Policing the Block: Pandemics, Systemic Racism, and the Blood of America

Alyasah Ali Sewell*

Emory University

The Coronavirus Pandemic has altered the ways we use shared space fundamentally. Policymakers across the nation have enabled police to deploy the power of the state to limit unnecessary and dense usage of public spaces and private gatherings. Such social distancing policies are critical in flattening the pandemic curve of an effective and efficient airborne virus and lessening the public health burden of an already-strained health care system. Yet, the stickiness of systemic racism persists. Racial inequities underpin the faces governing the matrices of the pandemic, policing, and protests.

DIAGNOSIS: POLICE BRUTALITY

George Floyd sat firmly in the matrix of domination highlighted by the Coronavirus Pandemic. He was confirmed as being positive for covid-19 through a test in early April 2020 and again post-mortem (Crist 2020; Neuman 2020). Additionally, earlier in the year, George Floyd was laid off in an economy weakened by the pandemic (Richmond 2020). Only in the systemic violence of this sociopolitical moment, could someone like George Floyd—a Black man living in a highly segregated city (Waxman 2020)—die simultaneously of covid-19 and police knees.

Yet, the preliminary autopsy report of his medical examiner—appointed and paid by the state—indicated that a legal diagnosis of homicide was troubled by competing causes of death, such as “arteriosclerotic and hypertensive heart disease” (MyStateLine.org 2020; Sandler 2020). He did not exactly die of strangulation and traumatic asphyxia (Melinek 2020; Stanley 2020). The medical examiner designated fentanyl intoxication and recent methamphetamine use as significant conditions. The autopsy report further detailed coronary heart disease and hypertensive heart disease as underlying conditions.

The medical stories told about David Chauvin in the aftermath of him murdering George Floyd thus feel eerily similar to those told about Daniel Pantaleo in the aftermath of him murdering of Eric Garner in 2014 (Pearson 2014; Sisak 2019). In both cases, the medical examiners released initial autopsy reports that told the video-viewing public that our eyes lied—that the actions of police officers caught on tape did not cause the losses of life they saw. Eleven months after the repeal of NYPD’s implementation of the

*Correspondence should be addressed to Dr. Alyasah Ali Sewell, Emory University, Department of Sociology, 1555 Dickey Drive, 225 Tarbutton Hall, Atlanta, GA 30322; aasewel@emory.edu

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infamous policy of Stop, Question, and Frisk (Floyd et al. 2013; White and Fradella 2016), an asthma attack was deemed the contributing factor to the homicide of Eric Garner (Sisak 2019). These medical assessments imply that Floyd and Garner would have died from their pre-existing conditions those days anyways—at those times, on those streets (MyStateLine 2020; Sisak 2019). Inequitably distributed proactive policing strategies have set the stage for the inequitable medicalization of lethal policing. In both cases, however, such initial claims were refuted enough to lay the grounds for claims of homicide (Allen 2019; Forliti and Karnowski 2020).

PARADOXES OF PANDEMICS AND POLICING

Proactive policing strategies proliferate as the arm of the carceral state (White and Fradella 2016). They serve as gatekeeping mechanisms of mass incarceration (Alexander 2020). Policymakers pitch such criminalization policies as means to protect the health of society (Haldipur 2018). Again, in the era of Coronavirus, policymakers are calling on police to engage with the community as public health agents—this time by enforcing social distancing policies (Kully 2020). Yet, the inequitable application of these social distancing policies bears the markings of surveillance policing and its disparate application on Black and Brown civilians in New York City (NYC) (Bates 2020).

Independent of the economic, criminal, and healthcare features of areas inundated by proactive policing, broad criminal surveillance policies are themselves a risk factor for sickness. A growing body of research suggests that the application of such policies can be linked to a host of physiological conditions (e.g., high blood pressure) that weaken a person’s capacity to live healthfully (Cooper et al. 2004; Geller et al. 2014; Jones 2014; Kerrison and Sewell 2020; McFarland et al. 2018; Sewell 2017; Sewell and Jefferson 2016). They set the background upon which new threats to health lean into inequitably-produced vulnerabilities revealing the social costs of infection from pathogens such as covid-19.

