Transcription details: **Clinical Problem Solvers Episode 120: Antiracism in Medicine Series Episode 1**

Racism, Police Violence, and Health (Full Transcript)

Speaker Legend:

UE: Utibe Essien, MD, MPH

DP: Dereck Paul, MS

MO: Michelle Ogunwole, MD

RH: Rachel Hardeman, PhD, MPH

RB: Rhea Boyd, MD, MPH

Transcription results:

UE: 00:12	Hey, everyone, this is Utibe Essien.
DP: 00:13	This is Dereck Paul.
UE: 00:15	And welcome to the very first episode of the clinical problem-solvers anti-racism and medicine series, racism, police violence and health. Ya'll, we are so grateful for the opportunity to be here and to the clinical problem solvers who gave us this platform to lift up this issue of racism as a root cause of health inequities. An issue that has increasingly been shown to deserve attention as a part of our clinical education. As Robby and Reza mentioned CP solvers saw this topic not just as a one-off episode for a moment but as a key part of the podcast mission.
DP: 00:52	The first thing we did when we started working on this was to put our team together and we have an incredible team. We're going to introduce them in just a few minutes. But the first thing we did as a team was to define our mission and the vision for the series and we want to share that with you. So the mission of the anti-racism in medicine series is to equip you, our listeners, across every level of training with the consciousness and the tools to practice anti-racism in the health professions careers. And our vision which for us that's what's the highest hope and dream for the series. And that's that our episodes can be a kind of living resource for folks who are looking to practice anti-racism. We're excited to do this. We're excited to be doing a lot of learning and thinking ourselves and we're so glad that you're coming on this journey with us.
UE: 01:45	So like all great things in medicine, this series really wouldn't be possible without our incredible team who work behind and in front of the scenes. These include Naomi Fields, Rohan Khazanchi, LaShyra Nolan. All of whom the audience are going to get to know much more over the upcoming year. We also have an incredible lead research assistant, Chioma Onuoha. So this is a rotating position y'all. Anyone can apply and we really hope that you guys will consider applying. And the last member of our team, last but certainly not least, we want introduce-- will actually be joining us today as a co-host of this episode. Dr. Michelle Ogunwole is a GIM fellow and health disparities researcher at Johns Hopkins University.
MO: 02:28	Thank you for that welcome and introduction and I share the gratitude that you both expressed in really being able to be a part of this history. And I can't think of a more timely topic then what we plan to discuss today and I'm thrilled to have two

trailblazers here to help us break down this discussion. And I also know that we can trust them to tell the truth and to keep it real about what really needs to be done for us to move forward in this moment. So first I'd like to introduce Dr. Rachel Hardeman. Dr. Hardeman is tenured associate professor in the Division of Health Policy and Management at the University of Minnesota. She's also a Blue Cross Endowed Professor of Health and Racial Equity and principal investigator of the measuring and operationalizing racism to achieve health equity lab. Her research interests are reproductive health equity as well as the impact of police violence on the mental health of birthers and other communities. The next person I will introduce is Dr. Rhea Boyd. Dr. Rhea Boyd is a pediatrician and public health advocate and scholar. She is director of equity and justice for the California Children's Trust. She worked at Palo Alto Medical Foundation and her research interests are child and public health impact of harmful policing practices and policies. And we're thrilled to have them both here.

DP: 03:54 Thank you both for being here. So as we start everybody comes this conversation I think at different stages we're thinking that one thing we can do to sort of get on the same page is define that term that we hear used all the time. But sometimes people don't really know what it means. That's structural racism. You've both defined social racism in your writing emphasizing policies that perpetuate inequities, the lack of identifiable perpetrator. I come to you first Dr. Hartman. How do you think about social racism? And how would you explain it to our listeners?

