GRAHAM, POLICE VIOLENCE, AND HEALTH THROUGH A PUBLIC HEALTH LENS

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ABSTRACT

That police kill black people with impunity is a concerning social issue—but is it a public health problem? In this Essay, I examine how certain public health concepts and approaches can inform both the answer to this question and the development of strategies to address the problem. Drawing on Ruth Wilson Gilmore's definition of racism as "the state-sanctioned and/or extralegal production and exploitation of group-differentiated vulnerability to premature death" and on the World Health Organization's charge to promote optimal health for all, I show that the police killing of black people with impunity constitutes a social exposure rooted in racism that contributes to population-level health inequities.

This Essay clarifies how public health differs from related fields and uses four criteria to determine whether this problem falls within the purview of public health professionals. Next, the Essay discusses three potential insights a public health lens adds to legal and social science discourse on the problem. Lastly, given the applied nature of public health work, the Essay offers several recommendations and cautions for developing strategies to address this problem.

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INTRODUCTION

I want to thank Professors Osagie Obasogie and Khiara Bridges for organizing this important and timely symposium and for inviting me to participate in it.

Before I discuss the topic at hand, allow me to acknowledge that I conduct my work in southern California on lands originally inhabited by and cared for by the Gabrieliño-Tongva peoples. No doubt the displacement of these nations enabled the establishment of my land-grant institution, UCLA, which is now considered by some to be among the best public schools in the country. This acknowledgement of the displacement of the indigenous caretakers serves as a humbling reminder that even those of us who have legitimate claims about U.S. racism are complicit with and benefit from the historical and ongoing injustices visited upon the indigenous peoples of the Americas.

This Essay has two objectives: The first is to offer criteria for determining whether police killings of black people with impunity constitutes a *public health* issue—that is, while it may be considered a social issue and one with which all citizens, including those who work within the field of public health, should be concerned, to what extent does the professional responsibility of addressing it fall within the purview of the field of public health as the field understands its mission and as evident from the conceptual and methodological tools it uses to conduct its work? The second is to consider what the discussion about police violence, bad apples, and black people might gain by viewing the issue through a public health lens.

I am pleased to have this opportunity to speak with and learn from scholars in the diverse disciplines represented at this symposium. This Essay, which is informed by the Public Health Critical Race Praxis ("PHCRP") that Professor Collins Airhihenbuwa and I developed, offers one of several possible public health responses to the symposium's broader questions.[1] Communicating across disciplines is often challenged by the lack of a common lexicon and by the multiple connotations any given term may have. The terms *racism*, *health*, and *public health* have been defined in a myriad of constructive ways. Both the title of our panel—"*Graham*, Police Violence, and Health Impacts"—and the title of this Essay promise insights rooted in the field of public health; therefore, this

[1] PHCRP is an offshoot of Critical Race Theory ("CRT") that Airhihenbuwa and I, two health-equity researcher-advocates, launched in 2010 with the publication of the PHCRP framework. *See generally* Chandra L. Ford & Collins O. Airhihenbuwa, *The Public Health Critical Race Methodology: Praxis for Antiracism Research*, 71 SOC. SCI. & MED. 1390 (2010). PHCRP promotes public health engagement with CRT concepts and approaches and encourages novel application of an iterative, critical process to carrying out empirical research. *See* Chandra L. Ford et al., *Anti-racism Methods for Big Data Research: Lessons Learned from the HIV Testing, Linkage, & Retention in Care (HIV TLR) Study*, 28 ETHNICITY & DISEASE 261, 264-65 (2018); Chandra L. Ford & Collins O. Airhihenbuwa, Commentary, *Just What Is Critical Race Theory and What's It Doing in a Progressive Field like Public Health?*, 28 ETHNICITY & DISEASE 223, 224-26 (2018).

Essay purposefully relies on definitions of these terms that resonate within a public health critical race frame.

Following Professor Ruth Wilson Gilmore's brilliant integrated definition of the term, I define racism as "the state-sanctioned and/or extralegal production and exploitation of group-differentiated vulnerability to premature death."[2] Two aspects of this definition are particularly salient with respect to public health: First, its emphasis on population-level racialization draws attention to the types of patterns that occur within and between whole groups of people above and beyond any patterns that occur between individuals. This population-level emphasis aligns with the orientation of public health, demography, and other population sciences. Second, the focus on the implications for physical death (i.e., mortality) suggests racism cannot be understood separately from the ways in which it affects and is experienced in the physical body. From a public health perspective, mortality is the most distal, ultimate outcome that any set of risk factors, risk conditions, and social exposures might be able to produce. Intermediate factors, such as one's physical health, mental health, and access to healthcare, occur along the pathway linking racism (or other social exposures) to death. Although physical health, mental health, and access to healthcare may appear to be the causes of the patterns of mortality, various forms of racism conspire to generate and sustain the social conditions that drive racial and ethnic disparities in death and disease.

