GUEST EDITORIAL

BLACK-ON-BLACK HOMICIDE: THE NATIONAL MEDICAL ASSOCIATION'S RESPONSIBILITIES

Carl C. Bell, MD, Deborah Prothrow-Stith, MD, and Catherine Smallwood-Murchison, PhD
Chicago, Illinois

During the 1986 National Medical Association's 91st Annual Convention and Scientific Assembly Plenary Session, the NMA's responsibilities in preventing black-on-black murder were discussed. The discussion was a timely one because the "Report of the Secretary's Task Force on Black and Minority Health" clearly states that homicide accounts for 38 percent of the "excess deaths" in black men under the age of 45.[1]

At the plenary session it was pointed out that a national public awareness campaign could be mounted as a black self-help initiative to focus on the prevention of black-on-black homicide. The black community must be made to realize that the leading cause of death of black men aged 15 to 44 years is black-on-black homicide, and for every one homicide there are at least 100 assaults.[2]

Because NMA physicians are often on the front line caring for blacks involved in interpersonal violence (the end point of which is homicide), NMA physicians have a responsibility to raise the consciousness of the black community about the problem of black-on-black murder. An example of how to exercise this responsibility is the role taken by the Community Mental Health Council, Inc., (CMHC) to raise the consciousness of Chicago's black community. CMHC designed a graphic "Stop Black-on-Black Murder" T-shirt. In preparation for the Black-on-Black Love Campaign's citywide "No Crime Day," CMHC requested several groups to wear T-shirts to raise consciousness about how blacks can be their own worst enemy by killing one another. As a result, on June 20, 1986, black physicians of the Cook County Physician's Association, members of the Chicago chapter of the National Association of Black Social Workers, members of the Cabrini Green Public Housing North Tactical Unit of the Chicago Police Department, staff of the Anchor-Coleman Health Center, staff of the Near North Health Service Corporation, medical staff of Jackson Park Hospital, staff of several black pharmacies, staff of CMHC, and numerous individuals throughout Chicago wore "Stop Black-on-Black Murder" T-shirts. A model effort was performed by the entire emergency room staff of Jackson Park Hospital who wore T-shirts and handed out fact sheets on black-on-black murder to everyone who came to the emergency room for service. These efforts were well received by the black community.

During the plenary session Dr. Prothrow-Stith presented her prevention efforts as an internist, which were designed to stem the tide of the black-on-black murder epidemic. A ten-session health education curriculum on anger and violence prevention, given to the tenth grade class of a Boston public high school, was modeled. Initial research on the pre- and post-testing of attitudes and knowledge about black-on-black violence indicates this effort is effective in decreasing attitudes that promote violence and in increasing knowledge about violence.

As emergency rooms are places of repetitive contact with victims and perpetrators of interper-

Requests for reprints should be addressed to Dr. Carl C. Bell, Medical Director, Community Mental Health Council, Inc., 1001 East 87th Street, Chicago, IL 60619.

sonal violence, Dr. Prothrow-Stith noted that emergency rooms are ideal settings for the early identification of individuals at risk of being involved in interpersonal violence. The emergency room also provides access to victims and perpetrators of interpersonal violence shortly after the violent episode, and as such, furnishes a good setting to investigate the biologic, interpersonal, and social causes of black-on-black homicide from which to frame interventions.

Speakers for the Cindy Smallwood Medical Education Foundation, Inc., added an essential part to the discussion by saying that the National Medical Association had a responsibility to assist in prevention by taking political action to reverse the cycle of black-on-black crime. Drs. Smallwood-Murchison and Hare of the Foundation remarked that the establishment of centers in high-risk areas that are designed to assist people with "quasi-morticide" (a newly recognized phenomenon that encompasses homicide, subintentional suicide, suicide, and all other forms of self-destructive acts within the black community) would be effective in decreasing the number of victims. Consequently, any decrease in victims with such tendencies would be reflected in a concomitant decrease in correctional and health care institutional expenditures.

A tertiary prevention approach that would also require political action and policy change was recently suggested in a recent JNMA guest editorial.[3] In this editorial Dr. Walker noted, "A strong case is being made for regionalization of care, for preparation of guidelines for acceptable trauma management, and for specialized centers prepared for handling around-the-clock trauma patients."

From the Cindy Smallwood Medical Education Foundation's contribution to the NMA's plenary session, it became apparent that the National Medical Political Action Committee (NMPAC)[4] needs to become involved in shaping the political decisions and legislation that could reduce the incidence of black-on-black violence. For example, NMPAC could be useful in implementing some of the recommendations from the "Report of the Attorney General's Task Force on Family Violence,"[5] recommendations that have been shown to have had a positive impact on reducing family violence.

The plenary session also focused on other new trends in research, procedures, and policy on the problem of black-on-black homicide. Neuropsychiatric correlates associated with "pathological agressiveness," such as signs and symptoms of electroencephalogram abnormalities, minimal brain dysfunction, histories of coma (traumatic and nontraumatic), histories of seizures, nonschizophrenic intermittent psychotic symptoms, pathological intoxication, and neurologic impairment,[6] were outlined as possible acquired biologic causes of violence that NMA physicians need to study further. In addition, the treatment of some acquired biologically predisposed violent subjects with carbamazepine, lithium, propranolol, or trazodone was highlighted as a possible answer to the treatment dilemma, once such an etiology was suspected. It should be understood that this focus on acquired biologic causes of black-on-black murder does not negate the intrapsychic, interpersonal, and social causes of the problem. Clearly, black-on-black homicide is a multifaceted, multietiologically based phenomenon that must be addressed by all black health and allied health professionals, but each profession should address the issue from its own area of professional expertise.

The new emphasis on providing services to victims was also presented, as to discuss black-on-black violence without mentioning the victims and relatives of victims would be remiss. The standard use of an assaultiveness or victimization history inventory was encouraged as an "at risk" case-finding tool by all black physicians. Such skills need to be taught as standard curriculum in all black medical schools and continuing medical education courses involving the care of black patients. The use of a brief victim-perpetrator screening form for violence was suggested as a quick, easy way for all black physicians to identify patients at risk for being involved in interpersonal violence that may result in murder.

Finally, the plenary session concluded by pointing out that these new proposed directions to solve the problem of black-on-black murder should be focused on populations where one is most likely to encounter a concentration of violent subjects, such as emergency rooms. Another likely setting for finding high numbers of violent individuals is in the nation's correctional facilities. Through the NMA's representation on the National Commission on Correctional Health Care, the issue of

identifying and appropriately treating "pathological aggressiveness" has been raised in formulating correctional health care standards aimed at improving the quality of health care in this nation's jails, prisons, and juvenile detention centers.[7]

It is sincerely hoped that the NMA will meet its responsibilities regarding black-on-black homicide.

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