Protecting Urban Health and Safety: Balancing Care and Harm in the Era of Mass Incarceration

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ABSTRACT *This paper explores theoretical, spatial, and mediatized pathways through which policing poses harms to the health of marginalized communities in the urban USA, including analysis of two recent and widely publicized incidents of officer-involved killings in Ferguson, Missouri and Staten Island, New York. We examine the influence of the “broken windows” model in both policing and public health, revealing alternate institutional strategies for responding to urban disorder in the interests of the health and safety of the city. Drawing on ecosocial theory and medical anthropology, we consider the roles of the segregated built environment and historical experience in the embodiment of structural vulnerability with respect to police violence. We examine the recent shootings of Eric Garner and Michael Brown as the most visible, most circulated symbols of this complex and contradictory terrain, focusing on the pathways through which theories of causality authorize violent and/or caring intervention by the state. We show how police killings reveal an underlying and racialized association between disorder and deviance that becomes institutionalized and embodied through spatial and symbolic pathways. If public health workers and advocates are to play a role in responding to the call of the Black Lives Matter movement, it is important to understand the interpretations and translations of urban social life that circulate on the streets, in the media, in public policy, and in institutional practice.*

KEYWORDS *Medical anthropology, Embodiment, Police, Police brutality, Violence, Broken windows, Ecosocial theory*

INTRODUCTION

People across the USA have called increasing public attention to the excessive use of violence by the police, and the lack of accountability for the crimes committed by state officers, particularly against people of color living in historically oppressed communities. Under the banner and hash tag #BlackLivesMatter, the growing social movement is challenging all Americans to address the deep racial disparities of our criminal justice system as a threat to the health, safety, and dignity of Black lives across the USA. Though activists in the movement often extend the slogan, as in #BrownLivesMatter, #MuslimLivesMatter, and #TransLivesMatter, there is pointed resistance to the phrase “All Lives Matter” because it erases the long, entrenched, specific histories of state repression that marginalized peoples have suffered under the guise of state protection.

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That this awareness has emerged from cities is no coincidence: the urban environment is so fundamentally connected to policing operations that Michel Foucault argued “to police and to urbanize is the same thing,” seeing “police... as a condition of existence for urban existence.”¹ Public health, too, shares its origins with modern urban planning. The industrial transformation of towns into dense cities gave rise to coordinated measures to curb social disorder and contagious disease, with physicians and epidemiologists serving as and alongside some of the first modern urban planners.

The functions and policy prescriptions of public health and policing institutions have evolved considerably from their early origins, each at times assuming the responsibilities of the other and in so doing, blurring the boundaries between control and coercion, violence and care. For example, medical quarantine in the service of the public good involves surveillance and confinement of sick or suspect peoples, while police are central actors in mobilized emergency responses to crime as well as infirmity. The famous Los Angeles Police Department motto, “to protect and serve,” frames the institution’s value with respect to public care, while variations of medical and public health oaths stemming from the Hippocratic mantra, “Do no harm,” implicitly acknowledge the potential for violence in medical practice. In settings like American mental hospitals in the 1950s, for example, it would be difficult to separate the logic of psychiatry from that of surveillance and imprisonment.² And given the massive numbers of mentally ill inmates in contemporary American carceral institutions, it is nowadays no less difficult to distinguish between the functions of the prison and those of the asylum.³

But as #BlackLivesMatter and related discussions about police brutality remind us, while harm is always a possible outcome of the state’s quest for urban health and safety, the probability of subjection to such harm is disproportionately distributed among populations along lines of race, class, gender, sexuality, mental status, and ability. For example, non-White men and people diagnosed with severe mental illness are especially likely to be incarcerated or to be directly affected by policing.^{4,5} Homosexual and transgender people for centuries have been criminalized and violently harassed in the name of protecting the public—particularly children—from “perversion.”⁶ And poor, non-White communities are most likely to be subjected to the harmful effects of technological and industrial development, such as environmental pollution, at the same time as they are most likely to be excluded from access to health care.^{7,8}

In attempts to make sense of patterned distributions of harm caused by state-sanctioned projects, medical anthropologists have advanced the concept of structural violence.^{9,10} While scholarly application of this concept has been useful in drawing attention to seemingly invisible forms of harm that are perpetuated by institutional structures, the concept of structural violence has been criticized for its susceptibility to imprecision. Wacquant,¹¹ as well as Bourgois and Scheper-Hughes,¹² argue that the notion of structural violence, when not used carefully, can lead to a failure to empirically identify or spatially and temporally locate specific institutional processes and mechanisms of harm. Instead, they argue, the concept may suggest a diffuse violence that operates through no particular mechanisms and that emanates from no particular agent but rather from vaguely defined structures.