As defined by the World Health Organization ("WHO"), health is "a state of complete physical, mental and social well-being and not merely the absence of disease."[3] Though other health sciences—most notably the clinical sciences—medicalize well-being in ways that narrow the scope of health to diseases and conditions amenable to clinical or pharmaceutical intervention, the WHO's definition is widely accepted as the fundamental understanding of health within the field of public health.[4] The American Public Health Association ("APHA") distinguishes between the two approaches as follows:

> While a doctor treats people who are sick, those of us working in public health try to prevent people from getting sick or injured in the first place.
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> . . . .

[2] RUTH WILSON GILMORE, GOLDEN GULAG: PRISONS, SURPLUS, CRISIS, AND OPPOSITION IN GLOBALIZING CALIFORNIA 247 (2007).

[3] World Health Org. [WHO] Constitution pmbl., para. 2, http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf [https://perma.cc/J7F2-X868].

[4] For example, the American Public Health Association ("APHA"), the flagship professional society of the multidisciplinary field of public health, accepts the broader definition. *See What Is Public Health?*, AM. PUB. HEALTH ASS'N, https://apha.org/what-is-public-health [https://perma.cc/FE8G-3PF6] (last visited Apr. 10, 2020).

> Public health works to track disease outbreaks, prevent injuries and shed light on why some of us are more likely to suffer from poor health than others.[5]

Public health is a multidisciplinary field. It comprises health services research, health policy and healthcare management, sociobehavioral sciences, environmental health sciences, health education, biostatistics, public health nutrition, and related disciplines. Epidemiology, which is the "study of the occurrence and distribution of health-related events, states, and processes in specified populations, including the study of the determinants influencing such processes, and the application of this knowledge to control relevant health problems," is considered by many to be the field's anchor discipline.[6]

The overarching goal of public health is to facilitate "the fundamental right of every human being to the enjoyment of the highest attainable standard of health."[7] One of the principles that flows from this goal is that marginalized communities are the populations of primary concern because they face the greatest obstacles to achieving optimal health. The concept of health equity means that optimal health should not merely be available but also attainable for everyone. Former APHA president Camara Jones defines health equity as the "assurance of the conditions for optimal health for all people."[8] Considering each of these terms and their relationship to one another suggests that promoting health equity is integral to the work of public health. Those populations experiencing the highest rates of disease and death (i.e., health inequities) are also vulnerable to various forms of racism. In fact, the populations can be defined based on their racialization and racial marginalization rather than based on any unique health-related propensities that accrue to them regardless of the condition. The concept of health equity draws into focus the utility of Gilmore's definition of racism for naming the root causes of the systematic differences in death and disease occurring across and within racialized groups. It shifts attention toward the need to clarify how racism serves as a fundamental cause of health inequities.[9]

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[5] *Id.*

[6] INT'L EPIDEMIOLOGICAL ASS'N, A DICTIONARY OF EPIDEMIOLOGY 95 (Miquel Porta et al. eds., 6th ed. 2014).

[7] World Health Org. [WHO] & United Nations Children's Fund [UNICEF], Glob. Conference on Primary Health Care, *Declaration of Astana*, art. 1, WHO Doc. WHO/HIS/SDS/2018.61 (Oct. 26, 2018), https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf [https://perma.cc/Y94C-NUYR]. For instance, the American Medical Association aims to foster health equity, which it defines as "optimal health for all." Press Release, Am. Med. Ass'n, AMA Outlines Ambitious Approach Toward Health Equity (June 13, 2018), https://www.ama-assn.org/press-center/press-releases/ama-outlines-ambitious-approach-toward-health-equity [https://perma.cc/VBB3-284Q].

[8] Camara P. Jones, Commentary, *Systems of Power, Axes of Inequity: Parallels, Intersections, Braiding the Strands*, 52 MED. CARE S71, S74 (2014).

[9] As advanced by sociologists Bruce Link and Jo Phelan in the first of their papers on this topic, a "fundamental cause" is a factor antecedent to most others that affects multiple

I. POLICE VIOLENCE: A PUBLIC HEALTH PROBLEM?

Does police violence—in particular, as experienced by members of the African American community as broadly defined—constitute a public health problem? The responses to at least four questions can guide us in answering this critical question:

1. Does the problem contribute to potentially predictable *patterns* of outcomes? This question draws a distinction between arbitrary, one-off occurrences of the problem (i.e., outcome) that lack a discernable root cause and the occurrences that are systematic, potentially predictable, and tied to corresponding sets of potentially predictable consequences. With respect to police violence, several patterns are readily discernible. First, not all persons or communities are equally at risk for exposure to police violence. Rather, the level of risk differs systematically by race and ethnicity at both the individual and neighborhood levels. Police violence disproportionately targets black, brown, and indigenous persons and their communities.[10] Thus, the risk for exposure to police violence depends in part on one's perceived race and ethnicity and the racial and ethnic composition of the community in which one lives.[11] Numerous studies have documented temporal, regional, and other patterns in the ways police treat black men, the predictors of escalation, the disciplinary and other processes that unfold following violent incidents, etc.[12] Many different discernible patterns have been documented. They reveal persistent differences in policing based on the race/ethnicity of individuals and the racial/ethnic composition of communities. This racialization of police violence across the country renders black men and black boys particularly vulnerable to police violence that is conducted with impunity.[13]

outcomes and drives the production and persistence of disparities. Bruce G. Link & Jo Phelan, *Social Conditions as Fundamental Causes of Disease*, 35 J. HEALTH & SOC. BEHAV. (EXTRA ISSUE) 80, 87 (1995). Clarifying whether racism is a fundamental cause independent of socioeconomic inequalities or whether it acts through them is the subject of current inquiry. *See* Jo C. Phelan & Bruce G. Link, *Is Racism a Fundamental Cause of Inequalities in Health?*, 41 ANN. REV. SOC. 311, 324-35 (2015).

[10] *See* Keon L. Gilbert & Rashawn Ray, *Why Police Kill Black Males with Impunity: Applying Public Health Critical Race Praxis (PHCRP) to Address the Determinants of Policing Behaviors and "Justifiable" Homicides in the USA*, 93 J. URB. HEALTH S122, S125 (2016).

[11] *Id.* at S130 ("The presence of black males in predominately white spaces may lead to higher risks of being policed or experiencing racial and gender discrimination.").

[12] *See id.* at S130-31 (surveying cases to "demonstrate how policing behaviors across the USA are legally structured to produce institutional entrapments that often disproportionately target and affect black males").

[13] *Id.*

2. Do these identified patterns pertain to populations?[14] This question shifts the focus beyond the experiences of individuals in order to discern whether whole groups of people with one or more shared characteristic, however the groups may be defined, are affected. This question can be answered in a word: yes. Whole groups of people who are defined as populations based on such shared characteristics as race, ethnicity, immigration status, and poverty status are affected by police violence. There are both direct effects and indirect effects of exposure to it. The most direct effects include the physical injuries inflicted on the bodies of individuals assaulted by police.[15] Indirect effects include the adverse physical and mental health consequences that family members, friends, and witnesses to police violence experience.[16] Whole racialized groups and communities also experience the indirect effects of racialized policing through, for instance, the threat it represents for any member of the group by virtue of their status as an actual or perceived member of the targeted group, the impacts on social features of the group (e.g., social cohesion and social support), and the consequences that result from the injury and removal of people from their families and communities (e.g., loss of income and wealth).[17]

3. *Which* populations are affected? The response to question two above suggests racialized populations are affected by police violence more than other groups are. The populations that policing disproportionately affects are some of the same populations that the field of public health is primarily intended to serve. The work of *public* health occurs primarily in communities where there is material

[14] Public health focuses on populations and thus differs from disciplines that focus on the experiences of (specific) individuals. *See* INT'L EPIDEMIOLOGICAL ASS'N, *supra* note 6, at 231 (describing goal of public health as "reduc[ing] the amount of health-related suffering, disease, disability, and premature death in the *population*" (emphasis added)). For the moment, I am setting aside concerns written about elsewhere regarding the role the field of public health plays in constructing and racializing populations to ask if the patterns identified above pertain to populations.

[15] Gilbert & Ray, *supra* note 10, at S133.

[16] *See* Jacob Bor et al., *Police Killings and Their Spillover Effects on the Mental Health of Black Americans: A Population-Based, Quasi-experimental Study*, 392 LANCET 302, 308 (2018) ("Our estimates suggest that police killings of unarmed black Americans have a meaningful population-level impact on the mental health of black Americans.").

[17] To explore how the effects of incarceration extend beyond the individual to impact the well-being of whole communities, see, for example, James C. Thomas et al., *Incarceration and Sexually Transmitted Infections: A Neighborhood Perspective*, 85 J. URB. HEALTH 90, 97 (2008) (describing mechanisms by which high incarceration rate of individuals in community leads to greater rate of STIs in that community).

need for health-promotion and disease-prevention resources. Globally and domestically, many of our efforts—probably a majority—occur among black, indigenous, and people-of-color communities.[18] The field cannot address the physical and mental health needs of members of these communities without understanding and addressing the ways in which racialized policing impacts their lives. That many of these populations already experience various health inequities makes them priority populations for public health efforts, which in turn lends support to the claim that racialized policing should be considered a public health issue.

