# Racism as a Motivator for Climate Justice

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*In the wake of the recent unjustifiable deaths of George Floyd, Breonna Taylor, and several other African Americans at the hands of police, we have witnessed persistent and widespread protests against systemic racism, even during the COVID-19 pandemic, which has killed African Americans and Latinos at two to three times the rate of Whites. Racism is undeniably an evil, pervasive, destructive force in our society, yet it can also be a great motivating force. This essay is a personal story of how being the subject of racism led one person to acquire and leverage his professional privilege to help create and change institutions to act on climate and environmental injustices while countering the systemic racism that he witnessed and experienced in childhood.*

Do you believe in a parallel universe? I do. I live in one. This is not the "fake news" universe, but rather the universe of racism. Racism is pervasive in American society and is a strong but silent social determinant of health, wealth, and general welfare. It creates a parallel universe where people living in the same environment have very different lived experiences. It can also be a powerful motivator for good or evil. This essay describes how my experience with overt, institutional, and systemic racism motivated me to become a witnessing professional for the health effects of climate change, and how I brought along other health professionals to that task.

In 1964, my family was the first African American family to move into one of the all-White suburbs of St. Louis. There, as a young boy, I experienced extreme, overt racism. At the age of seven, I did not understand why certain random strangers hated me and others were scared of me. I was called hateful names that I didn't understand by children from passing school buses or on the playground. Women twice my size would slam the door in my face in terror when I asked for donations for the March of Dimes. Virtually everyone would stare at me, smile, and lock their car doors when I crossed the street, clearly but silently letting me know that I did not belong. Relatives would complain that on their way to visit us they were frequently stopped by the police.

Over the next few years, I struggled to figure out how to keep people from hating me or being scared of me. I tried getting to know some of the haters, so that I could understand them, and they could understand me. I tried smiling and be-



https://doi.org/10.1162/DAED_a_01819

coming the class clown. I tried fighting and arguing with those who bullied me, but this only seemed to encourage some to try to provoke me further. I also tried becoming the teacher's pet and excelling in my schoolwork to show that I was just as good as my classmates. Nothing seemed to work, and I became frustrated and depressed by the time I reached nine years old.

In my first year attending a more diverse high school, which was only 90 percent White, I woke up one day – as if struck by lightning – and decided that I would change my life. I decided that it doesn't matter what others think of me, I will do what makes me happy and stop trying to please everyone else or to be what I thought that they wanted me to be. I decided that it was too emotionally draining to be angry or to try to conform to unattainable expectations. I decided that I would create the life that I wanted. I decided that I would not judge others and would not worry about how they judged me, because I could never satisfy everyone. I decided that just because something was a rule or a norm didn't make it right. I decided to defy social norms by rotating among the cliques that ate together in the cafeteria. One day I would eat with the jocks, the next with the thespians, the druggies, the intellectuals, the elites, the Black students, the nerds, and so on. However, I still disdained those who spouted racial slurs and jokes, and I knew that I was always being watched, always being judged, and always at risk of upsetting White people for little or no reason, which could get me in trouble or put me in danger.

To my surprise, despite or because I stopped trying to please everyone, I became popular, particularly among students who did not fit in. I found that others wanted the same things that I did, and although life is unfair, together we could change the unfair institutions and make them more just. I started organizing students to oppose perceived injustices. I joined the student council and restarted the Black Student Union during my Freshman year and continued being active in these and several other organizations over the course of my matriculation there. I was surprised that, in my Senior year, my classmates created a special Student Council officer's position for me to serve as a platform to organize students to address injustices.

