adherence is well-documented in rigorous studies, with estimated adherence to medications for chronic illnesses averaging around 50% in developed countries.¹¹ A 2011 study found that only 25% of patients remained highly adherent to statin therapy.²⁵ Oft-cited reasons are multifactorial and include fear, cost, misunderstanding, lack of symptoms, and mistrust.²⁶ Just as many have reframed the narrative of medical mistrust around vaccine deliberation instead of vaccine hesitancy, so it is also important to critique and reframe the narrative around patient adherence.²⁷ By centering mistrust as an individual's issue or problem, clinicians miss the historical context of trust violations by health care practitioners. How can clinicians continue to rebuild trusting partnerships with patients? How can clinicians examine their complicity in participating in carceral systems, and how can they atone for the harm perpetrated by health systems and institutions?

Abandoning Punitive Approaches

It is imperative that medicine engage in the necessary work of dismantling unjust carceral systems, internally and externally. As medicine has a long history of benefiting from, working with, and sustaining carceral systems, it must recognize how policing, surveillance, and punishment are reinforced by medical professionals and enacted upon our patients. Abolition medicine calls on clinicians to embrace transformative justice—that is, to respond to systemic violence or harm without reinforcing oppressive norms in order to cultivate accountability and healing.²⁸ In addition to addressing implicit bias and individual clinician prejudices, confronting systems of oppression requires transforming the laws, practices, and policies within the medical system.²

To condemn patients to the revolving doors of poor health and poor health care access based on their history of medical nonadherence—without interrogating the structures that produced nonadherence in the first place—is, in effect, an embodiment of carceral logic applied to medicine. Denying access to lifesaving treatments due to an assumed recidivistic pattern only further perpetuates health inequity in historically marginalized communities.

Part of the work of decarcerating and decolonizing health care policy and practice involves an investment in the idea that people are capable of change. A carceral framework implies that people are doomed to maintain their past patterns and behaviors. Transformative justice and abolitionist frameworks maintain that change is possible and within the capacity of human agency and will. It is critical for clinicians to recognize patients' capacity to grow and learn and be partners in their health care decision making.

This case presents an opportunity for the health care team to acknowledge the harm NM has experienced at the hands of the medical institution and to actualize accountability mechanisms that truly center principles of equity, patient-centered autonomy, and self-determination. Moving forward, health care teams must interrogate the systems and structural barriers like those faced by NM, while interrupting and dismantling carceral logic in clinical reasoning in an effort to build stronger patient-centered partnerships and yield more equitable outcomes. To be clear, the onus is on the health care system to critique, dismantle, and ultimately repair the harms caused by the legacy of medical racism. Eliminating policies and practices that withhold treatment based on nonadherence is a step towards meaningful institutional change and abolition medicine.

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

Alignment of Abolition Medicine With Reproductive Justice

Crystal M. Hayes, PhD, MSW and Anu Manchikanti Gomez, PhD

Abstract

Abolition medicine and reproductive justice are synergistic approaches that advance a radical vision of a racially just world. Abolition medicine and reproductive justice push medical and carceral systems towards a focus on the structural factors that impede safe and dignified parenting and childrearing, bodily autonomy, and sexual and reproductive health. Persons experiencing incarceration are stripped of authority over their health decisions, bodily autonomy, and freedom, with major implications for their well-being, sexuality, and reproduction. Black and Brown individuals and communities, who are disproportionately affected by mass incarceration and health disparities, are most in need of abolitionist reproductive justice. This article urges abolitionist clinicians to interrogate the health care sector's relationships with carceral systems and reproductive oppression.

Case

We get locked down at 10 o'clock. It wasn't until twelve before anybody came. And when they opened the door, there was blood everywhere. So, the gush that I felt was blood. They were looking at me like I was an alien. Nobody wanted to touch me. They were like, "Oh, can you walk?" I remember being furious, scared, angry, and crying, "No. I'm not walking down those steps. I've been asking you to move me for months." A few minutes later, the men brought a stretcher and took me out. They were debating whether to call 911 or the marshals, so at this point, I'm afraid not only for my baby but for my own life. I was hemorrhaging. I was like, "You need to get me out of here. Please call 911."

Commentary

The above quotation is an excerpt from an interview that the first author (C.H.) conducted with Beverly (not her real name), a Black woman who was formerly incarcerated and had a tragic and frightening miscarriage in jail. Despite being visibly pregnant, Beverly was **shackled** around her wrists, belly, and ankles during a trip to court. The shackling made it very difficult to walk. As she tried to enter the jail van, she fell; her jailers watched and did nothing. Shortly thereafter, she began spotting and bleeding. For weeks after the fall, she pleaded to see a doctor—pleas that were ignored. By the time she was moved to the hospital, it was too late. She miscarried. When Beverly's doctors asked to see the sheets where she hemorrhaged, the same prison

officials who ignored Beverly for hours informed them that the sheets had been thrown away. Beverly was devastated: those sheets represented the baby she lost, the baby that she desperately wanted to survive. As she explained to the first author, the entire experience was dehumanizing: “It felt like they threw a piece of me in the trash, like it was nothing.”

Beverly’s story highlights how racial and reproductive violence are perpetrated through the US carceral system^{1,2,3} and health care’s embedment in the carceral system.⁴ In this essay, we suggest that the US health care industrial complex has an important opportunity to reckon with its complicity and active engagement in perpetuating mass incarceration⁵ and its threats to **reproductive justice** (RJ). We argue that the centering of RJ within the abolition medicine framework is an emancipatory intervention for people experiencing incarceration, particularly to address reproductive violence like that inflicted upon Beverly. Such a paradigm shift away from complicity toward addressing the conditions that perpetuate reproductive rights violations will not only serve to restore patients’ bodily autonomy and authority over their health decisions but also inspire interrogation of the relationship between carceral institutions and medicine, particularly with respect to reproductive health care for the most vulnerable members of our society.

Incarceration

In 1994, Black women activists coined the term *reproductive justice*.⁶ These activists developed RJ as a human rights counterweight to President Bill Clinton’s proposed universal health care plan⁷ that deemphasized crucial reproductive and sexual health care and the White-led prochoice movement’s narrow focus on privacy and choice in relation to abortion—a focus that erased the primacy of structural oppression and White supremacy in constraining reproductive freedom for communities of color. RJ has grown beyond a social movement to become a value system for organizing society with respect to 4 major tenets: the right to have children, the right not to have children, the right to parent safely and with dignity, and the right to bodily autonomy.⁶ In other words, RJ makes clear that any system or institution that impedes these rights and individuals’ capacity to make healthy decisions about their reproduction and sexuality is a violation of human rights.

Beverly’s barbaric mistreatment reflects how the US carceral system and its institutions, practices, and policies have legitimized and even normalized the violation of people’s reproductive and bodily self-determination. For example, it is not uncommon for pregnant women who are incarcerated to be dangerously shackled to their beds during childbirth, where they are forced to labor alone, and have their newborn infants stripped from them almost immediately after childbirth.³ Scholars are beginning to identify the carceral system as a major threat to RJ in our society.^{1,8,9}

Jails and prisons represent the most extreme arm of the state’s control over people’s bodies. Mass incarceration occurs when a disproportionate segment of the population is locked up in prisons, jails, and detention facilities as a response to social problems.¹ Mass incarceration in the United States is well understood to have roots in settler colonialism, White supremacy, racism, sexism, and capitalism.^{10,11,12} From its inception, the US criminal legal and carceral systems disproportionately targeted and brutalized Black and Brown communities, people living in poverty, the undocumented, people with disabilities, and queer communities—the very communities that are blamed (and therefore criminalized) for social problems ranging from poverty to health disparities.

Mass incarceration and the entire carceral regime have helped to engineer a society in which people who are incarcerated are stripped of their reproductive self-determination and dignity. From the over-policing and surveillance of Black and Brown communities that rob people of reproductive autonomy (eg, fetuses defined as persons under the law and the criminalization of stillbirth, miscarriage, self-managed abortion, and drug use)¹³ to the denial of a safe and healthy pregnancy and the disruption of parenting for people who are incarcerated, mass incarceration poses an expansive and durable system of reproductive oppression.^{1,10} As recently as 2020, doctors were exposed for engaging in coercive and forced sterilization practices at an immigration detention center,^{14,15} reflecting a long pattern of reproductive violence and abuse against people under state control. Similarly, from 1997 to 2010, prison medical staff engaged in coercive sterilization practices at women's state prisons in California.⁹

Reproductive Justice and Abolition

The abolitionist framework is a set of ideas and a value system that helps build a racially just and free society. Like the abolitionist movement during slavery, prison abolition today is grounded in a vision of a radically different world, one where all people are afforded the resources to live a life with dignity. For abolitionists, this includes a world free from all forms of violence and control, including violence perpetuated by **state actors and institutions**—whether the focus is slavery or prisons and jails.

By extension, abolition medicine is the idea that our health care system has a moral, ethical, and professional obligation to use its social powers to interrogate and disrupt systems with a history of harming people. In this way, abolition medicine is deeply embedded in the Black radical tradition and emancipatory strategies and struggles dating back to slavery. Abolition medicine questions power and the structures and systems that enable violence and create racial health inequities—and especially questions their impact on those who have been historically and systematically marginalized.¹⁶ Most importantly, as Ruth Wilson Gilmore, founding member of the national grassroots prison abolitionist organization Critical Resistance, put it: prison abolition is not just the absence of prisons but the presence of “vital systems of support that every community needs.”¹⁷

Aligning RJ with abolition medicine must begin with the understanding that reproductive self-determination is ultimately racialized (and intersects with other forms of systematic marginalization) to **dismantle barriers to access** to reproductive care. In this way, the RJ framework is critical for people experiencing incarceration, who are disproportionately from poor, working-class communities of color.¹⁸ Abolition medicine is uniquely positioned to protect the human rights of incarcerated people, particularly pregnant women who are incarcerated, via its alignment with RJ. For abolition medicine to work towards creating a world where RJ shapes our society, it will have to focus on 3 main goals: (1) abolishing the entire prison industrial complex, (2) uprooting White supremacy and racism in health care, and (3) ensuring that pregnant people who are incarcerated have access to a full range of high-quality reproductive, sexual, and maternal health services. In other words, aligning RJ with abolition medicine requires health care practitioners to reimagine their role within prison systems and to leverage their power to support the fights to end mass incarceration and the criminalization of pregnancy.

