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Opinion

Hate and the Health of Populations

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During 5 days in October 2018, 3 acts of terror starkly reminded the country once again of the pernicious consequences of hate. Between October 22 and 26, Cesar Sayoc, a supporter of President Trump, is reported to have mailed at least 14 improvised explosive devices to critics of Trump, including 2 former US presidents, current and former Democratic party legislators, and career government professionals who held leadership posts during previous administrations. On October 23, Gregory Bush attempted to enter the predominantly African American First Baptist Church of Jeffersontown, Kentucky, and, failing to gain access, killed 2 African Americans in a nearby Kroger supermarket. Most horrific of all, on October 27, Robert Bowers, entered the Tree of Life Synagogue in Pittsburgh, Pennsylvania, armed with an AR-15 assault rifle and killed 11 congregants and wounded 2 others.

Each of these incidents of terror appears to have been motivated by hatred, on the perpetrators' part, of groups that were different from them. Sayoc mailed personally packaged explosive devices to individuals perceived to be enemies of the president, his inspirational figure. Bush's shooting victims were African Americans. Bowers trained his weapons on persons of Jewish faith as they worshiped. All 3 incidents represent targeted efforts to kill those who were other than the perpetrators themselves. All three occurred in the context of a multiyear rise in hate crimes, particularly featuring incidents directed against Jews, Muslims, and LGBT people, among others.[1] The year 2017 witnessed the largest 1-year increase in anti-Semitic incidents since auditing began more than 40 years ago.[2]

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Against this backdrop, there should be little question at this point that hate is a powerful motivator of harm against others. The direct consequences of hate—including violence, discrimination, and marginalization of out-groups—are associated with poor health. Apart from the direct physical harm they inflict, hate-induced actions are associated with substantial mental illness effects.[3] Racism and discrimination themselves produce negative health consequences, as does out-group marginalization, including Islamophobia.[4]

Unlike in most nations, hate speech is constitutionally protected in the United States. No hate speech laws currently exist. That does not mean, however, that those of us in population health should accept hate speech. Recognizing that hate is a determinant of health puts the issue squarely within the remit of the population health community, pushing us to consider what we can do to address hate. We suggest 4 steps in this regard.

Recognize Hate Crimes as an Assault on Population Health

This is slowly beginning to happen. For example, immediately following the hateful violence in Charlottesville, Virginia, in 2017, the American College of Physicians drafted its position statement on hate crimes, stating, "Hate crimes directed against individuals based on their race, ethnic origin, ancestry, gender, gender identity, nationality, primary language, socioeconomic status, sexual orientation, cultural background, age, disability, or religion are a public health issue."[5] Other organizations have followed suit, while some remain silent on the issue. It seems to us that it is important that all professional organizations concerned with health recognize the impact of hate, setting the stage for a broader public conversation that is unequivocal in its condemnation of hate.

Push Back on Hate

It is imperative to call out efforts that incite hatred in all its forms, with clarity of voice and focus. Perhaps the admonition of Rabbi Jeffrey Myers during the memorial service at the Tree of Life Synagogue, who urged political leaders "to stop the words of hate," captures well our responsibility.[6]

We have witnessed repeatedly how the words and actions of political leaders have actively diminished population health, sowing divisions based on a politics of grievance. Particularly dangerous from a population health vantage are the hateful depictions of immigrants and minorities who have been labeled as "rapists" and "animals," categorically excluded from entry based on country of origin, forcefully separated from their children at American borders, and now threatened with the loss of the birthright of their American-born children. Recent policies have been enacted that solidify marginalization, exclusion, and "othering," which gives license to hate. On the marginalization front, policies are being promulgated that will limit hard-won gains in transgender rights. Meanwhile, the dismantling of health care access for populations that have only recently been extended insurance coverage is discriminatory and hateful on its face.

Population health scientists and public health practitioners should be visibly opposing an approach to governance that is fueled by sowing division and hate. This was precisely the guidance provided by American College of Surgeon's president-elect Ron Maier when he stated, "Our profession requires us to fight the challenge for equity for the most vulnerable among us. Being a moral leader means standing up for truth, reason and science. It means not being afraid to stand up for your principles or hold elected leaders accountable for meeting the needs and values of our communities. . . . For example, with regards to trauma, no preventable injury can ever be justified."

Play a Role in Disarming Hate

Words fuel hate. Tools of war give voice to hate. Bowers used his AR-15 semi-automatic rifle, the same kind of weapon that had previously been used during the Orlando Pulse nightclub, Las Vegas, and Parkland massacres, to create the deadliest attack on Jewish people in American history. The ease of access by civilians to battlefield weapons allows those with ill intent the opportunity to act on their impulses far too readily. Public health practitioners can be powerful advocates for limiting widespread availability of assault-style weapons. It seems to us that public health has no choice at this point but to be clear and unequivocal about the role that guns play as instruments of hate, and the need for a

national strategy to minimize their availability to the end of promoting health.

Speak to the Need for Scholarship to Mitigate the Consequences of Hate

Public health practitioners are especially well-placed to speak forcefully on what is needed to mitigate the population health consequences of hate. This should extend both to the foundational role that hate and the broader echoes of structural violence—including discrimination, segregation, and marginalization—play in shaping health. Public health practitioners should be advocating for health equity and access, for inclusion of diverse populations, and for health care delivery that champions respect and equality. Population health scientists should also push for investment in research that specifically examines how hate shapes foundational social forces and what can be done to counter harmful, hate-driven beliefs and behaviors. Population health scholars should speak insistently, with one voice, on a research imperative that reflects the problems of consequence that plague us today.

There is simply no silver lining to the hate-fueled incidents that have threatened and killed too many at the end of October 2018 and that have done so again and again over recent years. And yet, if these incidents can galvanize population health science and public health practice to action, and can clarify our responsibility in trying times, these deaths will have purpose that transcends the current horrifying moment.

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