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Health Disparity in an Occupational Context: Law Enforcement

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Abstract

While health disparities are thought of as existing in different ethnic and gender populations, they may exist in groups that are strongly influenced by the context of the occupation. This presentation concerns health disparities for law enforcement. Recent research suggests that police officers exhibit higher cardiovascular disease (CVD) risk compared with the general population, which is not fully explained by traditional CVD risk factors. Police mortality studies also suggest that officer's experience increased risk for CVD at a younger age than the general U.S. population. A history of working as a police officer leads to an average age at death 10 years younger than that of the general US population.

Why such health disparities exist in a presumably healthy working population with good access to health care is an interesting question. Among factors which may contribute to this disparity are hazardous environmental exposures, stress and traumatic events, and the strong influence of occupational culture. Law enforcement officers are often exposed to chemicals or biological pathogens, including clandestine drug labs, bloodborne pathogens, decomposing bodies and traffic particles. Stress and traumatic event exposures are also commonly experienced by officers. Since such exposures are an integral part of this occupation it is difficult to avoid them. An avenue more amenable to change is the police cultural environment. Law enforcement operates within a framework of independence from the outside world. Officers dislike being probed for weaknesses and are hesitant to divulge personal information for fear that it may compromise their position or safety. Additionally, police unions resist preventive health measures such as annual physical exams in order to protect officers from administrative discipline.

How does one motivate an unwilling culture toward positive health intervention and reduce health disparity? Regular physical exams and education in lifestyle issues such as exercise, obesity, harmful substance use, and stress are examples. We addressed this issue in the Buffalo Cardio-Metabolic Occupational Police Stress (BCOPS) study, where officers were evaluated for subclinical cardiovascular and metabolic disease and queried about their lifestyle habits, psychosocial factors and risk factors. For some participants it had been ten or more years since their last physical exam. Yet, the study successfully recruited and screened over 460 officers. This was accomplished by establishing trust and proceeding with a positive tone toward the research. For example, the principal investigator for the BCOPS study is a retired police officer and academic researcher which established a trusting relationship with this population. The officer's image as leader and problem solver was not challenged. The study was projected as positive, not to find weaknesses in police officers, but to determine the types of intervention which improved their quality of life. Additionally, we successfully worked together with police administration and the union.

In sum, accessing any health care resistant population should depend heavily upon establishing trust and a positive tone toward the research. Recruiters should have ample knowledge of the profession and culture, and it may be best if persons from inside the population are involved.