Aligning RJ with abolition medicine would advance a radical vision that moves health care away from systems of control and punishment in which far too many health care and social service professionals have internalized the goals of an anti-Black repressive

system. Thus, we strongly urge abolition medicine practitioners to align with the RJ movement in **solidarity with Black Lives Matter**—and Black women in particular—to address the gender implications of mass incarceration, as exemplified by the treatment of pregnant people who are incarcerated like Beverly, especially the increasing criminalization of pregnancy. Doing so will help to protect women like Beverly from the brutal reproductive violence that has been normalized in the carceral system,¹⁹ where the incarceration rate is almost twice as high for Black women as White women.²⁰ It will also help to address health issues that primarily affect Black women²¹ but go unaddressed because of racial bias within health care. For example, Black women die at a much higher rate than any other group from pregnancy-related complications.²² Yet their experiences are often erased. To quote the Combahee River Collective: “If Black women were free, it would mean that everyone else would have to be free since our freedom would necessitate the destruction of all the systems of oppression.”²³

Iwai, Khan, and DasGupta assert: “Abolition medicine is a practice of speculation, of dreaming of a more racially just future and acting to bring that vision to fruition.”¹⁶ Abolition medicine imagines a racially just future and health care system. For this future to be *reproductively* just, health care practitioners must be trained to apply the framework of abolition RJ, both to provide high-quality sexual and reproductive health care and to disrupt institutional practices and structural factors that drive health inequity—and health care’s **relationship with mass incarceration**. To do so will require interrogation of the health care system with respect to racially unjust practices and policies (eg, drug testing) that lead to the policing and surveilling of systematically marginalized Black and Brown communities (eg, punitive treatment of pregnant women who test positive for drugs).²⁴ Moreover, it will require that we center free and accessible comprehensive reproductive health care and technologies so that all people, particularly those who have been marginalized (eg, people who are incarcerated, people living in poverty, and people with disabilities) are empowered to control their own reproduction and destinies free from stigma, violence, and coercion.

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MEDICAL EDUCATION: PEER-REVIEWED ARTICLE

An Abolitionist Approach to Antiracist Medical Education

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Abstract

Medical education is limited to the biomedical model, omitting critical discourse about racism, the harm it causes minoritized patients, and medicine's foundation and complicity in perpetuating racism. Against a backdrop of historical resistance from medical education leadership, medical students' advocacy for antiracism in medicine continues. This article highlights a medical student-led antiracist curricular effort that moves beyond a biomedical model and uses abolition as the guiding framework in the creation process, the content itself, and iterative reflection through further study and dissemination.

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Need for Antiracism in Medical Education

In 1971, Rodney G. Hood, one of the first Black medical students at the University of California, San Diego, protested a psychology professor's lecture about the intellectual inferiority of Black people.¹ The lecturer falsely claimed that because the Eurocentric intelligence quotient (IQ) was inherited, educating Black people was a waste of resources. The future Dr Hood was told by medical school administration that the lecturing professor was in his rights because of "scientific enlightenment and freedom of speech."¹

Fifty years later, medical students of color continue to face the same racism and White supremacy that Hood experienced.² Racism, a system of structuring opportunity and assigning value based on race,³ undergirds **minoritized groups' underrepresentation** in medicine,^{4,5} inequitable grading and evaluations,^{6,7,8} and exclusion from honor societies.⁹ White supremacy, a political, economic, and cultural system in which White people overwhelmingly control power and material resources, asserts White superiority at every turn.¹⁰ An important manifestation of White supremacy is the overwhelming whiteness of medical education leadership, from medical school deans¹¹ to journal editors.¹²

Medical education perpetuates racism by treating race as a biological rather than a social construct; asserting that Black, Indigenous, and people of color (BIPOC) are **biologically different**, unusual, or inferior; and maintaining medicine's complicity in pervasive racial health inequities.^{13,14,15,16} When students name racism in medical institutions, the White hegemony of medical leadership silences their voices in myriad ways—placating them without committing to real structural change, gatekeeping antiracism efforts, and gaslighting their lived experiences. Students cannot depend on medical schools to provide the antiracist medical education they deserve.

Antiracist Curricula

In 2020, through a grant from the American Academy of Family Physicians Emerging Leader Institute to one of the authors (R.M.M.), we, as a collective, decided to create antiracist medical curricular content that would be accessible to any student, health professional, or institution nationwide that wanted to engage in antiracism. We utilized our lived experiences as Black, Punjabi-Sikh, Filipino, and Mexican American people who have endured racism to create the antiracist education that we and our communities deserve. We aim to educate a new generation of physicians and to reeducate physicians who have harmed our family members through personally mediated racism and complicity with systemic racism.

Our content and process were rooted in *abolition*, a term historically applied to the movement to end slavery and more recently to the movement to vanquish the prison-industrial complex.¹⁷ As Iwai, Kahn, and DasGupta write: abolition medicine “interrogate[s] the upstream structures that enable downstream violence, like police brutality.”¹⁸ It reimagines “the work of medicine ... as an antiracist practice” by abolishing diagnostic tools and treatment guidelines that reinforce biological race, calling for desegregation of the medical profession and demanding reparations for communities devastated by medical experimentation.¹⁸

Abolition in the curricular development process. Rooting our process in abolition centered on rejecting the White supremacy culture central to medical training¹⁹ and fostering collective solidarity to bolster our shared efforts. Instead of pursuing perfectionism with urgency, we built a culture of appreciation and shared learning and prioritized reflective pauses. In place of individualism, we embraced our plurality, which enabled us to enlighten one another on where we would otherwise have had blind spots. We did not shy away from our tensions and instead dove into the conflicts within and amongst ourselves. We honored the different realities that have been so long erased by “objectivity” and worship of the quantifiable and of the written word.

We were humans first, beginning our meetings by checking in emotionally before delving into our work, thereby creating space for grief, frustration, and anxiety. We established an ongoing, dynamic system of informed consent for the emotional labor and spiritual work that antiracism requires. This informed consent process included periodically revisiting our individual involvement with the project, reflecting on whether our effort felt life-giving or draining, and determining whether we wished to continue or to take a break. We specified agenda items prior to each meeting, allowing participants to come and go as needed. We replicate this approach in our curriculum, which outlines how to create a safe learning environment that encourages learners to step away as needed. As individuals came and went due to life tragedies, we did our best to be loving and accepting, not punitive. With relationships grounded in **collective trust**, we avoided required attendance to minimize minority taxation and encouraged individuals to

participate as their bandwidth allowed. By eliminating hierarchy and centering process over product, we began our separation from the White supremacy culture indoctrinated in us by our medical training.

Abolition in medical curricular content. Most undergraduate medical education curricula are grounded in the biomedical framework, variably including health disparities data, social science principles, and, rarely, critical race theory. These limitations are magnified in graduate medical education, in which didactic time is limited. Instead of reforming the fundamentally broken curricula that exist, we redirected our energy towards creating something radical, bold, and new.

We began by rejecting the sanitized, apologetic frameworks centering White comfort and passivity, such as *racial disparities* and *cultural competency*. Instead, we rooted our work in abolition, critical race theory, and decolonization to emphasize racism and White supremacy's ordinariness, toxicity, and productivity for those in power (see [Supplementary Appendix](#)). These radical frameworks, each of which we explain in the curriculum itself, guided us in highlighting the carceral logic permeating our "caregiving" profession. This logic includes punitive, degrading, and patient-blaming language, such as "noncompliant," and clinical care's direct ties to institutions like policing and the child welfare system. Explicitly stating this logic and connecting it to the profession's deep ties to slavery helped us eliminate the euphemisms obscuring the racist violence that killed Dr Susan Moore and Daniel Prude.^{20,21}

Each of us led the development of an organ system-based module. Individually, we searched the materials that were left of our medical education. We compiled stories and data demonstrating decades of abuse of people of color by medical professionals and how medicine has perpetuated the oppression of our communities. Each module identifies key racial inequities pertaining to the organ system at hand and unpacks how they derive from the structural racism and institutionalized White supremacy forged by the legacies of slavery and *settler colonialism*. Together, we reflected on the evidence and identified 4 overarching themes permeating all modules: segregation and structural racism, racial essentialism and institutionalized racism, medical abuse and personally mediated racism, and medicine and the carceral state. We close each module by highlighting extensive antiracist strategies (clinical, research, otherwise) to challenge and dismantle racist practices.

A clinical case woven throughout each module renders the brutality of racism and White supremacy palpable. One of the modules describes the experiences of X, a 17-year-old child who identifies as gender nonbinary and Mayan-Haitian biracial. They were brought into the psychiatric emergency department by police in 4-point restraints after their parents stated that they made suicidal comments. The module utilizes elements of X's story to highlight the clinical coercion and racist abuse people of color face within the health "care" system. X's story provides an entry point into the far-reaching impact of segregated schools and the legacy of overpathologizing BIPOC's emotional distress in response to racism, White supremacy, and other systems of oppression. This narrative-based approach breathes humanity into statistics and guards against the intellectualizing and other defensive maneuvers preventing learners from implicating themselves in racism and other forms of oppression. The message to learners is clear: this is your story and your reality, too, and either you are part of the problem or you commit to being part of the change effort.

This content confronts the refusals of White supremacy—namely, its tolerance for perpetual violence and exploitation and its complacency in the face of a history of racial oppression that continues to shape the present.²² It renders the invisibility of Whiteness visible to highlight its role in upholding medical racism and preventing antiracist change. These modules reject sidelining antiracism to a lunchtime talk or a single lecture. Several hours long and requiring a half day or more, the modules are emotionally demanding and intellectually provocative to encourage interrogation of, rather than blind acceptance of, science as objective truth. As such, a significant amount of teaching is focused on creating the optimal space for transgressive learning. Furthermore, a detailed introduction module provides an overview of the key terms (eg, antiracism, oppression, racial essentialism), guiding frameworks (eg, critical race theory), and the 4 major themes permeating the modules.

Abolition in clinical practice. Our primary goal for this curriculum is positioning learners to undo racism within health care the minute they walk out the door—while anticipating White supremacist backlash along the way. By heightening their awareness of the racist beliefs, histories, policies, and structures in which we, as health care professionals, are complicit, the curriculum cultivates learners' skills for making their home institutions antiracist. The case of X, for example, demonstrates how clinicians can prevent forced injection medication for “aggression,” connect families to community alternatives to calling the police, and draft compelling school letters of support to mitigate X's risk of harm, violence, and punishment from the health care system and other institutions.

Remaining self-reflective, we recognize that abolition—to paraphrase Mariame Kaba²³—is a series of a million different experiments each day and that we are destined to fail. Similar to how we continue to evaluate, adjust, and refine our modules, we do the same with our process of collaborative creation and implementation.

In the initial iteration of our project, our perspectives were limited based on our privileged positions within academic medicine. Recognizing the opportunity we missed, we are now inviting community members and patients to partake in the module-creating process. The abolitionist way of teaching is to flip the script and allow patients to guide our learning—for once—and to dissolve paternalism so that we can extend solidarity and build a movement.

As we move into the dissemination and implementation phase of our innovation, we now face the challenge of bringing an antiracist curriculum with an abolitionist orientation into the system of oppression that never would have condoned its creation. We continue to weigh the risks and benefits of organizational involvement and formalized research, knowing that many aspects of the ivory tower are diametrically opposed to equity and justice. We question the processes by which these materials would be “vetted” by faculty and professional organizations molded by the systems of oppression we seek to dismantle. As we interrogate the avenues through which this work is disseminated, we refuse to dilute our curriculum's message or bend it to fit the reality of White supremacy for the sake of its acceptance. Recognizing that acceptance can be a challenge for a newly imagined antiracist curriculum, we are partnering with a medical school to ensure its practical application. Far from being forgotten, Hood's legacy and lessons endure in our consciousness and strategy 50 years later.