The ecosocial framework developed by Krieger provides a useful way to render more legible the specific processes that constitute police brutality as a form of structural violence.^{13,14} This approach emphasizes how humans “literally biologi-

cally embody exposures arising from our societal and ecological context, thereby producing population rates and distributions of health.”¹⁵ A core contribution of ecosocial analysis has been to stress the role of *embodiment* and *pathways of embodiment* in the production of health, disease, and mortality. Here, we emphasize how the harmful effects of policing are most frequently ravaged upon specific human bodies dwelling within specific geographies. Racial stigma, aggression, and violence circulate through specific politically and economically disenfranchised urban zones that are created, legitimized, and maintained by vast networks of institutions and actors—universities, scholars, scientists, public figures, media outlets, policy makers, police officers, various citizen populations, and the list could go on. Within this context, public health scholars and practitioners must be aware of their discipline’s historical and contemporary involvement in the institutional construction and political legitimization of these pathways. Furthermore, in attempting to heal the wounds inflicted through police brutality, public health practitioners must also consider the relationships that exist between individual and communal reference points for evaluating police oppression and for responding to or avoiding future manifestations of it—a task for which applied ethnographic and historical methods are well-suited.

Broken Windows and Quality of Life: Criminology and Public Health Specify the Relationship Between Deviance and Disorder

Few ideas have been as controversial in criminology as the “broken windows” theory first proposed by James Q. Wilson and George Kelling in 1982. “Broken windows” has become one of the most powerful principles of contemporary policing, underwriting the adoption of Mayor Giuliani’s policing strategies in New York City in the 1990s. The idea has more recently been used to frame hypotheses in public health research about the role of neighborhood conditions on disease rates.^{16–18} According to the theory,¹⁹ a broken window will attract people to break more windows until they are all either smashed or repaired; the broken window is “a signal that no one cares,” and thus cues social behavior that tends towards disorder. Disorder, according to Wilson and Kelling, is not only its own source of fear and unhappiness for city-dwellers, but invites crimes that escalate beyond the breaking of windows.

In practice, NYPD commissioner William Bratton has promoted and defended²⁰ sweeping patrol of “disorderly” New York City neighborhoods and increased arrests for low-level crimes under the presumption that this would deter more violent crime. In effect, this has meant a disproportionate detention of youth of color, most often for minor drug possession and petty offenses, with questionable impact on the deterrence of violent crime. Drawing on New York Civil Liberties Union data and NYPD records, the *New York Daily News* found that 81 % of the 7.3 million people cited with so-called quality-of-life violations between 2001 and 2013 were Black and Hispanic, and that despite the surge in arrests, no similarly sizable drop in major crimes was evident in that period.²¹ Controversy abounds over the efficacy of such policing strategies, but little argument can be made about the racial disparities explicit in their impact. Investigating the factors driving this phenomenon, Sampson et al.²² suggest that the perception of disorder itself is related to the racial segregation of urban space. Through a series of surveys, they found that a higher percentage of Black residents in a neighborhood increased the perception of its disorder among *all* ethnic groups.

Public health, too, has recently investigated this theory as an explanatory model for disease disparity. A team of researchers in New Orleans developed a site-survey instrument to measure community disorder and its correlation to gonorrhea rates by census block.¹⁶ Their “broken windows index” was based on drive-by videotaping of each street in the block group and subsequently: coding the level of cosmetic damage on a 4-point scale; tallying the presence of graffiti, garbage, and abandoned vehicles while walking the streets on foot; and counting the structural damage and building code violations of the block group’s public high schools. In their findings, a high broken windows index correlated with higher rates of gonorrhea, even in blocks with equivalent poverty levels (as measured by income, education, and unemployment).