I had decided that I wanted to go into medicine from a very young age as a way to help others and to challenge myself academically. I was accepted into a six-year medical school upon graduation from high school, and continued my student activism there in Kansas City, Missouri, through the student council and the Student National Medical Association (which represents African American medical students), and by participating in medical school policy-making bodies, such as the admission committee. Because my youthful experiences led to various levels of success and appreciation from others, I decided that I wanted to focus my life on changing policy, fighting racism, and pursuing social justice. I tried to figure out how to combine this with a career in medicine. One day, one of my profes-

sors advised me to explore Preventive Medicine and Public Health as a specialty. He helped me to locate Dr. Richard Biery, the Director of the Kansas City Health Department and one of only five public health–trained physicians in the 1.5 million-person Kansas City metropolitan area. I arranged a meeting with Dr. Biery, who taught me that the philosophical basis of science is to find truth; the philosophical basis of medicine is to apply science to health; and the philosophical basis of public health is to apply social justice to medicine.

After he explained that to me, I was hooked. I decided I wanted to go into public health as a career.

I studied public health and completed my medical residency in Preventive Medicine. I entered the field and practiced public health in senior positions at the Kansas City, Missouri, and later, Hartford, Connecticut, health departments. Through this experience, I found that although social justice is the philosophical basis of public health, this is not how things work in reality. I found that there are many constraints on public health practitioners – namely, political constraints – particularly if you lead a health department. Health departments are sometimes described as the fourth-most political department in local government, after police, fire, and public works.

There were political pressures from a variety of constituencies, including City administration, state, and local elected officials, the three employee unions in our department, regulated businesses, health care organizations, community activists, and the media. We were often in the local news. Some of the issues that were highlighted in the media included: protests of cutbacks in child health programs; measles, tuberculosis, and sexually transmitted infection outbreaks; immunization campaigns to stop measles; needle exchange programs to combat HIV; closing popular restaurants that failed inspections; protests that claimed the family planning program somehow promotes sexual activity and abortions; and removing families from apartments where children have been lead poisoned.

In addition to these normal public health issues, we also encountered a number of extraordinary activities. These included drug charges against employees, embezzlement, arson investigations, and several fatalities of employees and their families, including a mass murder-suicide. This was a stressful four years, indeed.

Yes, I went into public health, but once there, I learned how stressful and political it can be and how many limitations there are on what you can do (although these vary from place to place around the country and according to the level of government – local, state, federal – in which you serve). Because of political limitations, it is not easy to be a witnessing professional or to promote change in public health.

One concern I observed that calls for witnessing professionals is that the people who need the resources the most are not necessarily the ones who get them, even though philosophically that should be the case. Often-

times the people who complain the most – those with the most political power and money – are prioritized for getting resources and services. For example, although we know that cancer rates and toxic exposures are higher in low-income communities, and even higher in communities of color, the state health department unit that investigates cancer clusters spends most of its time investigating whether there are cancer clusters in suburban and rural communities; they seldom find any. Why focus on these communities? Because suburban and rural residents are more likely to complain and to engage powerful interests to support their complaints. The lesson I learned from this is that the people who wield the most power and influence are those who represent business interests or those who work in advocacy groups that engage politicians and voters. In addition, powerful political interests often operate to create state policies that disadvantage urban interests. One example of this is how waste disposal is regionalized in Connecticut and concentrated in the cities with the highest percentages of People of Color.

Although Hartford is the state capital of the wealthiest state, it is among the lowest-income cities with over one hundred thousand people in the United States. It is 80 percent African American and Latino. In the 1990s, when I was health director, Hartford had the largest landfill in the state, and it was poorly managed.

It also had the largest trash incinerator in the state, which took trash from over seventy municipalities in three states to burn in Hartford. It was the fifth-largest trash-to-energy incinerator in the country, by capacity. Incineration produces toxic gases, which include nickel and phthalates that are associated with asthma. Hartford had the highest asthma hospitalization rate in Connecticut.

The landfill and trash-to-energy incinerator were both run by a quasi-governmental agency controlled by the Governor. Their Board was composed of current and former elected officials and was chaired by the Governor's Chief of Staff. It had state legislators as employees and contracted with companies of major political donors. It was supposed to be regulated by the state environmental agency, but when they tried to do so, the legislature enacted laws that exempted the quasi-governmental agency from the regulations. The landfill created odors that were so strong that on several occasions they made employees in the nearby Hartford Public Works garage so sick that they had to close their operations. Actions by community groups were able to exert enough pressure to get the facility to meet environmental standards. Although the landfill eventually closed, the trash-to-energy facility is currently in discussions to be gutted and rebuilt in the same location, perhaps with a larger capacity than it currently has to become one of the three largest facilities in the United States.