Many understand this story as patients with underlying conditions that have brought vulnerabilities to illness into a destabilizing light because of the quick progression of severe covid-19 symptoms. Even asymptomatic carriers of covid-19 face significant barriers to getting tested for covid-19 because initial screening criteria required a recommendation from a doctor (Shear et al. 2020). Moreover, symptomatic carriers of covid-19 may not have even understood their need for testing because the initial list of symptoms prompting further review was limited (Gostic et al. 2020). Testing inefficiencies alone continue to present challenges to containing the spread of covid-related outcomes (Boburg et al. 2020; Tromberg et al. 2020) in a country that has long claimed to have the best healthcare system in the world. In emergency care during a pandemic, the evidence tells a different story.

There are many reasons a person may face the threats of these underlying conditions; however, I will focus on just one: inequitable policing. A closer look at the negative illness feedbacks of policing—a social and structural determinant of health—peels the curtains back on the virality of one block. In our case, we focus on a single street block of NYC that is average in all ways except one.

This is the block most people have made famous because of the last moments of George Floyd (Richmond 2020), Alton Sterling (Walker 2016), Eric Garner (Sisak 2019), and Amadou Diallo (Memimger, 2019). Research suggests, however, that this block is far more
prevalent than one might imagine: On it, the social structure of nonlethal injurious police practices visit us routinely—intervening on the memories and dreams of the present. Let me tell you a short story of this one block.

ONE BLOCK, ONE WOMAN, ONE LIFE

Imagine a woman, 10 street blocks, and a community health clinic. This woman has a 2 o’clock appointment to follow up with her physician about her diabetes care. She leaves her house precisely 30 minutes before her meeting—plenty enough time to get to her appointment on time. On five of the 10 blocks that she walks to the doctor’s office, she witnesses a police officer patting down someone walking through the neighborhood (Sewell and Jefferson 2016; Sewell et al. 2016). Most of these people she sees she does not recognize.

Now, take that same woman and place her in a neighborhood where she witnesses a police officer frisking a pedestrian on just one more block. The neighborhoods are the same in all other characteristics. Arrest rates are fairly low—less than one out of 10 pedestrians stopped are arrested. Robbery and incarceration rates are not unique. Buildings house midrange concentrations of Blacks and Latinos. One out of five families live below the poverty line. Half of the households bring in more than $50k a year. A third of the housing units are occupied by owners. In all respects, this is an average New York City neighborhood (Sewell 2017). The only difference being, that one block.

A doctor reviewing the file of that woman in that neighborhood—the neighborhood with that extra block of frisking—is 16 percent more likely to find an indicator of high blood pressure on her medical records than a doctor reviewing the file of that same woman who lives in neighborhoods without that proactively surveilled extra block (Sewell and Jefferson 2016). When the nurses ask her to step on the scale to measure her weight, she is 20 percent more likely than her counterpart to register a Body Mass Index that indicates she is overweight.

The story could stop here, but it does not. This woman, in that neighborhood with that extra block, is 15% more likely to present as comorbid with asthma than she would be if the neighborhood she walked through did not have that extra block (Sewell and Jefferson 2016). Further, the likelihood that she believes her health is a strong indicator of early mortality is not ignorable. She is 10 percent more likely than her counterpart to indicate that her overall health is “poor” or “fair.” Her doctors have treatments for all of these issues; however, the symptom checklist she is given upon her arrival at her doctor’s office is unlikely to know that the 10 blocks she just walked is a key determinant of the health conditions they are left with to face. As such their picture of her compliance with doctor’s orders paints incomplete.