RH: 04:31 I want to first start by thanking you all for having me today. I'm super excited to be a part of this and [inaudible] podcast. So thank you. And definitions particularly definitions of racism I think we haven't spent enough time as a field of public health and a field of medicine really digging into how we are specifically defining these things. And so you see a lot of different ways that they're conceptualized and discussed in the literature and in the media. For me, one of the things that I think is most important is to make sure that folks understand that we're talking about systems, we're talking about structures and with that comes policy, right? And the fact that structural racism is really how inequity is embedded and baked into all of the systems and all of the structures and all of the ways that we go about our day to day life. And that makes it hard to identify and hard to tease out for a lot of folks. I also think it's important to ensure that folks understand that there's a difference between that individual racist and structural racism, right? And that's not to say that we shouldn't have these conversations about individual racists because of course, that's incredibly important. I think that we would all agree on that. But that if we aren't really again tackling two of the systems in the history right and the sort of cultural ideology and the ways that inequity has sort of been a part of our day to day lives for so long, we're not going to be able to identify anything further than that. And so when I think about defining structural racism and discussing it in my work I always want to be very clear about the fact that-- again, it's part of the system and it's what then allocates resources based on race on a racial hierarchy. And also I think the other piece of that that I'm sure we'll dig into a little bit more as we go along, is that we often leave white supremacy out of the discussion of structural racism. And that has to be-- we have to get comfortable talking about white supremacy and naming it and making that link between structural racism and white supremacy in order to really move forward.

DP: 06:55 That's incredibly helpful. Dr. Boyd, we're so happy that you're here today. Anything you would you'd add to that or do you think about it in a similar way?

RB: 07:05 Absolutely. First, thank you again for having me. It's such an honor to talk alongside Rachel and each of you who touch giants in this field. I love what Rachel saying about

definitions. They are so critical and right now as we're talking even about something like anti-racism I think there's kind of these public perceptions and lay media of what these things mean. And when we talk about it in public health we have to be incredibly specific. I tend to lean on Camara Jones' formulation of structural racism where she says structural racism is essentially differential access to goods, services, and opportunities by race. And so she goes on to talk about it's not really inherited disease that poses a risk but inherited disadvantage. And these are her terms completely. I think it's a really useful formulation particularly right now during COVID where we're talking about underlying disease a risk to have COVID complications and premature mortality. And how that has shaped kind of the racial and ethnic distribution of this terrible disease. And what she teaches us is that it's not inherited disease. It really is this inherited disadvantage that then shapes the distribution of a disease like COVID-19. And then I also just want to underscore what Rachel's saying, we have to have definitions about other forms of racial exclusion and discrimination, like white supremacy. And I would add to it white hegemony, white normativity, and white privilege which are all terms that I have tried to - in my more recent pieces - kind of define really explicitly to then link it to what interventions could look like.

RH: 08:52

Can I add one more thing to what [inaudible] just described? Because I think it's so important that she brought Dr. Camara Jones' work into the discussion because she has been such an incredible role model and leader in the field and really setting the agenda for white racism as a public health issue should look like and what we should be doing. And I think one part of her definition, or the way she talks about it that's incredibly important to point out, is that she says-- she always says racism and structural racism, in particular, stop the strength of the whole society through the waste of human resources. And I think it's so critical that we understand that part of the definition and that part of what this is doing to us as a society, right? I mean, even as we look at the death rates-- the death toll in the black community related to COVID-19 and how much talent we're losing, how many incredible lives that still have the potential to contribute to our society, are being needlessly lost.

MO: 09:58

Thank you so much for that. For both of your-- for your comments. I do know that we are discussing all of these definitions and it's very important for us to know and understand this terminology but for the people listening I also want to bring back up this point that the topic that we are discussing today on police violence, really is a devastating one for the communities that are experiencing it. And I was reading a piece that Dr. Boyd wrote in The Lancet and she actually was talking about the topic of police violence and health outcomes. And she referenced a quote by Ta-Nehisi Coates that talks about the real brutality of racism. And I'd actually like to read it for our listeners. So the quote says, quote, "But all our phrasing, race relations, racial chasm, racial justice, racial profiling, white privilege, even white supremacy serves to obscure that racism is a visceral experience, that it dislodges brains, blocks airways, rips muscle, extracts organs, cracks bones, breaks teeth; you must never look away from this, you must always remember that the sociology, the history, the economic, the graphs, the charts, the regressions, all land with great violence upon the body." And so Dr. Boyd, as we really endeavor to do this, to not look away from the viscerality of racism, can you share with us what this great violence really means? Specifically police violence, in terms of health outcomes.

