Dr. Mary Bassett: We Must ‘Name Racism’ As A Cause of Poor Health

Racism is messy. But acknowledging its effects is a key part of improving public health.

**The Huffington Post**



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“It is important to name racism as something more than poverty concentrated in communities of color,” NYC Department of Health and Mental Hygiene Commissioner Dr. Mary Bassett said during her acceptance speech for the Frank A. Calderone Prize in Public Health in October.

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*The following is excerpted from Dr. Mary Bassett’s October 2016 acceptance speech, ‘*[*Public Health Meets the ‘Problem of the Color Line*](https://www.mailman.columbia.edu/sites/default/files/docx/10-24-16_calderone_speech_final.docx)*,’ for Columbia University’s Frank A.* [*Calderone Prize in Public Health*](https://www.mailman.columbia.edu/public-health-now/events/calderone-prize/2016-winner-dr-mary-t-bassett)*. Bassett is the commissioner of New York City’s department of health and mental hygiene.*

Before Hillary secured the nomination, before many “felt the Bern,” and indeed, even before there was change we could believe in, there was a presidential candidate of several firsts running to represent a major party ticket who broke the mold in more ways than many could comprehend, let alone support. I am speaking of Shirley Chisholm.

There’s so much to learn from, but what I want to focus on today is her bold, unapologetic, and explicit commitment to naming racism. In her memoirs, she wrote: “Racism is so universal in this country, so widespread, and deep-seated, that it is invisible because it is so normal.” If you think the conversation on race in our country is just getting legs now, can you imagine a presidential candidate saying this in 1972? And still, nearly 45 years later, her analysis stands.

Congresswoman Chisholm has us consider how we lose sight of what’s right in front of us.

This is a consideration that has woven its way throughout my working life. A little over 30 years ago, Nancy Krieger and I published an article in the *Monthly Review* titled “The Health of Black Folk.” In it, we wrote about the normalization of poor health among black people – how the status quo of poorer health and shorter lives comes to pass as one the “facts of being black.” The following passage begins this essay:

What is it about being black that causes such miserable odds? One answer is the patently racist view that blacks are inherently more susceptible to disease, the genetic model. In contrast, environmental models depict blacks as victims of factors ranging from poor nutrition and germs to lack of education and crowded housing. Instead of blaming the victims’ genes, both liberals and conservatives blame black lifestyle choices as the source of the racial gap in health.

The “facts of being black” are not, as these models suggest, a genetically determined shade of skin color, or individual deprived living conditions, or ill-informed lifestyle choices. The facts of being black derive from the joint social relations of race and class: racism disproportionately concentrates blacks into the lower strata of the working class and further causes blacks in all class strata to be racially oppressed.

I believe we’ve come a long way since the 1980s, but I’m not sure that our analysis of racism and health, or social justice and health, has grown more sophisticated, drawn more practitioners, or explicitly influenced much policy. I can say that because I continue to find myself explaining the very same concepts I wrote about in the 80s in 2015 and 2016, most recently in an interview with Big Think and in a piece for the New England Journal of Medicine about the importance of #BlackLivesMatter.

All of this is true even when there has never been more attention given to concepts like the social determinants of health and health equity. Representative Chisholm’s insight becomes prescient in this respect, for today our analysis of equity and social determinants is ironically myopic, a limitation that keeps us from fully realizing their potential as frameworks.

Today, we can speak of health equity without invoking race at all. Those who do speak of race seldom explicitly name racism, and even in those few forays into racism, there is hardly mention of the history and the contemporary of racial oppression, or the staying power of white supremacy. This troubles me, because it doesn’t take much for invisibility – what we don’t see – to become blindness – what we can no longer see.

My goal is to convince you all that we must explicitly and unapologetically name racism in our work to protect and promote health – this requires seeing the ideology of neutral public health science for what it is and what it does. We must deepen our analysis of racial oppression, which means remembering some uncomfortable truths about our shared history. And we must act with solidarity to heal a national pathology from which none of us – not you and not me – is immune.

There are many well-meaning and well-trained public health practitioners who disagree from the outset that we must name racism. That argument will sometimes claim that the very essence of public health is about helping people, pointing to increased lifespans and decreased infectious disease outbreaks over time. Their argument will at other times claim that we don’t want to muddy the clear waters of public health with the messy politics of race, that this sort of a topic is best left to protesters, opinion editorials and campaign stump speeches. I have also heard the claim that identifying racism opens this Pandora’s Box of problems that our modest field cannot hope to address comprehensively – that identifying racism hoists too heavy a burden. Last, there are those who say that racism is not the core issue, but instead poverty. We cannot fix racism, but we can fix poverty.

Of these, I believe the most dangerous claim is the first, that our technical expertise is enough to meet the challenges of poor health, wherever they are. This mindset presumes a neutrality of public health that has never been true – it ignores the fact that public health both operates in a political context and is itself, like any science, permeated by ideology.

Much is conflated when medicine and public health attempt to fly below the radar of politics by donning the armor of scientific objectivity – guarding the faith by positing the cold logic of the scientific method. Let me start by saying that science is not all methodology – one simply cannot judge the prudence of a whole ecology of funders, research proposals, theory-building, conferences, journals, institutes, and applications by reducing all of that to the scientific method. Each of these facets is fully penetrated by the biases of human behavior, by the ideologies of our time.

Consider two examples: funding priorities of the National Institutes of Health (NIH) and the public health, medical, and criminal justice response to the current opioid crisis.

In the case of the NIH, see its most recent 2012-2013 biennial report to Congress: as my colleague Nancy Krieger has pointed out, not only did it allocate only 9 of its 441 pages to “Minority Health and Health Disparities,” but within these 441 pages, the terms “genome,” “genomic,” “genetic,” and “gene” appeared 457 times, whereas “social determinants of health” occurred only once, “discrimination” and “poverty” twice, “socioeconomic” 12 times, and “racism” not at all.

Or, with regard to the current opioid crisis – and its appropriate reframing as a public health and not criminal justice issue – how differently it would have been had the same framing been used when Nixon declared his “War on Drugs!” But of course he did not. Today, the opioid crisis is perceived as primarily affecting white populations, people who need help. No such frame of deserving victims was used, however, by Nixon. Instead, as shown in Ava DuVernay’s extraordinary new film “13th” that was a “war” that aimed to criminalize the black population and reverse the gains of the Civil Rights Movement and the War on Poverty.

We must remember that objectivity is not a synonym for neutrality. Objectivity refers to the idea that independent researchers can independently seek to test the same hypothesis and, if the hypothesized causal processes are indeed going on, they should come up with the same results if they use the same methods. However, what researchers choose to study and how they frame hypotheses determines the context in which objectivity is deployed. I urge you to consider, for example, that a great deal of unacceptable actions have taken place when objective methodology is utilized without regard for the role of science in oppression: eugenics, forced sterilization, the Tuskegee study. Often these are dismissed as bad science, or unethical science, when they too, in fact, are science.

Knowing this, we must name racism in our research proposals, in our theories, in our oral presentations and conference tracks, and even in our hypotheses. The essence of naming racism is this – how we frame a problem is inextricable from how we solve it.