Conclusion

Kwame Ture once said: “When you see people call themselves revolutionary always talking about destroying, destroying, destroying but never talking about building or creating, they’re not revolutionary. They do not understand the first thing about revolution. It’s creating.”²³ It is in this spirit of reimagination and creation that we invite antiracist medical education’s abolitionist transformation.

BIPOC students’ and community members’ expertise, not faculty or administrators’, fuels transformation in medical education. We urge BIPOC students to take their seats at the tables they build outside of the house of medicine. The harm prevented, solidarity cultivated, radical vision nurtured, and movement advanced when like-minded medical students link up is not only worthwhile but absolutely necessary. And there is no time to wait.

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MEDICAL EDUCATION: PEER-REVIEWED ARTICLE

How Should Educators and Publishers Eliminate Racial Essentialism?

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Abstract

Racial essentialism—the belief that socially constructed racial categories reflect “inherent” biological differences—exacerbates learners’ racial prejudice and diminishes their empathy. Essentialism hinders health professions education programs’ capacity to generate a health care work force that motivates ethics and equity in health care and research. This article suggests how health professions educators and institutions should reform pedagogy on race, when clinically relevant, to emphasize racism as the root cause of health inequity. Publishers of research also have key roles in reform and should enforce appropriate and just references to race in journals and health professions education content.

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Essentialism and Inequity

In a large 2005 survey, 22% of respondents supported a genetic explanation of racial inequality.¹ Racial essentialism—the belief that racial groups form discrete genetic categories; that individuals of the same racial category are biogenetically similar; and that different races are fundamentally different—can cause people to perceive racial outgroup members as less worthy of affection and assistance.^{2,3,4,5} Indeed, the psychology literature demonstrates that **essentialist thinking** correlates with greater dehumanization of and heightened discrimination against racial outgroups and is actually a causal factor in increased racial prejudice.^{6,7,8,9,10,11,12,13}

What’s more, racial essentialism lessens motivation for redress of social inequities.^{14,15,16} For example, adults who believe that some groups lack biological potential to be highly intelligent and *children* who believe that human traits are immutable are less likely to support measures—such as affirmative action, welfare, tax-reductions (adults), or volunteering (children)—designed to repair social inequality.^{17,18,19,20,21,22,23} In a study of undergraduate students, those who were primed to perceive race as a social construct instead of a biological characteristic have been shown to be more emotionally distressed by social inequality.¹⁵ Conversely, participants primed to view race as a biological construct were more likely to see inequalities as unproblematic and were less interested in sustaining social contact with individuals of

other races.¹⁵ More generally, racial essentialism justifies negative attitudes and perpetuates inequity^{24,25}; thus, it is immoral. In the face of devastating educational, economic, housing, and health inequities in communities of color, genetic conceptions of race are direct threats to justice.

This article provides evidence of the ubiquity and negative consequences of racial essentialism. It also offers recommendations for how health professions educators and institutions can reform pedagogy regarding race and racism to combat these harms and suggests a role for publishers in enforcing appropriate and just references to race in journals and health professions education content.

Origins of Racial Essentialism

Even innocuous references to racial biology can reinforce learners' conviction in racial essentialism and negatively alter their attitudes.^{15,26,27,28} An announcement declaring that "Research studies indicate there are some medical treatments that work better for Black men and women," for example, increased anti-Black discrimination in learners despite its intent to promote public health.²⁹ American biology textbooks repeatedly include problematic essentialist teaching that increases student acceptance of racial determinism.^{30,31,32,33,34,35,36,37} References to sickle cell anemia's prevalence in Black populations or mention that an individual's race can be determined from skeletal remains, for example, are common.^{34,36,37}

Implicit racial bias not only perpetuates an incorrect understanding of race but can also elevate levels of racism and contribute to health care inequities.^{29,38,39} Recent research has found that when students read about racial differences in the epidemiology of genetic diseases, they had "(i) greater belief in a genetic cause for racial differences in behavior ... (ii) greater tendencies to use genes to explain the racial achievement gap ... and (iii) lower intentions to fix this gap if they already believe[d] that race was biological" compared to peers who received identical instruction on skeletal forensics, cystic fibrosis, and sickle cell anemia absent racial terminology.⁴⁰ Students who received racialized instruction also demonstrated significantly less interest in socializing with outgroup peers and were less supportive of efforts to address racial education disparities.⁴¹ Notably, these differences in beliefs—engendered after 4 text-based biology lessons that *implied* bioessentialism—persisted for weeks.⁴¹

Of great concern, then, is that across classrooms and clinics, health care learners are constantly trained with **race-based materials** that fuel notions of genetic racial determinism.^{42,43,44,45} If even K-12 students receive repeated incantations on racial essentialism,³⁷ imagine the extent of racialized messaging internalized by physicians who complete years of advanced, postgraduate biology coursework. What consequences does this messaging have on their ability to humanize patients, reign in implicit bias, and act against social inequities?

In their seminal work on bioessentialist teaching, William and Eberhardt demonstrate that even unassuming classroom discussions of racial essentialism engender racial prejudice and greater acceptance of racial inequity.⁴⁵ They magnify the significance of their findings by emphasizing how easily subtle messaging about racial determinism can potentially alter attitudes and behavior. They give the following example:

Imagine two people, each driving to work to meet a new coworker while listening to talk radio. In one car, a doctor is explaining why she uses racial group membership to tailor her diagnoses and treatment decisions,

arguing that the underlying biology of race affects how individuals respond to different drugs.... In another car, a historian is describing the changing boundaries of racial groups in American history, pointing out that “color” lines have typically been drawn to correspond to economic and political inequities, not physical differences.... If the new coworker is of a different racial group than our drivers, his or her outcomes may well be affected by something as innocuous as the topic of drive time radio.¹⁵

It is notable—and frightening—that these scholars of bioessentialism chose a *physician* as a prime example of how such messaging can inflict harm. This example highlights the degree to which genetic portrayals of race thrive in medicine⁴⁵ and underscores a final point: if essentialist conceptions of race have been shown to be antithetical to health justice, they have no place in medical education.

Race in Medicine

Everywhere you look in medicine, racial labels abound. They exist in coursework, textbooks, and national board assessments.^{42,43,44,45,46} They flounce across clinical resources, swagger in racialized treatment algorithms, and guide diagnostic protocol.^{45,47}

From the moment patients enter the health care system, race affects their care. It manifests in kidneys and lungs in the form of problematic race corrections for renal and pulmonary function.^{48,49,50} It sits in bladders and wombs as a consideration for urinary tract infection and sexually transmitted infection risk.⁴⁵ Race tracks along veins (heart failure medication, Joint National Committee hypertension guidelines), buries itself in bones (Fracture Risk Assessment Tool Osteoporosis Tool[®]), thumps in the heart (atherosclerotic cardiovascular disease risk calculator), and lumps tightly in the breast (breast cancer risk assessment).⁴⁵

Where race goes, medical students are asked to follow. So they memorize racial associations for cystic fibrosis, sarcoidosis, amebiasis, and gallstones.⁴⁶ Recent studies have found that 96% of preclinical lecture slides mentioning race at a single institution employ racially essentialist teaching⁴³ and that a majority of biomedical scholarship fails to define operative variables of race or ethnicity even when the authors’ conclusions rely on assumptions of fundamental racial difference.^{51,52,53} Racial essentialism is thus deeply rooted in physician training; reifies harmful, reductionist logic; and needs to be addressed.^{24,42,43,44,45,48,51,52,53,54,55,56,57,58} Although curricular reform efforts are underway, these activities are sparse, in a minority of institutions, commonly elective, and often bolstered by the labor of student activists.^{42,43,44,46,54,58,59}

But racial essentialism is learned even without explicit teaching. Generic statements, such as “girls wear pink,” imply categorical uniformity and can increase essentialist biases in learners.^{37,60} Research shows that belief that a category is meaningful, informative, and *essential* can be transmitted from parents to children simply through use of generic language.⁶⁰ If these lessons can be passed unconsciously within families, they can be transferred from attending physicians to students. So when Black residents are referred to as “you people,” or when trainees hear “African Americans get sickle cell anemia,” “Hispanic women complain about *total body dolor* and are unreliable historians,” or “Asian American tissue is more friable,” these generic statements might intensify biases.⁶¹ It is horrifying that a 2016 study demonstrated that a significant proportion of medical trainees believe in fundamental racial differences, including that Black nerve endings are less sensitive and Black skin is thicker.⁶² This finding may help to explain why Black patients—even children—suffer from **deficient pain management** in the hospital.⁶³

There are other dangers of racial essentialism in medicine. Essentialist medical approaches contribute to not only interpersonal racial biases but also *systemic* racial biases that create spurious standards of care for patients of color, delay diagnoses, and inhibit patients' ability to access surgeries, treatments, and social resources.^{39,45,48,49,64,65} It is shocking that racially essentialist teaching that has been demonstrated to increase belief in immutable racial capacity, create prejudice, and diminish support for policies redressing inequity looks identical to contemporary medical education materials^{37,40} (see Figure). Given these documented harms, teaching racial essentialism as a part of physician training is, as Donovan cogently writes, tantamount to "playing with fire."³⁷

Figure. Differences Between the Racialized and Non-racialized Texts^a

	Racialized Text	Non-Racialized Text
1	"The allele responsible for sickle cell anemia is particularly common among people of African descent; about 9% of African Americans are heterozygous for this allele. About 0.2% are homozygous and therefore have the symptoms of sickle cell anemia. In some groups of people in Africa, up to 45% of all individuals are heterozygous for this allele, and 6% are homozygous. Why is sickle cell anemia so common in Africa? It turns out that carriers of sickle cell anemia are more resistant to malaria, a common and serious disease in central Africa." (Raven & Johnson, 2002, p. 260)	"About 2 million Americans (0.6%) are carriers of the allele responsible for sickle cell anemia. Around 72,000 people have the symptoms of the disease because they are homozygous. However, in some groups of people in the world, up to 45% of all individuals are heterozygous for this allele, and 6% are homozygous and therefore have the symptoms of sickle cell anemia. Why is sickle cell anemia so common in some groups of people? It turns out that carriers of sickle cell anemia are more resistant to malaria, a common and serious disease in many parts of the world."
2	http://www.mhhe.com/biosci/genbio/raven6b/information/olc/samplechapter.mhtml . Use this link and then view page 260 of Raven & Johnson (2002) to see the figures used in the experimental text that depicted the distribution of malaria and SCA only in Africa.	http://www.understandingrace.org/humvar/sickle_01.html Use this link to view the figures used in the control condition that depicted the distribution of malaria and SCA in all world populations.
3	"Perhaps the best example is cystic fibrosis (CF), the most common fatal genetic disorder among Caucasians" (Raven & Johnson, 2002, p. 261).	"Perhaps the best example is cystic fibrosis (CF)" (Raven & Johnson, 2002, p. 261).
4	Frequency among human births: cystic fibrosis: 1/2,500 Caucasians sickle cell anemia: 1/625 African-Americans	Frequency among human births: cystic fibrosis: 1/3500 sickle cell anemia: 1/5,000

^a Reproduced with permission of John Wiley & Sons from Donovan.³⁷ © 2013 The Authors. *Journal of Research in Science Teaching* published by Wiley Periodicals LLC on behalf of the National Association for Research in Science Teaching.