RB: 11:45

Yeah. Thank you for reading that quote it's so profound. Right now I think the physicality of this moment is inescapable. I think public protest has only made it that much more visible which is really been the history of public protest and black protest in particular in this country. People are outside shouting but their bodies are on the

line when they're out there. And many of these protests have introduced, as they're captured by media and news organizations, have introduced broad swaths of America that may not have thought that police might react to peaceful civilians in this way. It brought it to their attention what that type of-- what kind of violence can happen at interactions with police. I don't think we talk enough about policing writ large. So right now we've been talking specifically about police violence in the public and highlighting the ways that police brutality harms health. But there is significant evidence that even routine exposures to policing can shape the health of populations and I can give you some examples. Some of those examples come from states like New York and cities like New York City that used to have stop and frisk policies, right? Where police would just routinely kind of surveil communities and disproportionately stop folks of color and particularly young men of color black and Latino young men in New York. And there was evidence to say that young men who were stopped reported higher rates of quote-unquote "stress and anxiety". It's part of why we started to think about the relationship between the literature on stress, toxic stress, and chronic exposure to cortisol and what it does to your physicality and your body and your health and policing. Because if there are events that occur in your community or as that one Lancet paper told us even in your state where police kill somebody who you associate with their racial identity, you may then move differently in the world.

RB: 14:04

You may try to keep yourself safe in ways that look like what we call hypervigilance. Where you are manifesting symptoms of PTSD to ensure that what you've seen transpire never happens to you or your kids or your loved ones. And those are the ways that even routine encounters can carry a perceived risk that is great, that is incredibly serious and dangerous. And if that is the case then each one of those encounters either in quantity the numbers of what you have in your life or in a given period of time or in severity if it actually amounts to violence during your encounter, can certainly results in health effects. Many of which are linked through that biophysical pathway we know about. Toxic Stress and the health of your brain and the health of your heart and lungs and mind.

UE: 15:00

That's such a huge and important discussion, Rhea to kind of remind us that it's not just those moments of violence that end up on the screen that end up trending on social media, right? It's these individual one off moments that can happen that may not necessarily lead to violence. Doctor Hardeman, I wonder if you might share a little bit beyond the physical force. There is a 2017 American journal Public Health paper that you are the senior author and where you are and your colleague suggests that we actually move beyond police violence towards the phrase police brutality. In that piece, you all suggested that it captures more than the physical force of the police. But also quote, "Police actions that dehumanize and degrade." And our team really thought that was such a powerful quote and would love to hear you share a bit more about what beyond the morbidity and mortality. What else aren't people aware of related to police violence?

RH: 16:01

and I would add to what Rhea just described. I have a paper that will hopefully be coming out soon that really talks exactly about what Rhea just described with respect to simply existing in communities where there are more police, there is a greater police presence. What we're seeing in our analysis is that that is having a direct impact on preterm birth rates in those communities. And we know that preterm birth and infant mortality have persistently impacted black and brown communities for centuries for as long as data has been collected. And so I think we haven't even scratched the surface, right, of understanding all of the health outcomes and the

health impacts of policing. And to your question around our paper from a couple of years ago, which was led by Dr. Cyril Long, who is an incredible medical sociologist at Lehigh University. We wanted first to point out that brutality goes beyond physical force. I mean, we're really talking about state-sanctioned violence in all of its forms and that includes emotional and sexual violence, verbal assault, psychological intimidation. And I think we need to be-- as we talk about definitions, right, and needing to define structural racism, we also have to be very clear about what we mean by violence at the hands of the state and what that looks like.