The suggested pathways for this increased risk rely on social psychology in much the same way as Wilson and Kelling—namely, that disordered environments produce permissive social cues that promote disorderly behavior *in contexts where informal social controls are weakened*. Though the authors acknowledge an inability to determine causation between environment and behavior, they speculate that “Poor housing and neighborhood environment may lead to pessimism and passivity, chronic stress, and a state of dissatisfaction” which, they argue further, may blossom in the absence of “traditional values” centered in the family and the home.²³ This interpretation threatens perpetuating the same individual and psychologized explanations that ascribe racialized deviance to the already-racialized images and landscapes of disorder. Valorizing “traditional” families, homes, and their health-protective norms in the absence of a critique of the institutions that keep parents locked away, cycling through punitive welfare systems, and protesting that their lives matter risks responsibilizing those who appear deviant rather than redressing the most harmful mechanisms of structural violence which pattern urban disorder.

We follow Fullilove and Fullilove²⁴ in advocating for applied ethnographic and historical research as a means of identifying key structural issues and the local and social resources best suited to redress them. Rather than reproduce geographies of racialized violence and criminalization, ethnographically and historically informed public health can advocate ways to treat the environment rather than deepen discrimination and disease by punishing those whose survival strategies are coded as damaging urban “quality-of-life.” This is best done when community members define for themselves what their ecosocial “quality of life” looks like, ideally engaging in the research process from design to interpretation and dissemination. Public health must work to affirm through its research and practice that the quality of Black lives matters.

Pathways of Embodiment: Mediatization and the Qualia of Pain

In calling for ethnographic and historical work on the problem of police brutality, we suggest that one fruitful area for future public health research would be to explore the contexts and mechanisms through which narratives and images of state-sponsored violence and oppression *become embodied* through various *pathways of circulation*. How do specific narratives and images mediate the embodiment and remembrance of police harm? And how does the *mediatization*^{25,26} of specific instances of police brutality shape how *relationally positioned* individuals and communities make sense of the role of the state and its various representatives in their everyday lives.

In an article on police torture in Chicago, anthropologist Laurence Ralph²⁷ demonstrates how specific “qualia,” or shaded experiences, of pain can be viewed as a “seedbed for historical consciousness.” As communities expand these “qualia” into public narratives, people engage in socially and politically charged forms of remembering the past and interpreting the present. Ralph focuses on the case of retired Chicago police commander Jon Burge, who gained a reputation for the racist tactics, constituting torture, he regularly employed in the 1980s. Ralph describes how residents of the Chicago neighborhood he studied used the figure of Burge as a point of historical orientation around which they made sense of their community’s relationship with the police. Ralph claims that residents, even those who never had direct contact with Burge, frequently referred to him as a primary cause of police corruption and oppression. “Because of Burge,” Ralph recalls one woman saying, “Chicago police officers know they can get away with murder.”

While Ralph focuses on the circulation of relatively local narratives of police brutality in a specific community, recent events spurred by several high-profile police murders of young black men have demonstrated the importance of social and mass media in converting the qualia of pain and violence into communal narratives and images. Perhaps the most salient example of this is the phrase “I can’t breathe,” which was uttered 11 times by Eric Garner as he was choked to death by NYPD officer Daniel Pantaleo. In a blog piece, Grace Ji-Sun Kim and Rev. Jesse Jackson²⁸ argue that the “dying words of Eric Garner symbolize our situation. ‘I can’t breathe’ speaks from the grave and describes the circumstances faced by many who are being choked by a system that treats different races and classes of people unequally.”

Here, the qualia of Eric Garner’s pain are converted into a phrase which encapsulates multiple narratives and histories of racist and classist oppression by the police. But the phrase can be seen not only as a figurative allegory for this layered system of racialization and discrimination, but a metonym for the literal compression of the airways experienced by Garner himself and the many Black Americans developing asthma from disproportionate allergen exposure in the industrialized ghettos of cities.^{29,30} Representative Peter King (R-NY)³¹ diverted blame for Garner’s death from police violence to his other health conditions—all of which are known to be racially disparate in prevalence—saying “If he had not had asthma, and a heart condition, and was so obese, almost definitely he would not have died from this.” The complicated entanglements between disease, stigma, and deviance were used to figure Garner as a legitimate victim in order to counter the broadcast videos showing Pantaleo’s use of illegal and extreme force.