Eliminating Racial Essentialism

Because race will not (and should not) cease to exist as a variable in scientific research or social identity, literacy on race is necessary for medical training.^{47,66} Yet many physicians admit they do not feel comfortable applying race-based metrics in clinical practice,⁴³ even as they are instructed that race is a biological risk factor.^{43,50} And though many doctors readily decry racism, racial essentialism—and the race-based medical protocols it informs—are not always recognized as examples of structural racism that harm communities of color.^{39,42,43,45,48,49}

Medical education can facilitate inequity or promote justice.^{37,56,67} The Liaison Committee on Medical Education (LCME) standard 7.6 in 2021 required medical schools to provide training on "[r]ecognition of the impact of disparities in health care on all populations and potential methods to eliminate health care disparities."⁶⁸ But in the 2017-2018 academic year, only 40.2% of accredited US medical schools documented

curricular content on racial disparities.⁶⁹ Because this educational requirement is an initial metric of success, medical institutions and the LCME should seek 100% compliance with this requirement in the coming years. It is important to recognize that even existing curricula on social determinants of health are not standardized, rarely integrated, and seldom engage with analysis of the political economies that engineer institutional racial inequities.^{56,69} Teaching social determinants of health as facts rather than as an impetus for social change has left these pedagogical attempts on a “road to nowhere.”⁵⁶ To prepare learners to think critically when faced with racialized clinical data in their careers and to support learner commitment to health equity, education on race-based medicine should encompass analytic frameworks supplied by critical race theory.^{45,54,69,70,71,72,73}

Without active undoing, maltreatment will continue across geographies and generations. As a first step, medical schools should systematically analyze how racial essentialism is being mobilized in current curricula. Efforts to catalog and reform bioessentialist teaching have been undertaken by advocates at the Warren Alpert Medical School of Brown University (AMS); the Perelman School of Medicine; the University of California, San Francisco; and Boston University School of Medicine, among other institutions, and demonstrate that rectifying existing issues requires new and explicit teaching on race, racism, and inequity for students, faculty, and administrators alike.^{43,54,58,59} The teachers need to be taught, too. Beyond undergraduate environments, making LCME compliance feasible will require commitment from national authorities in graduate medical education and continuing medical education as well.

These endeavors must be explicitly valued and compensated and institutionally supported. At AMS, for example, students petitioned to establish a dedicated fellowship and remuneration for continued work on equity and critical education. This effort assisted in the formation and implementation of the Brown Advocates for Social Change and Equity Fellowship,⁷⁴ which expanded programmatic training across the institution. In parallel, officially recognizing faculty members’ labor in justice work through metrics that support tenure and clinical buy-in is critical. Relying on voluntary efforts of professionals of color increases the minority tax—the undue burdens placed on minority faculty for improvement in institutional equity—underestimates the power of racial inequity and undermines the implementation of systematic and sustainable reforms.⁷⁵

Disrupting the foothold of bioessentialism in medicine will take concerted effort in multiple arenas. In addition to educational reform, journalistic mandates for the proper use of racial labels in scientific research must be enforced. Because utilizing race in the production of scientific knowledge is complex and can cause harm, clear guidelines—like those accepted by the Council of Science Editors—are readily available.^{76,77} They are, however, often not followed.⁵¹ Editorial boards should require adherence to these standards during review and prior to publication. From a practical standpoint, scientists who do not possess nuanced comprehension of race would face difficulty publishing scholarship. Thus, this measure would incentivize institutions to ensure that trainees are equipped with a robust understanding of race and inequity, as doing so would facilitate successful careers in academic medicine.

As part of developing an accurate understanding of race, physicians must also acquire strong command of structural racism.^{78,79,80} Even now, fables of genetic racial differences are being investigated to explain racial inequities in the SARS-CoV-2 pandemic.^{81,82,83,84} This type of theorization—which is propounded in prestigious medical

journals today—implicitly sanctions devastating racial health inequities as the natural result of biological variance rather than spotlighting injustices in labor, education, housing, incarceration, health care, and social investment that are the roots of disproportionate pandemic misery.⁸⁵

Conclusion

Unfounded theories of racial biology will not elucidate or remedy the disturbing racial injustices of today. Instead of mitigating racial injustices, race-based medicine ignores centuries of inequity and forces patients into a cage of reductionist logic whereby their disparate suffering is deemed predetermined. Recent studies also demonstrate that use of race-based clinical tools causes systematic underdiagnosis (or overdiagnosis of some conditions) and **undertreatment of populations of color**.^{86,87,88} In obscuring the realities of racism, this iteration of bioessentialism labels bodies of color as inherently deficient, abnormal, or substandard, which not only adds to the burden of racist stigma but also suggests that, without people of color, society would be free of excess disease, crime, and poverty.^{50,89,90}

The continued entrenchment of racial essentialism in medical practice and training engenders harm, operates in violation of existing scientific consensus, and ultimately impairs the advancement of scientific scholarship and health equity.^{15,37,41,91} Amidst national conversations on race and racism, medical educators and physician scholars should abolish racial essentialism.

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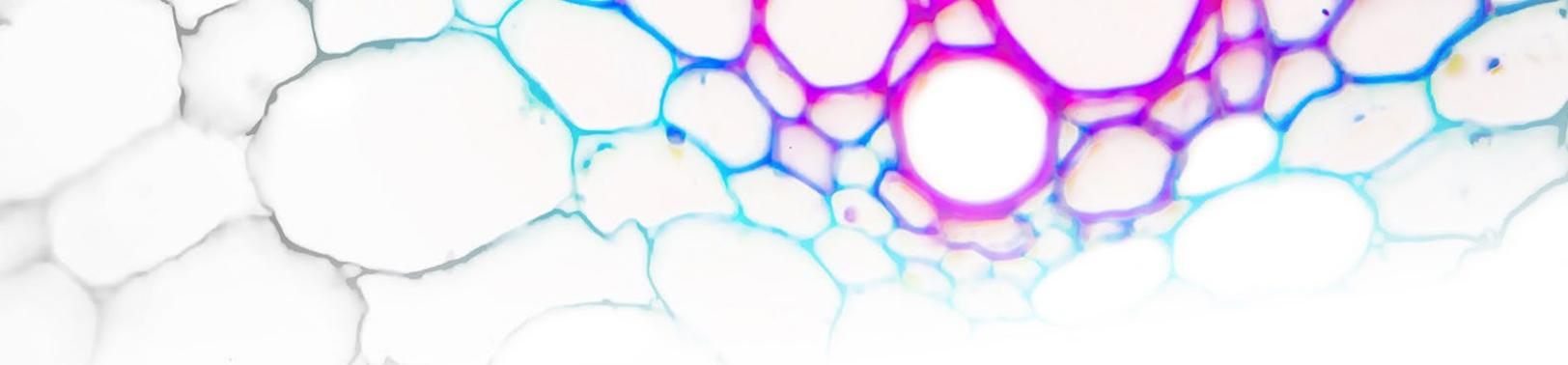
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MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

Narrative, Compassion, and Counter Stories

Aleksandra E. Olszewski, MD, MA

Abstract

Critical race theory (CRT) tools of evaluating stock stories and counter stories can help clinicians and researchers illuminate experiences of those at the margins in order to gain insights into the normalized injustices that are hidden from view in a dominant narrative. To do this work requires vigilance and intentionality. Here, CRT is applied to a patient case involving overevaluation for nonaccidental trauma (NAT) to describe the impact on patient care and experience of competing perspectives. CRT is also applied to assess the literature on the harms of inequities in NAT evaluations.

Start by Seeking Compassion

In *The Unbearable Lightness of Being*, Milan Kundera writes:

All languages that derive from Latin form the word “compassion” by combining the prefix meaning “with” (com-) and the root meaning “suffering” In other languages ... this word is translated by a noun formed of an equivalent prefix combined with the word that means “feeling.” ... In languages that derive from Latin ... [a]nother word with approximately the same meaning, “pity” ..., connotes a certain condescension towards the sufferer. “To take pity on a woman” means that we are better off than she, that we stoop to her level, lower ourselves.... In languages that form the word “compassion” not from the root “suffering” but from the root “feeling” [t]he secret strength of its etymology floods the word with another light and gives it a broader meaning: to have compassion (co-feeling) means not only to be able to live with the other’s misfortune but also to feel with him any emotion—joy, anxiety, happiness, pain. This kind of compassion signifies ... the maximal capacity of affective imagination, the art of emotional telepathy.¹

In Kundera’s definition of compassion that is “pity” rather than “co-feeling,” the feeler, a man, “stoop[s]” to the level of a woman. For many in medicine, the goal is to achieve compassionate care that is co-feeling, or “feeling with,” patients and families. However, the systems, hierarchies, practices, and policies in medicine may contribute to the perpetuation of stock stories that can cause unintentional harm to patient families while leading clinicians away from true co-feeling compassion. Thus, in order for clinicians to achieve Kundera’s definition of co-feeling compassion for all patients and families, intentional and systematic approaches are necessary. For example, applying critical race theory (CRT) to stock stories in the form of counter stories can help clinicians and researchers reframe their care approaches to center patient and family perspectives. Here, I use the power of counter storytelling to analyze abstract forces, such as racism

and anti-Blackness, and to consider when and how to use counter story in clinical care and research.

Definitions

The concepts of a dominant narrative, or stock story, and a counter narrative, or counter story, have been explored in CRT and narrative ethics.^{2,3,4} Stock stories and stories about stock characters are shared and shaped by people in power.¹ Such stories present perspectives that support existing power structures as the neutral and given reality, while skirting responsibility for injustice.^{2,3,4} Counter story is a tool that contradicts and exposes the oppression in the stock narrative by giving voice to the silenced, ignored, or oppressed.^{2,5} Counter story centers in the margins, bringing forward **perspectives of socially marginalized** groups.⁵ As Martinez notes, counter story “recognizes that the experiential and embodied knowledge of people of color is legitimate and critical to understanding racism that is often well disguised in the rhetoric of normalized structural values and practices.”⁵ When applied in medicine, counter story can help to expose injustices and highlight the voices and experiences of patients and families that might otherwise be missed or ignored. In doing so, this tool can help clinicians both recognize racism and other systems of oppression in their work and explore a patient’s or family’s unique experience or perspective in order to provide individualized, co-feeling care.