Another example that I observed as Hartford Health Director of how political power creates state policies that disadvantage communities of color was with electric power plants. New electric power plants, which were among the most polluting facilities in the state of Connecticut, were mostly placed in the communi-

ties with the lowest incomes and highest percentages of People of Color. These communities were the most densely populated portions of the state with the most air pollution and the highest rates of pollution-induced asthma hospitalizations and deaths. These communities were home to the state's largest existing power plants that already produced more electricity than these cities needed, and yet were the site for proposed new and expanded power production. This electricity was needed because of the growing wealthy suburbs with larger and larger mansions that needed to be air-conditioned in the summertime. Wealthy suburbanites wanted electricity, but refused to have the smoke stacks, air pollution, and electric power lines (with their "dangerous" electromagnetic waves) that would accompany electric power plants in their exclusive communities. In fact, they opposed high-voltage electric lines that would bring electricity to their communities from far away because they "obstructed the view of the woodlands," according to the well-heeled Woodland Coalition, an organization that sprung up to oppose power plants in wealthy suburbs. Therefore, the only possible outcome was to locate these new power plants in the nearby low-income, majority–People of Color urban areas. According to their logic, suburban residents have a right to as much electricity as they can afford, but no obligation to bear the negative consequences of it.

These are examples of *institutional racism*: although the policies are not racist on their face, they have disparate effects on communities of color.

While I was at the Hartford Health Department, I observed that although most diseases were decreasing in frequency, those that were related to environmental exposures – like cancer and respiratory conditions – were increasing. This appeared to be even more pronounced in African Americans and Latinos, contributing to increased health disparities. Yet it was the regulated community – not the public – that voiced their opinions on the health effects of environmental exposure, and it was to complain about perceived overregulation, when it was clear to me that they were not being regulated enough to prevent environmentally induced illness. I realized that at that time, the public had no idea they were suffering from environmentally related diseases.

Shortly after I left the Hartford Health Department, I was asked to conduct camp physicals for a group of about thirty Latino children for an urban church camp. I found that about one-third of the children had asthma, which is much higher than the national rates of less than 10 percent. I contacted a colleague at the state health department who was responsible for investigating environmentally related diseases. I was told that they would not investigate whether there was an environmentally related cluster of asthma because there were only thirty children examined, and it is not unusual for inner-city children to have asthma. I was outraged. I decided that I was going to do something about it.

This experience motivated me to start an environmental justice organization in 1998. At that time, environmental justice was a new concept. People didn't know what environmental justice was. They did not know that communities of color bear a disproportionate share of environmental hazards and suffer the health consequences from exposure to those environmental hazards. So I founded the Connecticut Coalition for Environmental Justice and was able to educate the public about the links between environment and health and the disproportionate burden of exposure to environmental hazards on African Americans, Latinos, and low-income people of every race. The low-wealth residents who I was training did not know that it was unusual for people to have that level of exposure to environmental toxins, as it was a normal part of their lives. Few of these people had confidence that they could get powerful people to change their situation. But we were very successful: we were able to change a substantial amount of environmental health policy over the ten years or so that I was there.

We saw proof of our effectiveness in influencing policy when a city council member came up to me and said, "Mark, you've got old ladies talking about things we can't even pronounce, so this MUST be important." Well, I had warned the council about the dangers of that exposure before, but when an individual scientist or physician says something it is often not enough. When an organized group representing constituents say the same thing, policy-makers more often perceive it as important, and decide to act.