4. Can the goal of public health, which is to promote optimal health for all, be achieved without addressing the issue of police violence? Again, in a word: no. First, it is not possible for populations to achieve optimal health while at the same time being subjected to high rates of violence from the police or other sources. That black, brown, and indigenous people experience high rates of police violence indicates that the conditions for attaining optimal health are not assured for them. Second, even if optimal health could somehow be achieved for some people, that would still fail to meet the goal of facilitating optimal health "for all." That police violence occurs along racial and ethnic lines—that its sequelae affect black, brown, and indigenous populations more than they affect whites—aptly ties police violence to Gilmore's definition of racism as "state-sanctioned . . . production and exploitation of group-differentiated vulnerability to premature death."[19]

So, based on this cursory consideration of four questions to guide the determination as to whether police violence might constitute a public health problem, it is possible to conclude that the police killing of black people with impunity can be viewed as an issue that falls squarely within the purview of the field of public health. Indeed, Professors Keon Gilbert and Rashawn Ray recently advanced a conceptual model based on Critical Race Theory ("CRT") that evaluates the problem of policing from the perspectives of black boys and black men.[20] Centering their perspectives and experiences allows the authors to reframe the issue not as one of, for instance, neighborhood crime but as one of

[18] *Cf.* James N. Weinstein, *Preface* to NAT'L ACADS. OF SCIS., ENG'G & MED., COMMUNITIES IN ACTION: PATHWAYS TO HEALTH EQUITY, at ix, ix-x (James N. Weinstein et al. eds., 2017) (describing discrepancy in health outcomes between populations based on race and ethnicity and asserting that achieving health equity will require resolving underlying conditions of inequity).

[19] GILMORE, *supra* note 2, at 247.

[20] *See generally* Gilbert & Ray, *supra* note 10.

health inequities in policing as directed at members of racialized neighborhoods.[21]

II. WHAT CAN BE GAINED THROUGH THE USE OF A PUBLIC HEALTH LENS?

Having established that at least four considerations lend support to the suggestion that police violence can be considered a public health issue, let us shift toward answering the next question: What additional insights can the legal and social science communities gain by viewing this problem through a public health lens? This Essay highlights just three of many potential insights a public health lens contributes: (1) the need for intersectional analyses, (2) the possibility of epidemiologic synergy, and (3) a concern with predicting the spread of the problem. Although an issue may be considered a public health problem, it can be inappropriate and potentially unethical to implement interventions without first establishing a basic understanding of the cause. Therefore, this Essay focuses primarily on illuminating the problem with an eye toward potential intervention targets; it does not take the crucial next step, which is to develop and implement a specific intervention to address the problem. It does, however, raise two cautions that should be considered prior to developing any intervention on policing in black communities.

Intersectional analyses conducted using public health approaches to research and community outreach acknowledge that racialized patterns of policing are also inherently gendered, classed, etc. Intersectional analyses are not unique to public health, nor did they originate in this field. Their value lies in their ability to help illuminate the complex, shared, and unique ways in which multiple groups, in addition to black boys and black men, are affected by police violence. For instance, intersectional analyses reveal how police interactions with black women involve gendered, sexualized forms of violence.[22] They might also call attention to the ways in which the devaluation of black women enables other, non-law enforcement people to brutalize and kill poor black women with impunity or with the complicity of the police.[23]

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[21] *Id.* at S133 ("[B]lack males who die from excessive force at the hands of police officers become involuntary martyrs for the sustained legacy of institutional and interpersonal racism. Those who do not die carry significant health threats displayed by physical scars and mental stress that may shorten their telomeres and increase their risk of CVD, cerebrovascular disease, and hypertension." (emphasis omitted) (footnote omitted)).

[22] *Id.* at S130.

[23] For more than two decades, the Black Coalition Fighting Back Serial Murders has sought to force the police to recognize this violence against black women as an issue and to help stop it, or at least to raise awareness about it in the community. BLACK COALITION FIGHTING BACK SERIAL MURDERS, http://www.blackcoalitionfightingbackserialmurders.net/ [https://perma.cc/9KEY-RYMD] (last visited Apr. 10, 2020). The Coalition generated a list of more than two hundred women in South Los Angeles, nearly all of them black, who had been killed or were presumed killed in apparent serial murders since the late 1980s. *Id.*

Criminal impunity and police complicity have been strongly suggested in the case of Los Angeles's "Grim Sleeper." When Lonnie Franklin Jr., an African American man who had been a longtime community member, was identified as the Grim Sleeper, the friendly ties linking him and the police became known. The public learned that Franklin had worked as a sanitation worker for the city and as a gas pumper for the Los Angeles Police Department.[24] Franklin had also driven a garbage truck from 1988 to 2002, a period during which no bodies were found.[25] This apparent gap in killings gave rise to the "Grim Sleeper" nickname.[26] Some suspect that the killing continued during this period, but that instead of dumping the bodies in alleys and dumpsters, as was done prior to and after the supposed gap, Franklin was discarding them in municipal trash dumps.[27] According to a documentary film about the killer, law enforcement had described the women victims using the code "NHI"—that is, "no humans involved."[28] After Franklin was arrested, police officers reportedly expressed their admiration of the killer "for cleaning up the streets" to Franklin's adult son, who was incarcerated for another matter at the time.[29]

[24] *See* Christine Pelisek, *L.A. City Pensioner Lonnie Franklin Jr.*, LA WKLY. (Aug. 19, 2010), https://www.laweekly.com/l-a-city-pensioner-lonnie-franklin-jr/ [https://perma.cc/ZV6K-LTC9].