Narrative Abolition in Clinical Care

Example of a stock story and characters. A 9-year-old boy was found to have severe hypocalcemia after presenting to a hospital with a new seizure and multiple leg fractures. When he transferred to another hospital, the emergency department (ED) doctors asked his mother about the fractures. She wondered why the 2 hospital teams had not communicated and refused to answer questions. The ED doctors became suspicious that the child’s injuries were due to **nonaccidental trauma** (NAT) and described the patient’s mother as “escalated,” and “uncooperative.” They reported her experience with child protective services (CPS) to further justify their suspicion about her character and motivations. A CPS report was filed, and law enforcement was contacted.

Reframing the stock story as a counter story. Upon meeting the patient and his mother, the admitting team learned that the patient’s mother felt that the ED team was immediately suspicious of her and that she was treated differently because she was Black. The admitting team also learned that her CPS experience was as a foster and adoptive parent of relatives’ children. Her son presented to care 4 times that year for severe leg pain after falling during sport activities. Repeatedly, he was diagnosed with “growing pains” without work-up. The night he was brought to the first hospital for a seizure, his mother learned her son’s previous injuries were undiagnosed leg fractures from severe calcium deficiency and a subsequent seizure. During chart review, the admitting team learned that the first hospital’s report described NAT as unlikely, given the etiology of severe hypocalcemia.

If the ED team members had approached the case with co-feeling and curiosity, they might have learned about important clinical, social, and relational context that could have guided their care and approach. The counter story from the perspective of the patient’s mother exposed how the ED team might have jumped to conclusions about the case history, diagnosis, and management (for example, by assuming that the mother’s prior CPS involvement might implicate abuse in this case or by failing to learn about the family’s painful prior experience with the health care system, which might have informed

the mother's mistrust and behavior on presentation). Learning these critical contextual features helps to expose the role of racism in clinical care. Thus, approaching all patient cases with co-feeling curiosity—and doing so systematically and intentionally—not only might help clinicians provide more compassionate care to individual patients and families but also might set the stage for identifying important systemic changes that could address racism in clinical practice.

When narratives are written, centered, and manipulated by those in power, and when these narratives shape medical and legal decisions, individuals and institutions can harm patients and families. Research on NAT evaluations shows that patients of color are overevaluated (or evaluated for NAT more often than indicated), while White patients are underevaluated, with the largest disparities being between Black patients and White patients.^{6,7} Although multiple factors contribute to inequities in NAT evaluations, one is the unquestioned perpetuation of stock stories and the selective—conscious or unconscious—ignoring of counter stories. This selective emphasis on stock stories occurs in the language used by clinical teams when discussing patients and families, both verbally and in the electronic medical record, and in the way that policies and procedures are disparately applied to patients and families. For example, in the above story, several tropes are utilized, including the angry Black woman, the “difficult” or “uncooperative” parent, and the history of CPS involvement as a red flag. These stock story tropes are shared and manipulated among those in power, resulting in overevaluation.

One reason that stock stories go unquestioned is the influence of **cognitive biases** on decision making. As an example, when clinicians anchor on a diagnosis, they shape a narrative around data that supports a diagnosis or decision and ignore counter narratives that contradict the suspicion. Especially when clinicians must act quickly, they are at risk of relying heavily on cognitive biases and of centering stock stories while ignoring counter stories.^{8,9} Cognitive biases can lead to incorrect diagnoses and inappropriate interventions. As a result, biases contribute to disparities in patient care and outcomes. One well-studied example is the underrecognized and undertreated pain in adult and pediatric Black patients across different presentations and diseases.^{8,9}

Cognitive biases are evident in this case. The ED team used new data (like prior CPS involvement) to support the stock narrative of NAT. “Prior CPS involvement” conjures an image of and nurtures assumptions about abuse, especially when we ignore the counter story (eg, that the involvement was as a foster parent). As with anchoring on a diagnosis, it is valuable to examine stock stories and to recognize counter stories in providing co-feeling care. Analyzing abstract forces, such as social injustice, through the more concrete and accessible form of a story helps us understand and address them.¹⁰ In medicine, doing so can prompt us to unpack racism and other oppressive forces at individual and systemic levels.

However, clinicians might be reluctant to look inwards to examine biased narratives when they contribute to oppressive forces such as racism rather than a missed diagnosis. Doing so requires intentionality and recognition of their own defensiveness when faced with stock stories to which they contribute. The admitting team in this case heard the stock story during handoff from the ED team, then learned the counter story upon meeting the patient. The patient's mother readily shared her counter story to educate the admitting team and to offer feedback so that another family might receive different care. The stock and counter stories were presented plainly and starkly, and it

was easy to recognize the harm caused by their dissonance. However, it is not a family member's or patient's duty to inform and educate clinicians about a counter story affecting clinical care. This case helped me to consider the many other stock stories I had perpetuated and the many counter stories I had missed because I had not systematically sought them out. In order to provide equitable, co-feeling care that centers justice, it is the clinician's duty to vigilantly seek out counter stories in every patient case.

Narrative Research

To conduct research that reduces the harms caused by racism in health care, we must critically examine the paradigms and hypotheses that shape such work. In addition, the direction and focus of such work ought to be determined and shaped by those we aim to serve. In a *Health Affairs* blog article on this topic, Boyd et al discuss how the current academic publishing process promotes research that “undertheorizes racism as a clinically relevant cause of poor health and underelaborates solutions to racism as a health intervention” and how researchers focus on documenting inequities without addressing them.¹¹ While there is literature on disparities in diagnoses, evaluations, and decision making for cases of NAT,^{6,7,12,13,14} there is little literature on strategies to address these disparities.^{6,13,14}

Existing research seeking to improve disparities in NAT evaluations implements standardized tools to help clinicians.^{6,7,13,14} These tools are framed as a way to increase rates of evaluation among White patients, thereby decreasing missed diagnoses of NAT.^{6,7,13} This approach assumes that missed diagnoses of child abuse among White patients is the primary harm of our inequitable system. This narrative of missed NAT diagnoses in White families ignores the critical counter story: overevaluation of families of color harms patients and families of color. For example, important harms of underevaluation, which existing research captures, include further child injury and trauma.^{6,7,12,13} Important harms of overevaluation, which are less explored in existing research, include parent-child separation and parental stress and **distrust in the health care system**.^{13,14}

In order to learn more about the potential harms of and solutions to overevaluation of families of color, researchers can apply tools like counter storytelling and community engagement in their work. CRT concepts, such as counter story telling, have been applied to public health research on the impact of racism on health disparities.¹⁵ Authentic community engagement means sharing power and control while listening to and attending to the interests and concerns of communities. Community-based participatory research, focused on perspective-gathering from the communities we harm with overevaluation, is an important starting point.^{10,15}

End Seeking Compassion

Research and clinical work ought to be shaped by the diverse perspectives of the people both endeavors seek to serve. As standpoint theorists argue, through the outsider-within phenomenon, individuals who faced marginalization are in a unique position to expose the normalized injustices that are hidden from view in a dominant narrative.¹⁶ Thus, bringing forward the experiences of those at the margins is the duty of clinicians and researchers seeking to center justice in their work. As we strive to provide compassionate care and create compassionate systems, a critical first step is recognizing that “knowledge” about a situation is fundamentally shaped by perspective, which is informed by social position. Next, we can recognize that there are likely

contrasting stock and counter stories that are informed by different perspectives, particularly when there is a conflict between clinical teams and patients or families. Beyond recognizing this fact, we ought to systematically and intentionally seek out counter stories and critically examine the stock narrative in every clinical case and in the research we design and conduct. Ultimately, providing equitable, co-feeling care requires seeking out, listening to, and centering the stories of patients and families.

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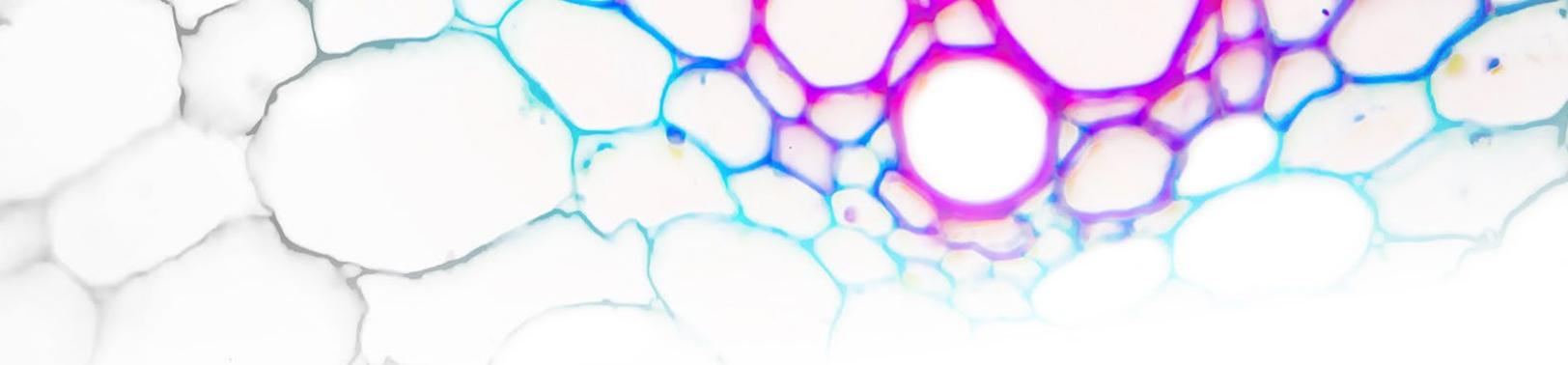
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MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

Community Mental Health Centers' Roles in Depolicing Medicine

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Abstract

America faces widespread gun violence and police brutality against Black citizens and persons with severe mental illness (SMI). Violence perpetrated against unarmed patients is common in health care, and evidence-based safety measures are needed to acknowledge and eradicate clinical violence. Community mental health centers (CMHCs) serve many patients of color and persons with SMI, so their overreliance on police or building security deserves ethical and clinical consideration. Policing of Black persons' health care begins in powerful, false narratives that White persons need protection from dangerous Black citizens who reside in urban areas or who have mental illness. This article considers White supremacist origins of the myths making CMHCs sites of policing and trauma rather than safety and healing and offers recommendations for advancing policy and practice.

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Intersections of Healing and Violence

Social justice movements against police brutality and killings of unarmed Black citizens like George Floyd and Breonna Taylor have prompted the medical community to recognize White supremacy's role in inflicting physical, social, and mental health trauma upon people of color,^{1,2} especially Black Americans, whom racial trauma and police violence most directly impact.³ As academic public psychiatrists, we believe that community mental health centers (CMHCs) should lead the medical community by example in healing racial and police trauma through depolicing.

There are over 2500 CMHCs in the United States providing care to over 1 million people, with many of those served having severe mental illness (SMI).⁴ A disproportionately high number of Black people receive care from CMHCs in inpatient, outpatient, and residential settings (19%, 16%, and 31% of clients, respectively) relative to their share of the population (13.4%).⁴ CMHCs also commonly perform citywide mobile mental health crisis calls, which unfortunately often involve armed police.⁵ Indeed, an estimated 25% of police shooting deaths involve mental health crises,⁶ with people with untreated mental illness being 16 times more likely to be killed by police than other civilians who

interact with police.⁶ Moreover, 12% of patients have police involved in their transportation to mental health services.⁷ Because CMHCs serve a high proportion of people of color and persons with SMI, they are thereby positioned at the forefront of healing racial and police trauma.