In addition, we were able to get substantial actions on asthma. We got Environmental Protection Agency (EPA) funding to conduct a community-based randomized, door-to-door survey on asthma prevalence and environmental health symptoms. In a reversal, we had the city and state health departments and hospitals named to an advisory committee to advise the community, which decided on the questions that went in the survey. The survey eventually determined that the city-wide asthma rates were upwards of 20 percent. Other accomplishments were that:

- We were able to get the Hartford City Council to declare an "asthma emergency," which included the actions that we had decided.
- We were able to get funding for a City environmental health educator.
- We were able to get funding for the State Health Department to hire two asthma specialists.
- We were able to launch a successful anti-diesel campaign, which increased public awareness, reduced school and transit bus idling, and replaced the whole Hartford school bus fleet with buses that were 90 percent cleaner.
- We were able to get state funding and launch a grassroots asthma education campaign.

- We were able to get the trash-to-energy incinerator to reduce air pollution.
- We were able to get the state environmental agency to deny an air permit for an electric power station in New Haven, based on environmental justice impacts, for the first time in its history.
- We were able to pass a state environmental justice law, which is still one of the strongest community notification laws in the country.

And, most important, we were able to build a multiracial organization led by grassroots People of Color and low-income people who became community leaders and engaged citizens. Most of our leaders said that they had never voted before joining our organization because they didn't know how or why, and, although this was not our intention, we started swaying elections in Hartford and New Haven. In both cities, they elected the first Green Party candidates in their history when the Democrats and Republicans opposed our agenda. The New Haven Mayor's Chief of Staff told me that part of his duties was to determine our agenda so that the city could co-opt it. At one point, we were getting at least one state law passed per year. As we trained community residents to speak about their experience and needs at public hearings and in meetings with elected officials, they observed what officials were or were not doing to support these community efforts. The issues that our group decided to focus on proved to be of concern to much of the community. As our members talked to their relatives, friends, and neighbors, they told them about what was occurring and how elected officials were responding or not responding. These actions and word-of-mouth discussions eventually built up to the level that it began to make a difference in the election outcomes as well as in achieving more policy successes, especially on the local level.

The climate justice movement started developing in the early 2000s. It was based on applying the environmental justice principles of fighting structural and institutional racism to climate pollution. We fought laws that did not appear to be racist on their face, but were in fact racist in their effect. One example is a proposed law to give tax breaks to build unwanted, greenhouse gas–spewing power plants in economically distressed communities. These facilities create very few jobs but have high rates of pollution with resulting respiratory disease and death and contribute to global warming.

We also experienced differential applications of the same laws, such as those that determined which power plants were required to be upgraded to modern pollution controls rather than being grandfathered in. Public hearings for a major pollution source in Bridgeport were held the week of Christmas, which predictably led to minimal public participation. Bridgeport is Connecticut's largest city and its population is also majority People of Color. These types of activities would never be tolerated in wealthy, White suburban communities.

The movement to address climate change was an easy transition for environmental justice groups: we were used to trying to fight sources of air toxics that posed existential threats that killed many of our neighbors, friends, and families. We defined the environment as where we live and understand how our health is affected by that environment. Our concerns about how laws are commonly manipulated against our communities were often ignored by the larger climate organizations and health organizations whose members did not face the same threats. For example, the big environmental groups supported cap-and-trade policies to reduce greenhouse gas. Our experience in Connecticut was that when we finally won pollution reductions from our trash-to-energy facility in Hartford, the city with the greatest percentage of People of Color in the state, the facility operator was allowed to trade pollution credits with the trash-to-energy facility in Bridgeport, the city with the second-largest percentage of People of Color, so that they did not have to reduce their pollution there. To add insult to injury, they then bragged that the EPA says that they are so clean that they can sell air pollution credits – even though they were, by far, the largest polluter in Hartford.

So when the large environmental organizations tried to promote cap-and-trade legislation in Congress, environmental justice organizations sided with Republicans to oppose it. The legislation did not pass. The approach that environmental justice organizations favored, carbon tax and dividend, has since become much more popular.