RH: 17:32

Particularly with respect to police brutality, it's one of the oldest forms of racism and control and state-sanctioned violence and that history doesn't just go away. It's embodied in black communities and in black bodies and passed through generations. And so our goal was really in that piece to lay out the fact that yes, we know there is the harm, the immediate physical harm that's happening to an individual who's being harmed or killed by the police, but that ripples through the community for the reasons that we had just described but also in a lot of other ways. So in addition to sort of the physiological responses that increase morbidity, we talk about the fact that the mental health and well-being of folks who look on the screen and say, "That looks like my son," or, "That looks like my dad," or, "That looks like my best friend," and carrying that with you in the day to day and then entering spaces where it's not acknowledged, right? So I distinctly remember 2016 and the days after Philando Castile was shot and killed by a police officer in my community and going into work and not having a single person say a word about Philando's life or what had just transpired and feeling very alone in that. And then you have sort of we watched over years that the trial play out, right, and justice not be served. And then being forced to relive that pain and also the pain of justice not being served is another way that black bodies are carrying through the impact and the weight of state-sanctioned violence. And I think there is also sort of we have to think about the socio-economic impact on communities, the lack of productivity. It takes a toll. So in the aftermath of the George Floyd murder by a Minneapolis police officer, we've seen an incredible amount of public protest and civil unrest as you all know. That means that we can't work, right we can't do all of the other things in our day-to-day lives because this has become the priority. And so thinking about all of these ways in which police brutality and state-sanctioned violence converge to impact black populations and the black community, I think, is so critical to the work that we have to do to dismantle structural racism.

RB: 20:31

I could say one more thing on that too because I think it's so critical to expand our notion of what we consider violence, just as Rachel was saying, because there is also a violence or a harm that will land on people's bodies to inaction that has existed within public health and within many of our medical institutions in response to police violence. Like in 2012, Trayvon was murdered, which was a state-sanctioned action of violence where George Zimmerman was protected by the law instead of Trayvon - right? - where George Zimmerman was given more right to be on that sidewalk than Trayvon with his hoodie and Skittles. Or in 2014, when Mike Brown died and then Tamir Rice died. These are all young adolescents and boys, and pediatricians across our country didn't say anything. And I can't say that we didn't say anything individual because many folks individually spoke up. But we as a lobbying force, we as a major advocating organization for children, we said nothing; not even condolences. And that also takes a toll. If we broaden how we conceptualize the violence that has hurt people, part of that violence has been inaction on the part of healthcare organizations and on the part of professional medical associations like the ones that I belong to. And some really interesting research that's going to come out of UCSF and is led by Dr. Rupa Maria is looking at that question. They call it the Justice Project and what

they are essentially asking about is that if one of the treatments for state-sanctioned violence and police-leveled harm is justice, what are the health impacts of justice denied. And part of that, I think, for us in healthcare is owning our role in ensuring that justice happens because it has to happen on multiple levels; the legal level, which is what many folks call for when they turn to the streets in protest, but also within our own health infrastructure to acknowledge this form of violence as a major cause of premature death and mortality in communities across the United States.

DP: 23:07 Oh, man. I'm just over here bathing in this brilliance and this flow. I mean, it's amazing to have you both having this conversation with us. I want to jump off exactly what you just said, thinking about public responses to these issues in the past and then also kind of what things have looked like in the last couple of months. And you both wrote with your colleague Eduardo Medina this powerful meditation on George Floyd and on Black Lives Matter in the New England Journal. And some people are saying we're going to look back at the last couple of months and say, "This was a turning point." Some people are saying it's a for a new civil rights movement I'm wondering, what do you think about that? Is that how you're reading this moment? And why do you think that the the public has--you have been doing this work for such a long time. Why do you think that the public is shifting its relationship to this work now?