Nevertheless, there are barriers to CMHCs serving as an example of depolicing in medicine. Mass fear of gun violence in America,⁸ along with actual high rates of unarmed workplace violence in health care, makes clinicians concerned for their safety and predisposes them to anxiety, trauma, and burnout.⁹ While a degree of fear of workplace violence is understandable, health care personnel may be overestimating perceived risk of armed health care violence.^{10,11} Also problematic is the lack of efficacy of health care policing for ensuring safety in care settings. Furthermore, reliance upon police and security is inconsistent with medical institutions' position statements that commit to upholding antiracist and antibias principles opposing gun violence and police and racial trauma. For example, a 2018 position statement by the American Psychiatric Association denounces the presence and use of weapons during unarmed clinical or behavioral emergencies.¹²

Frontline Clinicians to Marginalized Communities

One reason CMHCs serve so many clients with low income is because upstream mechanisms of insurance reimbursement introduce disparities in access to psychiatric professionals.^{13,14} Insurers frequently maintain noncompetitive psychiatric reimbursement rates that disregard exceedingly high psychiatric demand. Thus, many psychiatrists do not accept insurance at all.¹⁴ Additionally, a 2019 study found that psychiatrists were half as likely as primary care physicians to accept new Medicaid patients (35.43% vs 71.29%, respectively) during 2014 to 2015.¹³ As such, CMHCs are safety net providers to persons with Medicaid or Medicare and to the uninsured, all of whom cannot access a wider selection of mental health workers due to reimbursement disparities.

CMHCs are often the only option for persons of color and persons with SMI who, due to legacies of White supremacy and bias against mental illness, cannot afford private health insurance. Black communities have been fighting systemic educational, employment, financial, carceral, and countless other obstacles imposed by White supremacy for over 400 years.¹⁵ These factors sustain the unremitting poverty of persons of color that is reflected in their overrepresentation among the uninsured,¹⁶ and states that declined Medicaid expansion under the Affordable Care Act disadvantaged Black Americans most.¹⁶ Persons with SMI are vulnerable to downward socioeconomic drift, with social determinants exacerbating their mental health issues.¹⁷

Myths of Urban Dangerousness

White supremacy and bias against mental illness not only perpetuate the aforementioned barriers to mental health care access but also influenced the advent of health care policing, particularly at teaching and urban hospitals. Nearly 30 years ago, one national survey of 248 **emergency departments** (EDs) found that teaching hospitals were almost twice as likely to have in-house security as nonteaching hospitals (43.5% vs 24.7%, respectively), and 3 of the 4 hospitals using metal detectors at the time were teaching hospitals.¹⁸ Furthermore, urban centers were 2.4 times more likely to have 24/7, in-house security as rural centers, and 3 of the 4 hospitals using metal detectors were in urban locations.¹⁸ Today, armed security is "nearly always greater" at large and public (often urban) hospitals.¹⁹ One must wonder whether heightened security at urban

and teaching hospitals arose to protect predominantly White-bodied trainees²⁰ and clinicians from the presumed dangerous bodies occupying urban spaces—bodies more likely to be of color.

Although hospitals serving largely Black populations are most likely to be policed, a study of hospital-related shootings from 2000 to 2011 did not find inner-city locations or “dangerous” neighborhoods to have higher incidences of hospital violence.¹¹ Of interest, the authors also calculated a greater likelihood of being struck and killed by lightning than being a victim of a hospital shooting.¹¹ Furthermore, a 2018 study of metal detector implementation at EDs across a large hospital system found that hospitals with the most Black patients confiscated the fewest weapons, whereas the hospitals with the most White patients confiscated the most weapons.²¹ The prevalence of metal detectors and armed security at urban, academic, public institutions serving large proportions of people of color therefore contradicts data on where need for screening is highest. These policies, therefore, seemingly arise from White supremacist myths of Black urban dangerousness.

Myths of Psychiatric Dangerousness

Media coverage often falsely equates persons with SMI with perpetrators of violence, while also promoting White supremacy by broadcasting sympathetic portrayals of White shooters vs violent portrayals of perpetrators of color.²² Stereotyping persons of color and persons with SMI as violent may foster mistaken beliefs that additional security measures within CMHCs and in responding to mobile crisis calls are warranted. Deinstitutionalization unfortunately may have reinforced these stereotypes by fostering the criminalization of mental illness and increasing homelessness, leading to jails and prisons serving as de facto mental health facilities.²³ Indeed, a 2021 study found that reducing the number of **local psychiatric inpatient beds** contributed to subsequent increases in the number of people jailed regionally.²⁴ Stereotypes of violence may also be reinforced by the disproportionate levels of policing and criminalization experienced by people of color: Black individuals are significantly more likely than White individuals to be stopped by police, charged with more serious crimes, arrested for drug-related charges despite lower overall drug use, and sentenced more harshly.^{25,26} The confluence of anti-Black bias, anti-SMI bias, and actual—although rare—episodes of armed workplace violence conspire to make those treated at CMHCs very vulnerable to myths of dangerousness.

Policing Outpatient Mental Health

Policing measures are implemented with the idea of reducing health care violence, but it is worthwhile to briefly note that armed officers and metal detectors do not consistently reduce health care violence. Many hospital shootings occur outside the hospital itself or immediately beyond the perimeter of screening with metal detectors, like an ambulance ramp, thereby easily circumventing detection by screening.¹¹ Additionally, confiscating more weapons with metal detectors has not been shown to automatically equate with reducing health care assault,²⁷ as determined shooters are less likely to be deterred by metal detectors.¹¹ Finally, the presence of armed officers may actually introduce as many shootings as it eliminates: half of ED shootings would not have occurred were it not for the firearm being carried by security personnel themselves.¹¹

Moreover, the risk of workplace violence in outpatient settings is attributable to factors beyond lack of security. In a 2020 systematic review of studies on outpatient workplace violence conducted by survey and interviews with victims, violence was commonly

attributed to clinic-based factors, such as unmet service needs, misunderstanding between patient and clinician, and overcrowding of the clinic or long wait times.²⁸ These findings suggest that addressing workplace violence strictly by directing security measures toward people with mental illness is misguided and, furthermore, that responses to inhumane and inadequate medical care may be pathologized as violence or mental illness. Of note, this review did not find a single study conducted in the United States, which draws attention to the fact that there is no evidence base for policing practices commonly employed in outpatient clinics in this country.

Other data limitations regarding outpatient health care violence are noteworthy. Most studies examining health care violence were conducted in large-scale hospitals, EDs, and inpatient units.^{11,18} CMHCs are, by definition, predominantly outpatient settings serving less acute patients than most hospital settings. Caution is warranted when generalizing hospital-based risk and safety data to outpatient settings like CMHCs.

In the authors' experience as academic public psychiatrists, CMHCs more often implement police and security measures, including metal detectors and lethally armed officers, than clinics catering to those who pay in cash and the privately insured. Such practices disregard their ethical obligations of nonmaleficence²⁹ by iatrogenically inflicting psychological and physical harm as well as stigma upon clients with preexisting police and racial trauma—all in the name of "safety." Otherwise stated, outpatient providers and organizations purportedly practicing **trauma-informed care** invest in policing operations while accepting injury to clients. Yet, the "necessity" and "efficacy" of these discriminatory acts have no scientific basis. Policing CMHCs was never evidence based, and social justice movements provide a necessary culturally responsible, historically corrective path forward.

Depolicing Medicine

Although it is important to acknowledge how context influences fears of health care workplace safety, policing practices in CMHCs and mobile crisis interventions may represent non-evidence-based legacies of White supremacy, prejudice against persons with SMI, and policing bias against persons with mental illness and persons of color. Police brutality is a **social determinant of health** that fosters mistrust in medical institutions and is associated with victims' greater likelihood of unmet medical needs (eg, doctor's visits, tests, procedures, prescription medication, and hospitalizations).³⁰ It follows, then, that unjust policing of people of color with SMI may likewise foster this group's medical mistrust and unmet medical needs while also negatively affecting the mental health of those exposed to this unjust policing.³¹

In the wake of George Floyd's killing and COVID-19 inequalities, robust federal funding to remove police from mental health crisis interventions has been prioritized for the first time.³² Antiracism and antibias demand that we prioritize the comfort of those we serve rather than our own sense of security, which will require yielding historically predominantly White decision-making positions to medical faculty of color as well as community members, activists, and persons with lived experience of violence and mental illness. We must learn from and replicate models of depolicing mental health interventions (eg, the mobile crisis program CAHOOTS in Oregon³³) as well as liaison directly with community members and community activist groups to lift up their voices and demand depoliced communities and health systems.³⁴

Antiracist praxis may be best accomplished by incorporating and listening to the voices of leaders within communities of color. As clinicians, we can amplify their voices by critically examining data through a historically and culturally corrective lens that truly challenges long-held beliefs, assumptions, and frank myths behind facility policies that uphold the overpolicing of institutions. For example, data presented in this article reveal that metal detectors are implemented in a racialized manner and are not as efficacious in building security as their widespread use would suggest. By blending community leaders' voices and academic knowledge, we can craft a new, bold antiracist language for depolicing mental health.

Conclusion

Although gun violence afflicts America, inserting police into health care operations to promote safety is steeped in White supremacy and bias.³⁵ Perhaps more than any other clinical setting, CMHCs serve marginalized populations plagued by racial, gun, and police violence. Healing societal damage caused by multigenerational systemic bias demands that we expand mental health care access and outreach rather than discriminate against those we serve. CMHCs must therefore be at the forefront of depolicing medicine by developing a new body of trauma-informed, culturally responsible, and historically corrective literature and policies.

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MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

How Abolition of Race-Based Medicine Is Necessary to American Health Justice

Stephen P. Richmond II, MD, MPH and Vanessa Grubbs, MD, MPH

Abstract

Modern medicine has always endorsed White supremacy by maintaining social, political, and economic structures that have exacerbated Black and Brown persons' lived embodiment of racism. Racial essentialism persists in health professions education and practice, especially in kidney disease etiology and intervention. This article considers how glomerular filtration rate estimates are one example of historically, politically, and scientifically situated racialized practice in health care today that illuminates a glaring need to abolish race-based clinical care of any kind.

The function, the very serious function of racism is distraction...

Toni Morrison¹

Racism in Medicine

In the past 2 years, the medical community has once again witnessed a revival of passionate discourse and engagement centered on race and racism in medicine, a shift primarily incited by the resurgence of the Black Lives Matter movement following the racialized slayings of George Floyd, Ahmaud Arbery, and Breonna Taylor, among many others.^{2,3} The scope of these activities has been broad, ranging from position statements on antiracism proffered by national health organizations to renewed commitments by academic programs for enhanced recruitment and retention of individuals identifying as Black, Indigenous, or persons of color.^{4,5} Such efforts, together with a renaissance of racial justice-oriented research and publications, have spurred hope for transformative change in medical training, practice, and care delivery that will abrogate race-based disparities in health.