[25] TALES OF THE GRIM SLEEPER 1:39:08 (South Central Films 2014).

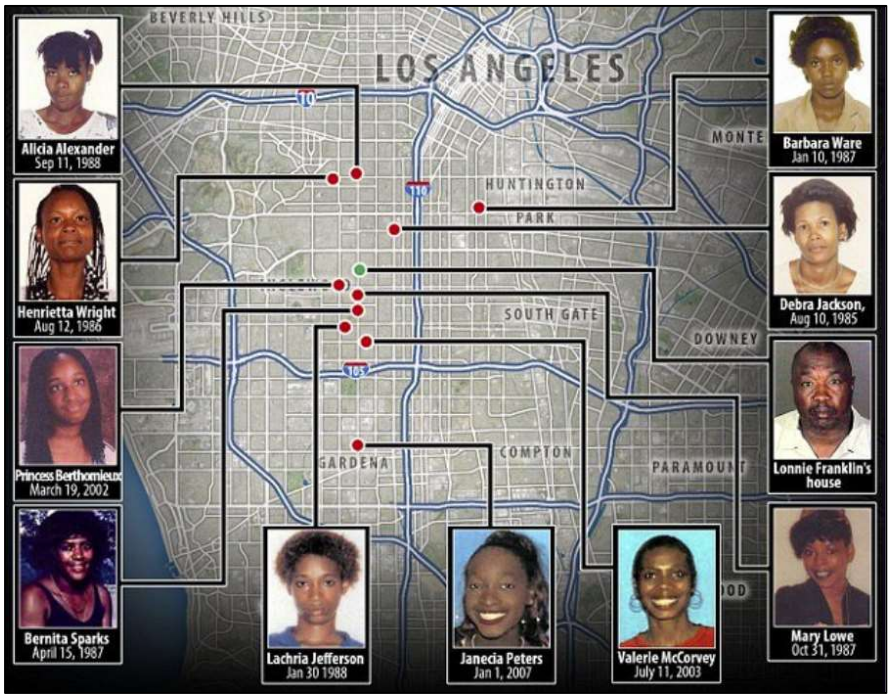
[26] Christine Pelisek, *Grim Sleeper Returns: He's Murdering Angelenos, as Cops Hunt His DNA*, LA WKLY. (Aug. 27, 2008), https://www.laweekly.com/grim-sleeper-returns-hes-murdering-angelenos-as-cops-hunt-his-dna/ [https://perma.cc/G4E3-6M5A].

[27] *See* Stephen Ceasar, *Penalty Phase to Put Spotlight on Other Killings; Five More Women Thought to Be Grim Sleeper Victims Will Have Their Cases Told.*, L.A. TIMES, May 8, 2016, at A1 ("In all, investigators believe Franklin is responsible for at least 25 slayings, including 11 that took place during the supposed dormant period that led to his sobriquet."); Brian Melley, *'Grim Sleeper' Headed to Death Row, but Mystery Remains*, ASSOCIATED PRESS, Aug. 14, 2016, https://apnews.com/d7ac3a473e0c4019b9ffe7d6206a9bb4/grim-sleeper-headed-death-row-mystery-remains [https://perma.cc/VU9W-ZQFF] (suggesting link between Franklin's work with city sanitation department and methods he used to dispose of victims' bodies).

[28] TALES OF THE GRIM SLEEPER, *supra* note 25, at 1:39:08.

[29] *Id.* at 1:34:38.

Figure 1. Map of the Locations Where the Bodies of the Eleven Plaintiffs Were Found. Courtesy of the Black Coalition Fighting Back Serial Murders.[30]



Intersections between police violence, gender, race/ethnicity, and sexual orientation also emerged in a qualitative study I conducted among racially/ethnically diverse survivors of intimate-partner violence in lesbian and bisexual relationships.[31] A recurring theme among all of the women in the study was their unwillingness to call on the police, even in potentially fatal crises. One hundred percent of the black and Latina participants rejected outright any possibility that they would call the police on the partner who was perpetrating

[30] BLACK COALITION FIGHTING BACK SERIAL MURDERS, *supra* note 23.