It was clear that the people who contributed least to climate change were the most affected, both on a national level – as evidenced by who was left behind during Hurricane Katrina – as well as on an international level, with small island nations being ravaged by hurricanes and existentially threatened by sea level rise. Yet their views and experiences are often not taken into account in policy development. When they are not invited to the decision-making tables, the policy solutions tend not to benefit those who are suffering the most and are often less likely to be successfully implemented. The most effective policy seeks and incorporates the knowledge of those who are most impacted. The "experts" don't know that many people will not get on an evacuation bus without their pets and without knowing where it is going. They don't know that children sneak through the holes in the fence and play on the contaminated site, which their mothers, who have been kept in the dark about its dangers, think is safer than playing in the streets. They don't know that even though there are two roads shown on the map that can be used for emergency evacuation, one is a dirt road that is overgrown with weeds and blocked by barricades, and the other crosses the railroad tracks that are often blocked by trains.

I have tried to make a career out of addressing the areas of most need at the intersection of health and anti-racism. This took me away from the traditional doctor-patient medical care, and even from traditional public health and

community medicine. Since I had selected such an unconventional career path, I thought that I would be disdained by organized medicine.

In 2008, I attended a national convention of the National Medical Association (NMA), which represents the interests of African American physicians and their patients. I knew their history of fighting racism, which was part of the impetus for their founding in 1895, when African American physicians were excluded from the American Medical Association (AMA), limiting their training and practice opportunities. I knew that this continued until the 1970s in some counties in Southern states, where African American physicians were excluded from their county medical societies, preventing them from being able to join the AMA. But I didn't know if those in clinical practice would be interested in and supportive of environmental health and justice.

At this NMA conference, in addition to my participation in community health and public health activities, I somehow wound up attending a luncheon of obstetricians. When they asked me where I practiced obstetrics, I sheepishly admitted that I didn't practice obstetrics, but was an environmental health and environmental justice physician. To my surprise, they got very excited. They told me that they were seeing increasing rates of congenital malformations and other maladies that they thought were related to environmental exposures. They said that they did not know much about environmental health but were very interested in learning about it. They asked me what I could do to help them. I thought long and hard about this. Would I be willing to leave the grueling but spiritually rewarding work of raising the voices of grassroots needy people at the local and state level in order to echo their voices in Washington, backed by the credibility of African American physicians? Could we be as effective?

In 2010, Dr. Leonard Weather was elected as the 111th President of the National Medical Association. He was an obstetrician and gynecologist who specialized in infertility. Because of his concern about the contribution of environmental exposures to infertility, he named environmental health as one of his three top priorities and re-established a long dormant Environmental Health Task Force. Because of my interest, he named me as co-chair of the Task Force. I was thrilled with the interest and support that the NMA provided to environmental health policy that affected vulnerable populations. It became clear to me that although there were not many physicians who were knowledgeable about environmental health, there was great interest and enthusiasm; they were seeing the effects of toxic environmental exposures in their patients firsthand.

I became convinced that, as an African American physician with grassroots environmental justice experience, I had a unique opportunity and responsibility. I could bring my environmental justice and environmental health advocacy experience learned at a local level to national policy decision-making bodies by engaging NMA physicians to fight unjust and racist environmental policies. I applied for

grants and became a consultant to environmental justice organizations nationally as well as to the NMA. I started training a lot of physicians on environment and health, how to counsel their patients, how to speak out in public, and how to speak on radio and TV about environment and health. I found that many physicians had very little knowledge or interest in environmental health at first, but once I spoke with them, I was able to help them see the connections between the diseases they encountered in their patients and environmental exposures.

On the policy front, we again had several successes, although they were fewer and harder to recognize. We were effective in stopping polluting industries from misleading some civil rights groups as well as Black and Latino politicians into supporting policies that were damaging to health: for example, opposing the industry narratives that poor people want coal because it's cheaper (they don't) or that poor people need chemical flame retardants to stop the excessive rates of fires (they don't). We were told by staff people on Capitol Hill that we were effective in our meetings with members of Congress and their staff, that they talked about our visits weeks later. The Chief of Staff of a Louisiana senator stated that in his two years there, our Louisiana affiliate was the only professional organization that had talked to him on behalf of poor people. We lobbied against one bad bill that had been scheduled for a vote the following week on the basis of its detrimental effects on health. The vote was first delayed and then canceled. We were told by staff who supported our position that we influenced this decision.