Even with the density of historical entanglements and spatial relationships at play, the mediatization of police brutality circulates representations of police violence that travel much farther and faster than either oral or print communication alone would allow. When stories of police brutality travel extremely wide social and geographic distances, they can be quickly incorporated into the historical consciousness of people who do not live in neighborhoods or belong to social groups directly affected by police brutality. They are then, of course, equally available to the eyes of those outside the local community, and may strike the notes of an oppositional historical consciousness. For example, a group of pro-NYPD protestors donned t-shirts that read “I Can Breathe.”³² One man wearing the shirt was photographed holding a sign that said “My father raised his five sons to obey the laws of this Great Country and RESPECT the police who risk their lives to make this CITY SAFE! Good advice to LIVE BY!”

In juxtaposing these divergent appropriations of the phrase that expressed the qualia of Eric Garner's pain, we mean to draw attention to the fact that narratives of Black oppression have historically competed with conservative arguments concerning the lack of "traditional values" and healthy lifestyles in Black communities. For Ji-Sun Kim, Jackson, and many members of the #BlackLivesMatter movement, the figure of Garner being choked to death by an NYPD officer is symbolic of a long-standing history of blatant racialized oppression and brutality. For the pro-NYPD protestors, on the other hand, the question of oppression is irrelevant; his signs imply Eric Garner would have had no trouble breathing if he stayed in line, showed respect, took Good Advice and obeyed this Great Country—in other words, if his very being had not threatened the sanctity of "traditional values." For Representative King, this moral deviance takes on the veneer of objective, individual culpability when represented through Garner's illnesses. In pointing this out, our goal is not to equate this counter-protester's message with the "culture of poverty" argument offered by the aforementioned public health researchers, but to call all of us who do public health-related work to be more attentive to the ways in which our analyses may reproduce moralizing assumptions that further alienate, demonize, and responsabilize the populations we intend to serve.

The negative effects of stigmatizing representations and interpretations can also be seen in the police murder of Michael Brown. In this case, a young White officer in Ferguson, Missouri intercepted two teenagers for walking in the middle of a suburban street. Officer Darren Wilson's testimony³³ of the resulting encounter, which ended in the shooting death of Brown, reveals the way in which a police officer's perception of the 18-year old as a "brute" not only compelled the use of deadly force but also absolved him of this violence under the law. Wilson alleges that Brown grabbed his arm when the teen approached the car on his command, and the officer grabbed back. "When I grabbed him," Wilson testified, "the only way I can describe it is I felt like a five-year old holding on to Hulk Hogan." Wilson infantilizes himself, as if he were the child in need of protection, while casting the unarmed teen as a threatening heavyweight wrestler. Wilson then fired a shot that drew blood, and Brown stepped back. "And then after he did that, he looked up at me and had the most intense aggressive face. The only way I can describe it, it looks like a demon, that's how aggressive he looked." Switching between the pronouns "he" and "it," Wilson portrays Brown this time as a demon, altogether nonhuman, reading a monstrous aggression into his face just after Brown had been hurt by the officer's bullet. In the media, Brown was called a "thug" and "gangster" for the "petty crime" of stealing cigarillos (later contested),³⁴ aligning the officer's monstrous portrayal of the young man with tropes of moral deviance, public disorder, and racialized dehumanization.

As we argue with respect to Garner's case, these mediatized representations of Black men as criminal and inhuman ascribes responsibility for police violence onto the victims' bodies—precisely the site where marginalized peoples come to embody the symbolic, spatial, and structural violences of racialized disparity. A 2008 archival psychology study from Stanford showed that despite progress in race relations in the USA, there is a powerful, implicit association between Black men and apes, circulated in criminal justice courts and media. This disturbing and dehumanizing association rendered Black subjects more likely to suffer state violence—in these cases, conviction as well as capital punishment. Extrapolating to Michael Brown's case, then, Wilson's vision of Brown as "a demon" may in fact have altered Wilson's (and the media's) visual perception of the man, as well as triggered his quickness to use force.

Whether race, ability, mental status, or sexuality,^{35–38} the appearance of certain peoples as “out of order” in the eyes of police makes them extremely vulnerable to violence, triggering fear and apprehension among officers armed and authorized to use extreme force. This figure of the target of police aggression as deviant, disorderly, or even demonic, and thus deserving of a violent fate, is a powerful factor in perpetuating police brutality through policies and practices that target the most socially and economically marginalized groups as purveyors of deviance and disorder.