RH: 24:23 So I'll say a few things I think there's so much to say here that I feel like it would warrant a back and forth, our conversation, Rhea, so feel free to jump in. I want to start by saying I think that what the reaction to George Floyd's murder would not have been the same if we didn't have the backdrop of COVID-19 in place. Because for me particularly, as someone-- I'm born and raised in Minnesota, where we have sat on our good health and consistently talk about the fact that we are a great place to live and rank as one of the highest, healthiest states in the nation, yet here we are having experienced multiple high-profile incidents of police brutality over the past four years. And when I saw the headline of George Floyd prior to the news breaking more largely, sort of in the middle of the night, I couldn't sleep, I was restless and scrolling through my phone and see, "Black man dies in police custody," and thought, "Here we go again." And when I think about the work that I wrote in 2016 in the aftermath of the Philando Castile's murder, we could easily drop in George Floyd's name and that work would still be relevant four years later because we haven't changed quickly enough. I do feel like we're in a different moment. And I'm hoping, desperately hoping, that this moment will-- it's turning into a long-term and impactful movement. And I think we're having conversations now that we weren't having four years ago and a lot of that has to do with the fact that we have been grappling with a global pandemic and a pandemic that is disproportionately impacting black and brown communities, which means that people can't look away in the ways that they have before. The folks who sit in lecture halls as I talk about racism as a public health issue can no longer push back in the ways that they attempted to before. And so in that way, I think we have some really important opportunities to move forward. I think I'm going to pause there and let Rhea jump in and hopefully we can kind of continue to chat about this.

RB: 27:07 Yeah, I agree. I think this will be a good back and forth, because there's so much to say about why now. And I hope we can touch on many of those things. Some of the ones that come to the top of my head, as I've thought about this question over the last few months, have been about ways that COVID-19 and our federal government's lack of response to it has distributed suffering and to such an extent that it almost peeled back what was happening behind these veils of segregation for folks, where it felt like you may have been in-- some folks may have lived in what felt like a

protected area. They may have worked in a protected sector. They may have thought they were somehow shielded from the devastation that can occur if we don't have protections in place. We have. A major political party right now that has for decades tried to peel back critical protections. Protections in our voting system, protections in health care, through the ACA, states that still have yet to expand Medicaid. There still are 13 states, I believe. Missouri was the most recent to do so. That peeling back of protections only worked because certain folks remained buffered. They still had a shield. And I think COVID has been able to pierce that shield in a way that's been alarming to people and perhaps have made them pay a bit more of attention. But I also hope we could touch a bit on something about George Floyd himself.

RB: 28:46

I think there is a reason why we, as a country, pay more attention to the deaths of black males at the hands of police than any other [demographic?] demographic even then children even then women. George Floyd was a tall, strong man. He used to be a security guard and I partly wonder how watching a man like that who should-- from all of society's conceptions of what masculinity and strength look like, who should never if facing a physical threat actually succumb watching him succumb to that threat perhaps made people feel vulnerable in a way that watching women succumb to a threat like that watching Atatiana Jefferson shot in her house or Aiyana Jones shot while she was sleeping or Breonna Taylor shot while she was sleeping the same way watching-- the same type of violence transpire against women hasn't sparked the same national response. And it's in some ways also distorted our perception of who is impacted by police violence and who is most at risk. We have these conversations, we typically talk about men, and it's part of why we have this whole movement around say her name so that we also center the women who are affected directly by police violence and indirectly by police violence.

RB: 30:24

There's a study that just came out from Alyasah Ali Sewel I think it was last month where she looked at neighborhoods where there is high police lethality, where police kill a number of people. The greatest health effects on hypertension and obesity in that neighborhood were seen among women who live there or Rachel highlighting her forthcoming research that I'm so amped to read about the effects of living in an area surveilled by police and preterm birth. That is like an intergenerational impact of police violence that happens through the female body, and we don't talk about it in that same way.

RH: 31:02

And I would add also what Black motherhood means, right? So George Floyd called for his momma like three times during that horrific eight minutes and 46 seconds. And what it means to be a Black mother and to bring a Black child into this world-- and I think that him calling for his mother in that way also activated mothers who are not Black, right, because we all know what it feels like to need our mom at some point in our lives and that I think along with the way that this particular murder was broadcasted through social media led to the sort of undeniable reality that you can't-- I mean, you can't watch that and not-- and I haven't watched it to be completely transparent because I don't have the-- I don't have the mental bandwidth but I do think for those who did watch it you can't watch that and not be disturbed in some way. And that's not to say that all of the other ones that have not been recorded or have not been so blatantly obvious that there was this-- all of these things that were wrong. But there's something about this video I think that really has had an impact on our communities in a way that others have not.