[31] I presented my research findings at the Gay and Lesbian Medical Association's 2016 annual meeting. Chandra Ford, *Barriers to Getting Help for Intimate Partner Violence: A Qualitative Study Among Lesbian and Bisexual Women*, *in* GAY & LESBIAN MED. ASS'N, INTERSECTIONALITY IN LGBT COMMUNITIES: GATEWAYS TO NEW UNDERSTANDINGS 59, 59 (2016), http://glma.org/index.cfm?fuseaction=document.viewdocument&ID=CEB9FEE4B8DD8B7F4F7575376BD476C38E0BE2CC4027727A56496CDFA65D886FC0731320B03D2F5E1022F1C15602FBEA [https://perma.cc/73GE-5GBH]. Another study found that diverse lesbian, gay, and bisexual people were half as likely as their white counterparts to report intimate-partner violence. Xavier Guadalupe-Diaz, *Disclosure of Same-Sex Intimate Partner Violence to Police Among Lesbians, Gays, and Bisexuals*, 3 SOC. CURRENTS 160, 166 (2016).

violence against them, even during extremely violent incidents. Several women talked about having faced ridicule and threats of violence from the police upon their realization that the two women were involved in a lesbian relationship.[32]

Intersectional analyses conducted through a public health lens would also emphasize the need to account not only for demographic intersections and the social forces that drive them but also for the complex relationships between the physical and mental health consequences of lethal and nonlethal police encounters. Furthermore, focusing narrowly on deaths—that is, the killings that result directly from interactions with police—obscures the myriad of other direct and indirect health outcomes police violence may produce. The narrow focus errs to the extent it implies that the consequences of police violence are necessarily proximal to an incident. The narrower focus also likely underestimates the true number of deaths due to police violence by excluding from the count deaths that occur months or years after the index police encounter, ostensibly due to some other factor such as substance abuse or chronic disease.

My perspectives on policing as a public health problem are informed by the empirical arm of my program of research, which primarily examines well-documented racial disparities in HIV infection. This work seeks to explain whether and how African Americans' poorer long-term prognoses relative to those of other groups and their shorter survival periods following HIV diagnosis are attributable to racial inequalities and racism.[33] The concept of epidemiologic synergy is critical to this work because it shifts the focus from identifying causes of the disparities purportedly rooted in the behaviors and attitudes of African Americans to identifying causes rooted in the embeddedness of social inequalities. Certain conditions and factors that appear on the surface to be unrelated to the problem may actually work together in ways that exacerbate the relationship being studied.[34] The concept of epidemiologic synergy guides research to go beyond the standard practice of identifying and adjusting for confounders, which are factors that may cause both the putative cause (i.e., racism) and outcome (e.g., shorter survival after HIV diagnosis) to include additional, seemingly unrelated conditions and factors that affect the nature of the focal relationship. Being exposed to HIV does not necessarily mean an individual will become HIV positive.[35] The conditions under which exposure

[32] Ford, *supra* note 31, at 59.

[33] *E.g.*, Ford et al., *supra* note 1, at 262-63.

[34] *See* Douglas T. Fleming & Judith N. Wasserheit, *From Epidemiological Synergy to Public Health Policy and Practice: The Contribution of Other Sexually Transmitted Diseases to Sexual Transmission of HIV Infection*, 75 SEXUALLY TRANSMITTED INFECTIONS 3, 4 (1999) ("Recent conceptual and empirical work has underlined the reciprocal relation, or 'epidemiological synergy,' between HIV infection and other [STIs], by which each may alter the transmission or manifestations of the other, resulting in a potentially explosive, mutually reinforcing spiral of infection.").

[35] *See id.* at 14.

happens play an important role in determining the level of risk and possible outcomes of any given exposure. At the individual level, epidemiologic synergy holds that if the virus, HIV, is introduced in the presence of certain "classic" sexually transmitted infections ("STIs"), such as chlamydia, gonorrhea, or syphilis, the risk of seroconversion (from HIV negative to HIV positive) increases synergistically.[36] For example, for an individual with gonorrhea, the presence of any lesions near the site where HIV exposure occurs facilitates entry of the virus and enables more efficient access to the T cells it seeks.[37] Likewise, a person with a suppressed immune system due to HIV infection has an elevated risk of acquiring a classic STI should they be exposed to it.[38] At the population level, when the prevalence of both STIs and HIV is high in a geographic area or sexual network, HIV transmission occurs more efficiently.[39] In short, all else being equal, the likelihood of becoming HIV positive is not reducible to the number and types of behaviors in which an individual engages. Both the context in which a behavior occurs and the presence (or absence) of co-occurring factors impact the likelihood of infection.

Drawing on the concept of epidemiologic synergy raises another question about policing: Are there conditions or factors that seem unrelated to the primary problem of police violence yet can nevertheless compound, exacerbate, or, alternatively, mitigate the lethal or sublethal effects of policing for black people? If so, what are they?