Despite the medical community's current energy to foment change, a cursory glance at the history of biomedical science and medicine demonstrates that neither the presence of racism nor ardent calls for its elimination are novel. That is to say, *we have been here before*. This history speaks to the enduring nature of the problem of racism in medicine and begs the question: Are we truly addressing racism as a root cause of health disparities or merely reengaging with its downstream consequences? The answer to this query depends not only on the metrics used but also on the ideology and biases that

these measures reflect. In this work, we affirm that modern medicine has been from its inception deeply grounded in ideologies of White supremacy and that its continued support for such frameworks sustains the socioeconomic, political, and health inequities that derive from them. Furthermore, we hold that **racial essentialism** (ie, the notion that race is biologically based) is one such deleterious framework that is not scientific but rather is a method for operationalizing views of racial minorities as inferior.⁶ With this in mind, the abolition of race-based ideology must be included in our contemporary movement to end racial injustice in medicine.

Race as Biological

Detailed accounts of the unethical and unscientific use of race as a biological concept have been elaborated for decades, as has strong evidence for social determinants of health.^{7,8} What has seldom been discussed in the medical literature, however, is why race-based medicine rather than race-conscious medicine—ie, consideration of the ways in which society’s handling of race affects health—continues to prevail as the dominant explanatory model for racial disparities.⁹ Conversely, we have seen staunch advocacy for the faulty concept of “biological race” in scholarship purportedly aligned with principles of racial justice.¹⁰ These contradictions demonstrate how deeply embedded and intertwined are race and racism in medical theory and practice and how challenging it is to disentangle racial ideology from science, even when equity is at stake.

In line with best practices on publishing on race and racism, we provide the following definitions.¹¹ *Racism* is defined as a sociopolitical and economic system that creates and uses race as an organizing principle for the unequal distribution of wealth, power, and resources, including health. *Race* is defined as a social construction created by racism that establishes group-based differences (eg, physical appearance) as the basis for differential treatment and outcomes. To better understand the threat of race-based medicine and the necessity of its abolition, we propose as a case example the racialized assessment of kidney function examined through 3 critical lenses: (1) language and meaning, (2) racism as science, and (3) power and practice.

Race-Based Assessment of Kidney Function

Estimation of the glomerular filtration rate (GFR), or the rate at which the kidneys filter one’s blood, has become the centerpiece of national discourse on the use of race in medicine.^{12,13} It is perhaps the quintessential example of race-based medicine purporting race as biologically meaningful in accordance with claims of early researchers who accounted for apparent racial differences in GFR estimates by claiming that the kidney function of African Americans must be racially distinct in response to changes in dietary sodium.¹⁴ These assumptions were not further investigated; rather, they were codified in race coefficients that would presumably confer greater precision to GFR estimations. The MDRD and CKD-EPI equations, which are now widely used to assess kidney function, include “race corrections” that result in 21% and 16% higher estimates, respectively, for African Americans alone.^{15,16,17,18} These specious estimates can result in years’ delayed referrals to kidney specialty care and kidney transplant evaluations for Black patients compared to other racial groups.¹⁹

Debate about abandoning race correction has transpired against a backdrop of some of the most profound racial disparities in medicine. Prevalence of end-stage kidney disease is more than 3 times higher in African Americans than in White Americans.²⁰ While Black candidates make up a third of the **waitlist for deceased donor** kidney transplants and White candidates make up more than half, African Americans receive a quarter of

transplants, while White Americans receive roughly two-thirds.²¹ Some attempt to lay the blame for these disparities on the Black community itself, pointing out that the absolute number of kidneys donated from Black donors is less than the number awaiting a kidney transplant.²¹ However, such attempts ignore the facts that race concordance is not a requirement for transplantation and that African Americans only make up 13% of the US population²² but are disproportionately affected by conditions that make many ineligible to donate. Furthermore, that this discourse ensued even though a GFR-estimating equation that not only performs better than currently ubiquitous methods but also does not include a race correction *already existed* underscores the hold that race-based medicine has on the American health care system.²³

Language and Meaning

Perhaps the most obvious threat to the abolition of race-based medicine concerns the ways in which we in the medical science community speak of and understand the race construct. A lack of common language and understanding has led to misrepresentations of its place, purpose, and value in medicine.²⁴ Such misrepresentations have not occurred in isolation but are heavily informed by our nation's history of racializing individual differences. Yet, it is crucial to realize not only what meanings we have made for race, but also how race itself makes meaning. Race possesses an almost magical quality of obviating the need for sound scientific explanation. As it obscures the mechanisms of racism, race makes meaning where there was none, providing the substrate for **implicit bias** and stereotypes alike.

Consider how numerical coefficients like those found in race-based estimated GFR (eGFR) equations demonstrate the symbolic power of racialized language, how scientific meaning is made through belief, and how that belief is thereafter reinforced by science. These coefficients situate race correction as a mathematical rule, a universal truth, as unchanging as *pi* or the speed of light. In doing so, they ignore the sociopolitical and semantic complexity inherent in racial identification and fail to quantify how much "Blackness" is necessary to qualify for said correction. Thus, we hold that contemporary mechanisms, such as race-based calculators and clinical decision rules that claim a biological basis for race, are simply racism by another name.

Racism as Science

Abolition of race-based medicine is further threatened by its continued validation as a component of sound science. Likewise, sound science is jeopardized by the continued inclusion and reproduction of race as biologically meaningful. This convention derives in part from a poor understanding of what race is and how it functions. Race-based medicine violates basic principles of scientific integrity, including the need for variables to be discrete, unique, and measurable.²⁵ As a social construct, race defies these criteria and is instead arbitrary, fluid, and unquantifiable, as immigration, intermarriage, and the mixed-race populations have eroded some racial boundaries and social science research has repeatedly shown that racial identity fluctuates at the individual level.²⁶ Moreover, any variable serving as a proxy must have close correlation with the variable of interest.²⁷ Such correlations with respect to race are not demonstrated in sound biomedical research but are routinely assumed or omitted with a normative understanding that race itself (rather than racism) is the associated or causal factor.

Regarding our eGFR case example, the MDRD and CKD-EPI studies are emblematic of how race operates as a unique exception in medicine, thereby precluding the need for high-level scientific rigor as is demanded elsewhere in biomedical research. Despite

these alarming compromises to validity, researchers continue to sew bias into the fabric of study design, priming their results to suggest statistically significant biological differences between races. For example, the biracial stratification (ie, African American or other) used to develop the MDRD equation was not only put forward as the only relevant intergroup difference without supporting evidence but also carried forward to the subsequent development of the CKD-EPI equation within a multiracial study population.^{15,16} Subsequent findings are declared evidence, and interpretations are widely accepted as valid because ideological constructs like racial essentialism predominate in biomedical sciences.²⁸ Thus, the overwhelming normativity of race-based medicine and its associated biases allow racial ideology to be translated into medical research, education, and clinical practice with relative ease. Dismantling these connections is the formidable work of abolition.

Power and Practice

Just as racism cannot be separated from race, neither can it be divorced from power. The role of race in medicine depends not only on the complexities of racial language or its validity in biomedical science, but also on who has decisional power to make change and the ideology espoused by such persons.²⁹ White supremacy in medicine has historically concentrated predominantly White-favoring biases and ideologies in roles of power and provided robust socioprofessional structures and practices to support them. Therefore, the problem that race-based eGFR represents is not simply one of race-based medicine—it is one of all of medicine. While we know elimination of racial coefficients from GFR estimations alone will not resolve disparities in kidney disease, it is an integral step to dismantling racism in power and practice.

The eGFR discourse has thus far resulted in a recommendation to omit a race correction, but it was mired in deliberations on the potential repercussions of removing race coefficients and paid little attention to the potential harm already done by race correction and by maintaining the status quo throughout the 10-month deliberation process.³⁰ What the eGFR discourse has done is to demonstrate the validity of the late Nobel laureate Toni Morrison's oft-quoted words that, indeed, "the very serious function of racism is distraction."¹ Race-based medicine has provided the easy-to-digest explanation that race itself underlies disparate outcomes. It has decentered our focus from known determinants like structural racism and obscured them behind flawed ideology masquerading as science. Moreover, analysis of important determinants of health, including sociopolitical, economic, and environmental factors, has been largely ignored in favor of racial essentialism. Thus, we as a medical community remain distracted, lost in the ever-present hunt for evidence that Black people are biologically other and yet unwilling to accept racism as a root cause of this belief.

Race-based coefficients, calculators, and decision rules should have been the low-hanging fruits of dismantling racism, but the resistance to abolishing race-based medicine demonstrates that our true problem lies in the orchard. Because systemic racism persists as a function of how power is organized and distributed, abolition of systemic frameworks like race-based medicine must necessarily involve the erosion of White supremacy. Moreover, it will not be the presentation of new and compelling evidence that ends race-based medicine but rather a shift in our thinking away from the ideology that needs it to exist.

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MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

Why Equitable Access to Vaginal Birth Requires Abolition of Race-Based Medicine

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Abstract

In 2010, the National Institute of Child Health and Human Development Maternal-Fetal Medicine Units (MFMU) Network developed a decision aid, the Vaginal Birth After Cesarean (VBAC) calculator, to help clinicians discern how one variable (race) might influence patients' success in delivering a baby vaginally following a prior birth by cesarean. The higher rate of cesarean deliveries among Black and Hispanic women in the United States has long demonstrated racial inequities in obstetrical care, however. Although the MFMU's new VBAC calculator no longer includes race or ethnicity, in response to calls for abolition of race-based medicine, this article argues that VBAC calculator use has never been race neutral. In fact, VBAC calculator use in the United States is laced with racism, compromises patients' autonomy, and undermines informed consent.

Prediction as an Endeavor

Every year, 1.2 million women in the United States give birth via cesarean, with around 517 000 of these births being repeat cesareans.¹ Due to the escalating risks of sequential surgical births, in 2010 the National Institutes of Health (NIH) declared increasing the rate of vaginal birth after cesarean (VBAC) a public health priority.² After peaking at a rate of 28% in 1996,² the VBAC rate stood at around 13%, or 80 000, in 2019.¹ In their 2010 appraisal of the scientific VBAC literature, the NIH also noted that prediction tools that could accurately estimate the probability of a successful VBAC had been developed.² In theory, the VBAC rate would increase if the women with highest probability of success went on to attempt VBAC, assuming some of those women currently undergo repeat cesareans.³

In 2007, the NIH-funded Maternal-Fetal Medicine Units (MFMU) Network published results for what would become the most widely used VBAC calculator in the United States.⁴ The MFMU found that a combination of 6 factors, among them race/ethnicity, accurately predicted the probability of successful VBAC, with each factor being independently associated with VBAC. Greater body mass index (BMI) and age both decreased the predicted probability of successful VBAC, whereas prior vaginal birth and self-identification as a White woman increased the predicted probability. Specifically,

women who self-identified as Black or Hispanic had half the odds of having VBAC as White women.⁴ Some institutions began to use the VBAC calculator routinely to support pregnant women in making more informed decisions that expressed their autonomy.⁵ Amidst calls for the abolition of race-based medicine,⁶ the MFMU developed a new calculator that excludes race/ethnicity.⁷

In this essay, I will argue that cesarean use in the United States exhibits racial inequities in care that challenge the possibility of a race-neutral VBAC calculator. These inequities have been underappreciated in both the bioethical and the clinical literatures on VBAC and are tied to histories of obstetric racism. The new VBAC calculator continues to be laced with racism, compromises patient autonomy, and undermines informed consent.