Pathways of Harm: The Public Health Consequences of Urban Policing

Racial residential segregation has a long history in the USA, and one with serious health consequences,^{39,40} limiting access to care and expanding susceptibility to violence. Rarely has this been placed in relation to the structural landscape of policing and incarceration, though Golembeski and Fullilove compellingly document the impacts and pathways of perpetual inequality within this context.⁴¹ Drawing on such work, further research might better understand why New York neighborhoods with the highest density of so-called “quality-of-life” arrests are also those with the highest rates of infant mortality.⁴²

Importantly, these inequitable geographies are also differently surveilled by the police and public health proponents, and differently portrayed in the circulation of media narratives. An ecosocial approach seeks to understand *how* these spatial and symbolic landscapes become embodied as the disparities public health is well equipped to document.

Hannah Cooper et al. attempt to characterize the public health impacts of perceived police violence on communities. Citing global research on urban residents’ susceptibility to and fear of police-perpetrated abuse in the context of the WHO’s definition of violence, the authors argue that police-perpetrated harm materializes through both implicit and explicit routes. Using qualitative data from interviews with injection drug users and non-users in New York City, the authors found that knowledge and fear of police-perpetrated harm may limit civilians’ willingness to access public services in urgent situations, as well as impair their ability to inject safely and otherwise manage harms of their own drug use. They note, as we do, that little research exists in the USA investigating impacts of policing on public health and call, as we do, for further attention.

Several Canadian studies have recently examined the way in which police presence impacts marginalized peoples. A study of female sex workers in British Columbia mapped their geographic access to health centers and clean syringe exchanges.⁴³ Women were found to avoid these services because of their proximity to police, who they identified as sources of threatened and actual violence, moving instead to more dangerous industrial settings and side streets. Indeed, heightened police presence creates an atmosphere of intensified legal and physical vulnerability for injection drug users (IDU), whose fear of apprehension or drug confiscation can lead to several harms,^{44,45} from rushed and risky injection practices to overdose to accidental syringe exchange after hurried concealments of paraphernalia in police presence. Such drug-market enforcement, moreover, does not lead to arrest of high-level drug dealers or have proven effect on curbing drug use; instead, it involves the frequent, repeated arrests of low-level drug dealers and users.⁴⁶

This “order maintenance” policing has been shown to complicate HIV prevention efforts in Vancouver,⁴⁷ though research is also underway investigating the intertwining of police and public health efforts by training officers to refer IDU to

safe injection sites rather than performing arrests.⁴⁸ This might spare not only the direct effects of police presence, described above, but also the indirect but serious harms posed by incarceration and its after-effects.⁴² It is telling that among a population of structurally unhoused people in Toronto, only 69 % expressed willingness to call police in an emergency, whereas 92 % were willing to call paramedics.⁴⁹ Undocumented people, who suffer severe health hazards crossing heavily policed borders and working “under the radar,” may also fear exposure of their immigration status when they present to hospitals or clinics.⁵⁰ The form of public assistance available to vulnerable peoples is thus vitally subject to their perceptions of safety and fears of harm, learned from anecdote, history, and personal experience of encounters with legal and health institutions, particularly policing.

CONCLUSION

The challenges facing urban communities today, the challenge of making Black lives matter, is one, in part, of understanding the way in which the socio-spatial (or ecosocial) environment patterns populations unevenly. We have attempted to show how historical narratives of police brutality reproduce disparities among marginalized and minority populations through symbolic, spatial, and structural pathways of embodiment. That landscapes marked by broken windows correlate to geographies of both illness and arrest signals a need to push our understandings of place-based disparity further, including critical interpretations of institutional efforts to control for disorder in the built environment. Because these measures crisscross tactics of coercion and care, the practices of policing may compound the harms incorporated by residents of disorderly neighborhoods through direct and indirect means. Such connections may naturalize the relation between disorder and disease or deviance without disentangling the racialized biases driving social action and public policy alike.

As the acceleration of gentrification and its discontents in many urban areas under austerity governance meets the “viral” sharing of mediatized visual narratives of police brutality, we will be increasingly compelled, in our professional and personal work, to confront the balances of care and violence that shape the pathways through which cities, bodies, and lives are made to matter—or not.

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