In 2014, I was approached by Dr. Mona Sarfaty, a physician from George Mason University, to gauge the NMA's interest in climate and health. She wanted to test the hypothesis that climate would affect health to see if it was already happening or if physicians were expecting it to do so. We teamed up and conducted the first national physician survey on climate and health. We found that 88 percent of NMA physicians were already seeing the health effects of climate in their patients. To our surprise, tied with exacerbation of cardiac and respiratory disease, the leading health effect of climate was injury from severe weather events, which of course varies a lot from place to place. On the West Coast, it manifested as lung injury from smoke inhalation from wildfires. In the Northeast, it was an increase in flood and snow-related injuries. In addition, almost 90 percent of NMA doctors said that they wanted more education on climate and health, and a full one-third of respondents said they wanted to be engaged in community education and policy advocacy. About 80 percent said that it was relevant to patient care, and that they wanted the National Medical Association to engage more in climate and health.

I have found that professional associations, such as medical societies, are important to witnessing professionals. One emerging trend in medical practice is that more physicians are working for hospitals or insurance companies rather than engaging in independent private practice. This trend limits their ability to

speak out publicly without risk to their jobs and livelihood. However, being involved in a professional organization, such as the National Medical Association or another medical society, allows them to speak out as a group, without jeopardizing their hospital privileges. In addition, if views have gone through the vetting process and are condoned by established professional societies, they are, by definition, mainstream views and are credible. So medical societies and other professional organizations are important vehicles for the expression and acceptance of responses to new challenges.

It also turns out that medical societies are important for motivating action on climate change. The George Mason University Center for Climate Change Communication found through their research that physicians and nurses are some of the most trusted voices on climate change, and that they have the ability to change opinions and motivate climate action through educating the public and policy-makers on the effects of climate change from a health perspective. George Mason University put these research results into practice by starting the Medical Society Consortium on Climate and Health in 2016. In four years, it has increased from eight member medical societies to twenty-nine member medical societies, representing more than 60 percent of all physicians in the United States. In addition, the Consortium has more than fifty affiliate health organizations and a dozen state affiliates. I am now the Director of State Affairs for the Consortium. We train health professionals to speak out through op-eds, radio/TV, and social media about the health effects of climate change, the need to adapt to and develop resilience against climate change and its health effects, and the health and health equity benefits of climate mitigation through reduction of fossil fuel use. We encourage the adaptation of climate policies that reduce racial disparities. We identify clinicians who are willing to be out front, to be witnessing professionals.

My experience of racism and my commitment to medicine as a child have served to motivate me toward dedicating my life to fighting individual, institutional, and structural racism in health, and toward the achievement of health equity. My ability to live in several cultures and institutions but not be tethered to any one of them has provided me with the perspective to imagine a world that is different and better; to use my professional knowledge, experience, and privileges to identify the institutional change that is needed; and to connect with those who can help me make that world a reality.

I have faced many challenges, made many sacrifices, and achieved many successes as well as failures. I have made my own path to address pressing, unmet needs that I have identified throughout my career. There are many more challenges ahead. As a witnessing professional with a national viewpoint, I am heartened by the depth and breadth of the recent awakening of people of all races and ethnic groups in the United States and internationally to racial injustice in the aftermath

of the indefensible death of George Floyd at the hands of police. This awakening is not only to criminal justice policies and practices, but also to health policies, with the disproportionate impact of the COVID-19 pandemic, to environmental policies, to climate policies, and throughout the institutions that govern our lives. As a witnessing professional, I invite you to join me and seize this moment to deepen our understanding of this parallel universe of injustice, and what is required to dismantle it. We need every voice.

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