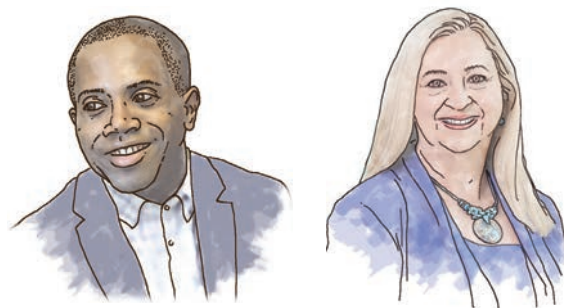


Editorial

DIALOGUE AS A DISRUPTIVE DISCOURSE ORIENTED TOWARD JUSTICE

By Aluko A. Hope, MD, MSCE, and Cindy L. Munro, PhD, RN, ANP



How do we respond to the fact that Black Americans are nearly 3 times more likely than White Americans to be killed by police?¹ Black Americans account for more than 40% of the victims of police killings and are more than 5 times more likely than White Americans to be killed unarmed.^{1,2} Such violence may have a disproportionate impact on the mental health of Black Americans: In a recent study of a nationally representative sample of Americans, poor mental health days among Black Americans seemed to increase after police killings of unarmed Black Americans.^{3,4}

What are we to do with the data emerging that Black Americans suffer higher rates of infections and higher mortality from coronavirus disease 2019 (COVID-19) than White Americans?⁵ There are multiple potential factors related to acute care that could explain these disparities.⁶ Black Americans are more likely to be exposed to factors (like chronic comorbidities, public-facing jobs, higher housing density) that may increase their susceptibility to severe COVID-19 infection. Black Americans are more likely to be exposed to factors (like less access to diagnostic testing or less health insurance) that

may delay their access to adequate treatment for COVID-19. Black Americans face unconscious bias against them in clinical encounters that may lead to lower quality acute and postacute care, which may have a negative impact on their morbidity and mortality risk from COVID-19.⁶

And yet, as Marilyn Nelson reminds us in her poem “Pigeon and Hawk,” these “human horrors are not inevitable.”⁷ The disproportionate effect of these public health crises on Black bodies must embolden us toward forms of communication that disrupt systemic racism and move us toward equity and justice. The scale of the human suffering, death, and injustice that we have witnessed through these crises demands a culture of communication that is rooted in gentleness, compassion, humility, and humanism. For us to be able to cohere justice from the emerging data on the impact of COVID-19 and police violence on Black lives, we must be willing to sustain a communication culture rooted in *dialogue*.

By suggesting a dialogic communication culture as a means toward disrupting racism within our health systems, we do not mean to suggest that a simple conversation or discussion can cure injustice. Rather, we think that health organizations must be willing to completely transform the way that individuals engage with one another. Kumagai et al^{8,9} highlight some key differences between dialogue and discussions in the context of medical education that will help illuminate the power

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and potential of dialogue for health care organizations. Discussions tend to be goal-oriented, focused on solving problems and producing urgent output for the moment of crisis. During discussions, people tend to defend the status quo and are often afraid to make people in power uncomfortable. Participants in a discussion are often encouraged to defend their own opinions rather than reflect on another person's thoughts and feelings. Discussions tend to value cognitive over emotional data, and participants' emotional expressions of conflict are often deemed inappropriate.⁹

A communication culture oriented toward dialogue dares to bring people with multiple points of view together so they can forge a relationship rooted in deep affective regard. In a dialogue, a diverse group of individuals are invited to bring their whole selves into communication; their identities, their values, and their perspectives are allowed relevance. Although intentional diversity is a necessary prerequisite, the posture of dialogue goes beyond mere inclusion toward authentic engagement of these multiple contradictory and often inconsistent voices.^{8,9} Dialogue disrupts by intentionally acknowledging the struggle for power and justice inherent in communication discourse; each participant enters the encounter with multiple social identities, identities with various degrees of status and power. Dialogues are not interested in maintaining the hierarchy of the status quo; rather, dialogues try to ensure that the previously silenced voices are heard. Dialogues welcome the wide variety of human emotions, hoping that such emotions can engender trust between potentially conflicting participants. Dialogues try to shift an “either-or” type of language to a “both-and” type of language to forge space for new questions and new possibilities.⁸⁻¹⁰

What might such a dialogic approach look like in an American hospital struggling with the allocation of resources during the COVID-19 pandemic? Such a hospital might empower a health equity committee to create policies and practices to ensure the just distribution of scarce resources during the

pandemic. Such a hospital might ensure that this committee is intentionally diverse: well represented with health care workers from many disciplines as well as with laypeople from its catchment area. The meetings for such a committee engaged in discernment might be structured to allow time for personal reflections from committee members.⁹ Such a hospital might then be asked by this committee to track outcomes and resource allocation by race and ethnicity to ensure that treatment decisions during the pandemic are not amplifying racial inequities. Such a committee in such a hospital might be well positioned to recommend that the hospital consider health equity and justice as relevant priorities to be integrated into their crisis allocation framework during the pandemic. Such a hospital with such a committee might be better situated to call into question the many crisis guidelines that recommend the allocation of life-sustaining treatments based solely on the utilitarian principle of saving the most lives possible.⁵

And how might such a hospital situated in a working-class neighborhood in a large American city respond to the social media footage of a police officer's knee on a Black man's neck for more than 8 minutes? Let us imagine that in such a hospital, the committee has a layperson from the neighborhood who can speak to the psychological stress of what it feels like to be both scared of the police while also being disheartened by the callous underreaction by the health system to these incidents. Such a hospital might be asked by this committee to develop protocols to screen patients for social and emotional determinants of health, including a history of traumatic events in patients.^{1,11} Such a hospital might therefore be well positioned to collaborate with the local police force to test the feasibility of novel crisis intervention teams (including both a police officer and a mental health professional) to respond to community members with acute psychological problems.¹² When the leaders of such a hospital decide to put a Black Lives Matter banner in their halls, we can imagine them doing so while also advocating for legislative strategies to improve the physical and psychological safety for all people in the communities they serve.¹

We would like to imagine that this hospital would have spent the past 2 decades transforming their safety culture from a no-blame culture to a “just culture” of quality, safety, and accountability.¹³ Such a culture recognizes clinician accountability as an essential component of equity and justice.¹⁴

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In response to medical errors, just-culture principles recognize the qualitative differences among errors that are made inadvertently, errors that signal at-risk behavior, and errors that signal reckless behavior.¹⁴ We can imagine therefore that clinician leaders in such a hospital are well positioned to speak compassionately with leaders of police unions on the benefits of a just culture of safety and accountability while also urging their state legislative leaders to eliminate the barriers to identifying, investigating, and addressing police misconduct.¹

The disproportionate impact of COVID-19 and police brutality on Black Americans is an urgent call to eliminate the racial inequities in our health system. If our system is to be transformed toward justice, we must be willing to transform our culture of communication toward a disruptive, compassionate, and humanistic discourse oriented toward dialogue.

The statements and opinions contained in this editorial are solely those of the coeditors in chief.

FINANCIAL DISCLOSURES

None reported.

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