Furthermore, this woman is the mother of a son who walks those same streets—even more so than she. He goes to and from his school, which is nearby. After school, he heads to the playground to shoot some hoops upon finishing his homework. He visits his friends within the two-mile radius in which they reside. He makes sure not to break into a run as he paces with sheer excitement at the thought of playing with his gaming buddies from across the world—an excitement that distracts him at school to the point that he is often relegated to detention. He is always aware of the probability of policing—aggressive, unnecessary,
and frequent (Boyd et al. 2019; Brunson 2007; MacDonald et al. 2007; McFarland et al. 2019; Weitzer and Tuch 2014).

That extra block increases his exposure to those policing determinants of psychological distress more so than the femmes in his neighborhood (Sewell et al. 2016). That son, when he arrives in that doctor’s office, or that clinic, or that student health center, is 10 percent more likely than his counterparts in less surveilled neighborhoods to indicate that he experiences nervousness a couple of times in the past week. And, if in that extra block, he witnessed pat downs that were a bit more aggressive—entailing, for instance, usage of a handcuff, a baton, or a taser, he is more likely than the femme counterparts in his neighborhood to report to his doctor that he feels worthless all the time and thinks that everything is just so difficult (Boyd and Clampet-Lundquist 2019; Brunson 2007; Jones 2014; Sewell et al. 2016). Clearly, to his general physician, he is clinically distressed. They suggest that he starts taking selective serotonin reuptake inhibitors regularly. He refuses.

Furthermore, if those 10 blocks are located in a neighborhood where medical examiners confirm at least three police killings in the decade prior to the repeal of SQF, that woman—with or without that son—is more likely to be diagnosed with high blood pressure and morbid obesity, as are the men in that neighborhood (Johnson et al. 2019; Sewell et al. 2020). These “legal intervention deaths” (Krieger et al. 2015) represent the medicalization of police killings and serve as a formal recognition of state-sanctioned violence (Sewell et al. 2020). Such police brutality also situates her as having a higher risk of obesity than comparable women living in less lethally surveilled neighborhoods (Sewell et al. 2020). Even when compared to men who live in her neighborhood, the medical records of this same woman are 30–54 percent more likely to indicate the cardiovascular disease trifecta—these are, diabetes, high blood pressure, and obesity (Sewell et al. 2020).

The story, nonetheless, does not stop here. Remember: That one block of frisking this woman is exposed to increases her likelihood of perceiving her overall health as “poor” or “fair” (Sewell and Jefferson 2016). So, in the age of covid-19, when she has an asthma attack in the middle of the night and weighs whether or not to go to the hospital emergency department, she will decide against doing so (Kerrison and Sewell 2020). Instead, she may head to that same doctor’s office she regularly visits. This doctor’s office offers urgent care at night and operates as a covert community health clinic for Afro-Latinx immigrants like her parents—a population that sits at the crux of 62% of NYC covid-19 deaths (Stieb 2020). After-hours access to the clinic is through a concealed door on a poorly-lit back alley of the street block. Still, as she turns the corner into the alley, she sees a police officer standing by the door. The officer is not looking for people like her. Rather, he is there to scroll the sign-in sheets for names he recognizes as someone he suspects is a criminal or can inform him of criminal activity. She nods nervously as he greets her.

Now, that mere head nod—a defensive coping strategy, not an affirmation of allegiance—holds a different but equally disease-provoking risk (Geller et al. 2014; McFarland et al. 2019). As she walks towards her go-to place of health services in her greatest time of need (Sewell and Pingel 2020), the risks of having all those same illness conditions activated by walking through that single block evidencing a simple pat down are awakened again. This time—through personal contact with a police officer—the accelerated aging, biological weathering, and allocated load (McFarland et al. 2018; McFarland et al. 2019) that she grapples with invisibly finally takes a toll that is unprovoked under mundane risks and circumstances.
Simply, because of all the things she knows has happened to people within her three
degrees of freedom, because of her own past personal contact, because of her concerns
for her son’s future, her nervous system collapses (Horton 2018; Johnson 2004; Lee et al.
2014, 2015; Lee and Wildeman 2013; Neyfakh 2015; Topel et al. 2018). She feels the full
weight of the fret she has normalized because her routine navigation of that one block
has encoded its imprint onto her biological cells. Her immune system, weakened by years
of the wear and tear of policing and police violence, fails her. The stress response that
could improve her ability to fight off infections like covid-19, which she has but does not
know yet, catches up to her: She can no longer fight or flight.