Drawing on literature in the subfields of social epidemiology and community-health sciences, a public health lens also suggests the needs to view the problem of police violence as a multilevel, social exposure—that is, a multidimensional risk factor that operates across at least two socioecologic levels (individual level, interpersonal level, community level, etc.) concurrently—and to clarify how place matters. The implications of *Graham v. Connor*[40] likely vary depending on physical, social, political, or other aspects of the specific places where policing occurs.[41] Multilevel analyses emphasize that factors and relationships occur on multiple socioecologic levels simultaneously. They also emphasize structural determinism, which holds that macrolevel factors exert greater impact

[36] *Id.*

[37] *Id.* at 5.

[38] *See id.* at 12-13.

[39] *Id.* at 3.

[40] 490 U.S. 386 (1989).

[41] Much of the work on "place" focuses on the places where people live (i.e., their neighborhoods). How place, especially neighborhoods, contributes to health disparities is captured by such commonly used statements as "your ZIP code determines your health." Identifying the aspects of place that matter most is a growing area of interest. *See, e.g.*, NAT'L ACADS. OF SCIS., ENG'G & MED., *supra* note 18, at 116; Ichiro Kawachi & Lisa F. Berkman, *Introduction* to NEIGHBORHOODS AND HEALTH 1, 13 (Ichiro Kawachi & Lisa F. Berkman eds., 1st ed. 2003); Brian D. Smedley, Commentary, *The Lived Experience of Race and Its Health Consequences*, 102 AM. J. PUB. HEALTH 933, 934 (2012) (describing effects of residential segregation on health outcomes).

than do more proximal ones and that the factors and relationships occurring at the microlevels are nested within a set of dynamics present in the community or higher socioecologic levels (e.g., at the state level).[42]

Multilevel approaches help explain why the personal characteristics of individuals and contextual factors both matter. They enable researchers to account for the fact that certain characteristics render some individuals more vulnerable than others while at the same time explaining how specific structural mechanisms (e.g., residential segregation) undergird the increased vulnerability. For instance, a multilevel analysis might include relevant aspects of one's personal or family history—such as history of violence or drug abuse, which increases the risk of police engagement—as well as characteristics of the community in which the person lives, such as the nature of local policies, how they are implemented and enforced in the community, the resources dedicated to policing, and community capacity to resist or circumvent the adverse impacts of policing.[43] The results of multilevel statistical analyses would reveal the portion of the effect that is due to the individual-level factors as well as the portion of the effect that is due to the neighborhood factors.

Finally, public health relies on predictive models both to calculate the rates at which a problem or solution is likely to spread and to characterize the nature of the spread. Therefore, a public health perspective on policing would involve the development of models to reliably predict policing-related factors and their health implications for communities. The models would help communities identify target points at which to intervene to address this public health problem. Considerations driving the appropriateness and utility of any model include the nature of the condition; the populations being affected; and other factors, such as the stage of the epidemic (e.g., early vs. mature). Different types of models serve different purposes. Consider how the formulas epidemiologists use to calculate the spread of infectious diseases differ from the theories health educators apply to predict the dissemination and uptake of tailored health-promotion messages. With respect to policing black people and communities, then, what information is needed to generate reliable analytical models to predict policing, its precursors, and its consequences?

III. DEVELOPING AND IMPLEMENTING INTERVENTIONS

My remarks thus far have focused on the use of a public health lens to understand policing as a public health problem; however, public health also involves developing and implementing interventions to address identified problems.

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[42] *See* NAT'L ACADS. OF SCIS., ENG'G & MED., *supra* note 18, at 2 ("Communities exist in a milieu of national-, state-, and local-level policies, forces, and programs that enable and support or interfere with and impede the ability of community residents and their partners to address the conditions that lead to health inequity.").

[43] *Cf. id.* (recognizing that communities may vary in causes of health inequity, resources available to address challenges, and ultimate objectives).

The black feminist poet Audre Lorde once asserted that the "master's tools"—in this case, the system of policing—will not protect those whom it marginalizes.[44] Yet, I believe it is possible to revisit this assertion in order to explore more extensively whether there are indeed master's tools that communities might borrow to address the lethal, subjugating impacts of racialized police violence. One tool on which police rely extensively to monitor, predict, and control behavior in communities of color is surveillance.[45] The use of cameras, listening devices, tracking devices, and human informants keeps the carceral gaze focused on marginalized communities. Increasingly, however, technological advances are making it possible for community members to access various tools of surveillance, too, which they are using for their own purposes. Videos circulating on social media of police interactions with civilians, especially with African Americans, attest to this.[46] In short, some of the tools of surveillance being used to focus the carceral gaze on marginalized communities are now being wielded by communities to shift the gaze back onto state actors, such as the police. This begins to raise a number of questions, which include: Might the use of surveillance devices and strategies constitute a "master's tool"? If so, to what extent could it be deployed to unmask and curtail police behavior? And, if used, what if any unintended consequences are there that make such endeavors harmful to black people in the long run, however effective they may be in the short term?