Lineages of Obstetric Racism: From Slavery to the VBAC Calculator

Dating to its origins in slavery, the study of obstetrics and gynecology (OBGYN) played a foundational role in medical racism in the United States.⁸ OBGYN research produced and **naturalized racial differences**, with the result that such differences became focal points for operationalizing racism.^{9,10} As examples of obstetric racism, OBGYN researchers refined experimental surgeries on enslaved women and controlled the fertility of racialized minorities.^{9,11,12}

To understand why the VBAC calculator is another example of obstetric racism, we must first understand its origins. Like past forms of obstetric racism, the VBAC calculator considered race and ethnicity to be markers of an intrinsic health difference between human populations.^{13,14} Certain approaches to epidemiology supported the application of race as a population risk factor in the study of obstetric outcomes.¹⁵ For instance, regardless of mode of birth, obstetric researchers found Black women to be “at risk” for higher rates of maternal mortality than White women.¹⁶ Since the 1990s, when cesarean deliveries began to increase, US researchers have noted that Black, and sometimes Hispanic women, are more likely to give birth via cesarean than White women.¹⁷ The suggestion that the higher rate of cesarean birth for Black than White women due to nonreassuring fetal heart tracings may reflect “a true biological difference in the ability of the fetus to tolerate labor” perpetuates obstetric racism.¹⁸ Different from the risk factor approach, critical race scholars argue that racism—and not race—is the fundamental cause of racial health inequities.^{14,19}

Because the VBAC calculator naturalized racial differences, it’s likely that certain uses of the calculator contributed to cesarean overuse among Black and Hispanic women and that this overuse is a form of obstetric racism.²⁰ Contrary to its intended use as an adjunct to counseling, in many institutions clinicians used the VBAC calculator to undermine informed consent. In one survey, roughly 1 in 5 certified nurse midwives reported that the calculator was used to discourage or prohibit women from attempting a VBAC.⁵ Using the calculator to discourage or prohibit VBAC hinged on the issue of whether attempting a VBAC for women with low calculator scores (ie, higher risk) should be considered safe and reasonable.

“Safe and Reasonable” VBAC Debates

Bioethicists consider the choice between VBAC or a repeat cesarean to be one of dual equipoise.²¹ Because repeat cesarean and VBAC have distinct maternal and fetal risks, mode-of-birth counseling should be nondirective, favoring neither option.² Furthermore, the decision to attempt VBAC or schedule a repeat cesarean involves a host of personal considerations that only the woman herself can assess. Thus, bioethicists have

concluded that repeat cesarean and VBAC are both safe and reasonable options.²²

The bioethical approach is at odds with how many obstetricians privilege relative risk to turn VBAC into an *unsafe and unreasonable* option.²³ When a woman labors after a first cesarean, the *absolute* risk of a uterine rupture is only 0.5%, and 1 in 12 ruptures leads to fetal neurologic injury or death.²⁴ New data from the late 1990s found that uterine rupture tripled the *relative* risk of fetal injury or death,²⁵ compelling the American College of Obstetricians and Gynecologists (ACOG) to recommend that a surgical team be “immediately available” in all VBAC-offering hospitals.²⁶ Many hospitals did not have the resources to comply, and the national VBAC rate declined from 28.3% in 1996 to 9.2% by 2004.^{1,23} Nationally and in many states, some 50% of rural hospitals don’t offer VBAC, especially those lacking access to 24/7 anesthesia coverage.^{27,28}

Bioethicists have argued that the emphasis on relative risk leads to a risk distortion that magnifies the small absolute risks of VBAC.²⁹ Despite incisive bioethical critiques that were contemporaneous with the development of the calculator, the MFMU ended up emphasizing relative risk. The MFMU discovered that when women who had calculator scores below 60% attempted a VBAC, there was an absolute risk of 3.1% for maternal or newborn morbidity compared to a 1.5% risk for those who also had scores below 60% and scheduled a repeat cesarean.³⁰ This statistically significant relative risk of 2:1 led the MFMU and ACOG to suggest that scheduling a cesarean for women with scores below 60% or 70% could be a safer option.^{30,31} In some institutions, the 60% threshold became another example of relative risk being used to discourage or prohibit VBAC.⁵

Although bioethicists center women’s care preferences in mode-of-birth decisions, they may have underestimated the impact of racism on both the formation of and the respect for women’s VBAC preferences. For instance, **structural inequities** and unequal health care treatment can make postcesarean recovery more difficult,³² and having a difficult postoperative recovery informs preference for VBAC.³³ In one analysis, 75% of Black and 54% of Hispanic women preferred VBAC compared to 43% of White women.³³ Bioethicists’ calls to **support women’s autonomy** did not protect Black and Hispanic women who faced a calculator that systematically disregarded the inequitable experiences that led many to prefer VBAC in the first place.^{12,20}

From Explicit to Implicit?

Removing race will help mitigate the VBAC calculator’s most negative consequences. However, racism might continue to operate implicitly in the calculator.³⁴ Racism may explain in part why more Black and Hispanic women than White women undergo unnecessary primary cesarean births.^{18,35} Because the new VBAC calculator treats every prior cesarean as if it were clinically necessary, the scores of more Black and Hispanic women become eligible for entry into a VBAC prediction tool. Furthermore, 2 of the calculator’s variables, BMI and treated chronic hypertension, are shaped by structural and interpersonal racism. For example, neighborhood lethal policing is associated with a greater risk of hypertension and obesity in women.³⁶ The incorporation of these 2 variables could mean that the prior birth experiences of Black and Hispanic women make their data more likely to be eligible for entry into a VBAC prediction tool. Although BMI and hypertension may have some biological plausibility, the new calculator disconnects risk factors from structural forces and shifts responsibility for successful VBAC onto the individual.³⁷ The calculator unfairly presents a free “choice” while concealing factors that contribute to successful VBAC, many of which, like hospital culture and racism, may be beyond the control of any individual.³⁸

Conclusion

The movement for the abolition of race-based medicine has caused researchers, clinicians, and patients to reflect on removing race from race-adjusted clinical algorithms.⁶ Removing race from the VBAC calculator does not fully address the ways that racism continues to cloud the issue of VBAC. In order to make **fairer algorithms**, we must pay attention to the explicit and implicit ways that racism structures the risk of a primary cesarean, the quality of postoperative care, and clinicians' willingness to respect women's care preferences. Bioethicists have recommended that we center women's preferences in VBAC decision making.²² However, the VBAC calculator demonstrates how relative risk can be used to trump a woman's preferences for VBAC. Both the new and the old VBAC calculator compromise patient autonomy and undermine the principle of informed consent.

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VIEWPOINT: PEER-REVIEWED ARTICLE

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 Butler¹

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 Davis⁹ 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 hospitals¹⁹ and restraining elderly patients who are terminally ill²⁰ 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 racism²² and criminalize the lives of marginalized people¹⁹ 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 grassroots 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.

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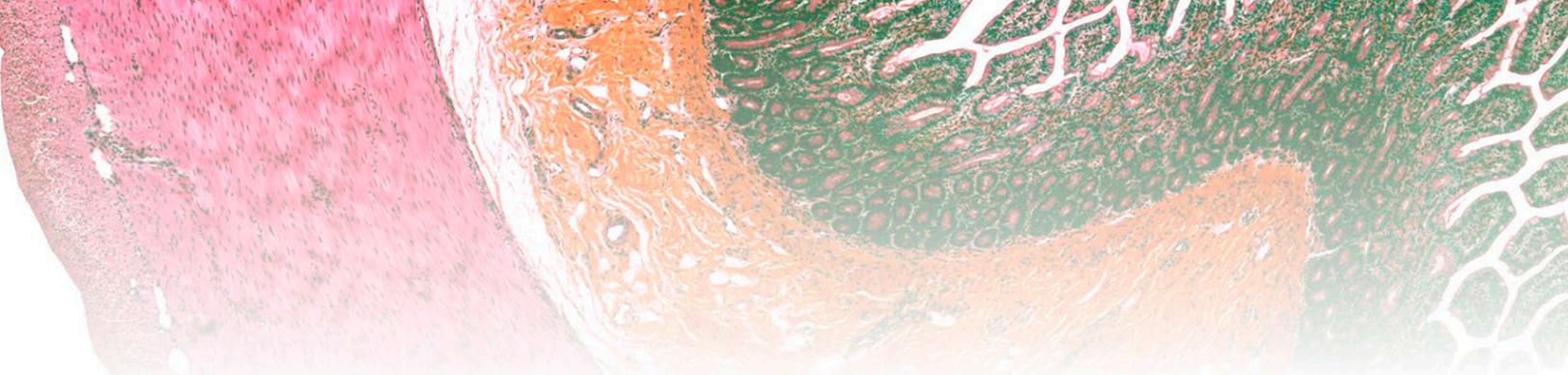
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LETTER TO THE EDITOR

Response to “Education Solutions to the Medical-Dental Divide.” A Novel Approach to Creating Unifying Organizational Cultures in Medicine and Dentistry

Carolyn A. Chan, MD and Nora Makansi, DDS, PhD

We appreciate the perspective presented in Rasmussen and colleagues’ “[Education Solutions to the Medical-Dental Divide](#)” and the call for “purposeful educational unity” between medicine and dentistry. In addition to educational reform, unifying the fields¹ requires changes to organizational culture (OC), which includes shared assumptions, beliefs, and values. Overcoming organizational separation also requires investment in interprofessional education (IPE), such that IPE does not become “something I did once in graduate school.”

Implementing IPE requires diverse groups of professionals to collaborate, support, contradict, and adjust in the face of omnipresent complexity and uncertainty. Successful collaboration requires competence-trust and openness-trust within organizations.² A novel solution we propose is the use of improvisational (improv) theater techniques, which have been conventionally used to create unscripted performances. *Medical improv* is the application of improv techniques to improve communication and collaboration in the health professions.³ Medical improv has been used to teach interprofessional students empathy and [develop personal and social competencies](#) in a dynamic and practical way, and students have reported its positive impact on their capacity to cultivate quality interprofessional relationships.⁴ Within the business literature, teaching agreement and [collaboration through improv games](#) has been used to foster an OC of effective communication and team building.⁵

Medical improv is a promising solution to the medical-dental educational divide, and training curricula could be developed for students, faculty, and staff as a way to start changing OC by focusing on fostering collaborations within a safe learning and working environment. If we fail to address OC, it might take another 182 years to achieve educational unity between medicine and dentistry.

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