The battery of underlying chronic conditions and acute stressors ball themselves up into
a complex series of biophysiological reactions. After summoning her last bit of strength
left to scribble her name on the sign-in sheet, she collapses to the floor. Several health care
workers try to wake her into consciousness; one calls 911. She is rushed to the hospital in
an ambulance.

THE BLOOD OF AMERICA

Policing is the blood of America. Inequitable policing is the conduit by which the struc-
tures of ethnoracial bias seep through the pores of our skins and deteriorate the organs
that we need to live. From the angles of pedestrians, neighbors, and family members,
people residing in proactively and brutality surveilled neighborhood walk through that
illness-inducing block.

The words—“policing”, “blood”, “America”—elicit visceral reactions. Yet, the words
themselves just are: They are the “is” that is. As such, the noun components of the sen-
tence are interchangeable as subject, verb, or object; they are also interchangeable as the
result of preposition or declarative. However, the affective sentiment attached to the pos-
sible combinations of those words reveals one’s own positionality to each of these syntactic
systems. These positionalities are derivations of one’s ascribed status within the structural
hierarchies founded upon the colonial projects of anti-Black and anti-Indigenous racisms
that twisted pro-immigration sentimentalities into a white supremacist, anti-immigrant
imperial state (Blackwell et al. 2017; Jung 2015; Paradies 2006, 2016; Robinson 2000).

The global systems of violence that betray themselves in this pandemic-policing matrix
have motivated analysts to call upon biological and behavioral explanations of ethnorac-
ial inequities in vulnerability to covid-19 and its socioeconomic fallouts. I offer a heart
root systems science of pandemics and policing that places illness as a manifestation of
the consequences of ethnoracial domination as well as a sociopolitical conduit itself. This
situating is where policing takes on the position of blood—not as blood, but as the nutri-
ents that feed the organs of the system. The blood, our life force, is infected—dirty. The
disease emanating from this infection does not manifest because of a genetic curse from
inception, but because the blood of society is exposed to systems of control (policing)
that increase exposure to toxicities.

Policing occurs at every level of society, in every stage of the life course. Policing can
be life-affirming, such as the act of blocking the hands of a 5-year old reaching towards a
burning stovetop, and life-brutalizing, such as the act of shooting a 27-year-old man two
times in the back while he runs away (Shammas 2020). The manner and intent in which
we police society affects the ability of our blood to flush out infection, plaque buildup,
and rotting flesh. Policing differentially orders our abilities to survive the onslaughts of an efficient and effective virus and an equally efficient and effective system of segregation.

Brutal policing is itself a public health event (Edwards et al. 2019; Krieger et al. 2015) and disease-producing (DeVylder et al. 2018; Sewell 2017; Sewell et al. 2020). Because policing is the blood America, the roots of its brutality seeds the strain of its infection into the root structure of our hearts, shaping face-to-face systems of interaction as well as those virtually and backstage. Brutal policing exposes the American body politic to fatty substances—in the form of “stuff we do not need”, such as indiscriminate stops in the name of “gang” control and control of the homeless population; spoiled seasoning—in the form of “stuff that no longer work,” such as outdated plumbing, underfunded schools, and lead poisoning; and excess salts—in the form of “unnecessary displays of domination,” such as militarized body suits and the use of tasers against college kids stuck in traffic after curfew (Crenshaw et al. 1995; Deere and Boone, 2020; Delgado and Stefancic 2017; Fullilove 2016; Stuart 2016; White and Fradella 2016).