At least two cautions exist regarding this symposium's broader interests in empirical critical race approaches as applied to issues of policing violence and racism. First, critical public health approaches force us to answer the question: Is the mere production of evidence, however rigorous and compelling the evidence may be, sufficient to achieve justice and racial health equity? A public health lens would suggest the need for skepticism. Over the last century, the field has identified many preventable causes of poor health, such as tobacco consumption, exposure to certain environmental toxins, and, more recently, various forms of racism.[47] Yet, policymakers and advocates have faced

[44] AUDRE LORDE, *The Master's Tools Will Never Dismantle the Master's House*, *in* SISTER OUTSIDER: ESSAYS AND SPEECHES 110, 113 (rev. ed. 2007).

[45] Gilbert & Ray, *supra* note 10, at S130 ("The practice of criminalizing black males in order to monitor and control their bodies in contexts such as schools, stores, neighborhoods, public roads, highways, and college campuses is orchestrated not only by formal agents of law enforcement (e.g., municipal, county, and state peace and police officers) but also by informal agents of law enforcement (e.g., neighborhood watch program participants, store owners, and everyday citizens).").

[46] *Id.* at S135 (noting rise in municipalities requiring officers to wear body cameras).

[47] *Id.* at S136. While a growing body of scientific studies examines the contribution of racism to health disparities, few strategies exist to guide public health professionals in developing and implementing strategies to help address racism. One recent resource published by the APHA translates much of this science and provides resources (e.g., case studies of community-based projects that attempted to tackle the health implications of racism) on which public health professionals can draw. Chandra L. Ford et al., *Preface* to AM. PUB. HEALTH

tremendous challenges trying to enact evidence-based policies and social changes based on the findings.[48] Therefore, even if police violence were defined as a public health problem, merely supplying scientific evidence that it affects health likely is not sufficient to generate the large-scale efforts needed to eradicate the problem. Strategies from outside the field of public health, such as those that involve movement building and storytelling, may compel responses to the problem more effectively.

Second, community-led strategies that, for instance, confront and challenge the police may have varying levels of success shifting the carceral gaze from black people or black communities to the police. As alluded to above, however, unintended consequences of such approaches will likely impact the communities that attempt to implement such interventions.[49] This does not mean that strategies of resistance should not be undertaken. Rather, it underscores how important it is for any such strategies to account for adverse short- and long-term potentialities and to use analytic approaches that allow them to precisely predict the problem, its correlates, and its consequences in diverse communities.

CONCLUSION

This Essay introduces several basic public health concepts to illuminate ways in which police violence can be considered a public health problem. The adverse effects of police violence on the physical and mental health of black people and the clear racial lines along which police violence occurs place it at odds with the overarching goal of public health, which is to promote optimal health for all

ASS'N, RACISM: SCIENCE & TOOLS FOR THE PUBLIC HEALTH PROFESSIONAL, at xxv, xxvi (Chandra L. Ford et al. eds., 2019).

[48] See, for example, Robert Bullard's seminal book on environmental justice, ROBERT D. BULLARD, DUMPING IN DIXIE: RACE, CLASS, AND ENVIRONMENTAL QUALITY, at xvii (3d ed. 2000) (describing development of body of empirical evidence and interest in discriminatory waste-disposal practices but noting that "we are a long way from achieving a fair and just society in the environmental and other arenas"). Bullard is considered by many to be the father of environmental-justice research. For more scholarship in the field, see Gilbert C. Gee & Devon C. Payne-Sturges, *Environmental Health Disparities: A Framework Integrating Psychosocial and Environmental Concepts*, 112 ENVTL. HEALTH PERSP. 1645, 1647 (2004) (identifying "siting of pollution sources (e.g., waste incinerators), illegal dumping, poor enforcement of environmental regulations, and inadequate response to community complaints" as causes of greater negative health outcomes in "disadvantaged communities"); Sacoby M. Wilson et al., *Environmental Injustice and the Mississippi Hog Industry*, 110 ENVTL. HEALTH PERSP. (SUPPLEMENT 2) 195, 199-200 (2002) (describing well-known negative environmental effects of Mississippi's hog industry as disproportionately borne by marginalized communities); Steve Wing, *Whose Epidemiology, Whose Health?*, 28 INT'L J. HEALTH SERVICES 241, 249 (1998) ("Hazard identification without social justice can increase the effectiveness of discrimination against poor and nonwhite populations.").

[49] *See* Gilbert & Ray, *supra* note 10, at S135 (advocating for body cameras and community review boards but acknowledging that such measures "do little good" if the "power imbalance between police officers and community members" is not addressed).

based on the understanding of health as not merely the absence of disease but full physical, mental, and social well-being. This simple analysis suggests that police violence involves the "production and exploitation of group-differentiated vulnerability to premature death," which renders policing a racist social exposure.[50] Needed are public health strategies that treat it as such.

[50] GILMORE, *supra* note 2, at 247.