PRESCRIPTIONS AND CURES

Just as a diseased heart can be cured, so too can policing. So much as it is true that humans die, so can disease-producing policing. Policing, in any of its variants, are social artifacts written by the rules, processes, and norms of the biases and intentions of society. Decentering policing institutions as a solution to resolve social problems is a start. We must also do so as we reimagine the trauma-informed helping professions.

The exact institutions advocates are calling upon to be refunded as we defund, divest from, and abolish policing are also infested by colonialism and imperialism (Tchoukleva et al. 2020; Davis 2011; LaVeist and Isaac 2012; Peters 2020; Gilmore 2007). The hierarchies and processes of providing care through the institutions of medicine, social work, nursing, and psychology are also seeded with the infectious systems of anti-Black/Indigenous/immigrant racisms. These institutions have secured their professional prominence by systematically abdicating care of the social problems confronting marginalized and multiply-subjugated populations (Slate et al. 2013). The removal of these service populations from the transformative power of these institutions parallels that of the removal of these same populations from non-institutionalized spaces through processes and policies organized around criminalization (Alexander 2020). The strategic projects of colonialism and imperialism must be rooted out in these spaces as well.

Healthcare practitioners, policymakers, and civilians alike must place pressure on repressive institutions and organizations to root out racist hierarchies (Lewis 2014). The institutionalized hierarchies are reinforced through the unethical exploitation of the biophysiological byproducts of vulnerable populations for the benefits of research and the provision of inequitable services for uninsured and underinsured populations. At the same, the helping services must professionalize with an eye turned towards the structural determinants of disease, help-seeking, and the distribution of services. They must train mindsets to precision in muting the sociopolitical forces feeding the inequitable conditions from which they receive their patients.

People in the helping sciences face no small feat to save the life of our protagonist—particularly, during the Coronavirus Pandemic. We have the tools to treat her. Yet, the
systemic violence of anti-Black/Indigenous/immigrant racist ideologies offers the reality that there is a small chance that we will do so successfully.

When the protagonist of our story reaches our hospitals, she does not trust the team of doctors and nurses that fervently try to save (Sewell 2015). Moreover, she faces the finality of the blood flowing through her arteries alone, since the pandemic has ushered in new cultures of bereavement. Rushed from a neighborhood offering her a slow progression to the certain death that befalls all people—like that faced by Erica Garner, Venida Browder, and Yolanda Carr (Sewell et al. 2020), her organs instead offer her a painful struggle for oxygen and the flow of blood. Her histories of diabetes, lung disease, cardiovascular disease, and obesity—induced by the systemic violence of that one block—places her among the eight of nine people who die of covid-related complications because they have underlying conditions (CDC 2020).

Her team of medical professionals will pull out all of the stops to save her life (Bauchner et al. 2020; Zucker 2015): She has just entered middle adulthood; she is gainfully employed as a healthcare technologist; she is a mother of a young son; she has healthcare insurance. She is needed—central to the hum and drum that will resurrect a failing economy. Yet, after draining the average share of oxygen tanks, the bank account of systemic racism leaves her with a debt she must repay with her own blood. In no small part because of how policing sediments the cycle of separate by design policies, she will begin multisystem failure through constraints brought on by a lack of blood flow. We will try; yet, alas we will add her body to the hundreds of thousands cremated or placed in mass graves because of lack of sufficient burial ground to feed the rage of covid-19.

Even the most composed and prepared healthcare workers will have to live with the failure systemic racism brings. However, they live so unnecessarily. As servants of and advocates for our protagonist, we must take direct responsibility to curtail the public health crisis fueled by structural inequities and systemic marginalization.

The structures that govern her 10-block walk do also provide an opportunity for redemption. Their eventual effects and very presence can be mitigated. Advocates for safer communities have taken up the banner to take the breath out of disease-generative systems. Policymakers must join them and raise a steadfast finger to mute the destruction brought by systemic racism. Otherwise, policing will continue to be the blood that systematically engineers an inequitable, unjust, and undemocratic America.

REFERENCES