MO: 32:46

One of the things that I was thinking about and I think [it's just?] timely-- as we approach on the 28th of August the 65th anniversary of the murder of Emmett Till, I was thinking about, historically, just the things that we can't turn away from. And for

the listeners who don't know, Emmett Till was a 14-year-old black boy who was visiting his family in Mississippi and who allegedly whistled at a white woman. And his punishment for that, which was extra judicial, was that he was taken from his home, beaten, shot, burned, brutalized. And one of the, I think, important points about that story is that his mother, Mamie Till-Mobley, made a decision to have an open casket at his funeral so that people could really see the brutality of white supremacy. And people, I think, were mocked when they talk about Emmett Till. Not that it started the civil rights movement, but it did make it impossible for people to look away. And it was this catalyzing step, and I think, similarly, when we think about the Black Lives Matter movement, the thing that started around Trayvon Martin. But what we're seeing now in this public murder of George Floyd and maybe even the way that it happened, which for anyone who has seen it, it looked like it was easy for the police officer to do this. And I think part of that has made it so difficult for people to look away. And it holds its own brutality. And so that was just my reflection kind of on this moment and trying to bring some of the history to that as well.

RB: 34:50

I appreciate you sharing that. And I wonder how, Rachel, you feel. I feel conflicted about the need for some folks to see before they believe, to witness brutality before you can act on it. And what Mamie Till-Mobley did was profound and it changed the course of our nation's history. And I am living in a legacy that's so grateful for such an incredible sacrifice of hers, to relive and continue to be exposed to a [whore?] in her own [life?], and to share it for other people to learn. But for people to still ask for that in 2020, my patience is running thin, to be frank. I get that that is also how the civil rights movement worked, by bringing the cameras down and preceding these predictable events of violence between state actors and black folks integrationists, people who wanted their right to vote. Showing that helped the rest of the country say, "Okay, we need to do something about what's happening down to folks in the south." And it culminated in major civil rights legislation that we're all grateful for. It's 2020. How many times do we really need people to go into these streets and get banged up by the police for somebody to say, "You know what? Maybe we shouldn't call that a pillar of public safety anymore. Maybe they actually do hurt people." I don't know. How do y'all feel about that?

RH: 36:38

Yeah, I mean I feel conflicted too, Rhea, I mean, because I think what's happening is we're relying on folks, mainly white folks, to see our humanity, right? I mean, and that's why we started out and why you so brilliantly host the including Toni Morrison's quote in our New England Journal of Medicine piece about black people being loved, right? Because that is missing from the discussion. It's missing from how black people are viewed in our communities, in our society. And so here we are relying sort of on folks to now say, "Oh my gosh, I see that. I value all lives. I value black lives in the same way that I value the lives of my own family and community and children." And that's painful and it's frustrating as hell. And like you said it's 2020. I mean I feel the same way with a lot of the research I do frankly because I'm asking and I'm posing questions that I, as a black person, living in a black body in a black community know the answer to. I know that police violence is harmful to my health and well-being on many levels. But yet, I am conducting the research and getting the research funding and writing the papers to be able to tell that story to convince someone else who doesn't live in this body. It's like this vicious cycle on this game that I'm not sure how close we are to shifting that. I think we're closer than we've ever been but are we there? I don't know yet. I don't know.

DP: 38:24

All three of you have just given voice to something that I know that I felt in the last couple of weeks which is like, this awakening is great but also, it hurts. It's painful too

at the same time and trying to understand why that is and the frustration with sometimes having to prove that water is wet so that we can onto to the next-- to get onto changing policy and doing this work. I want to pivot as a little bit. So you know we've been talking about the relationship between policing and the public and public health. One of the things that's come up over and over again in our team discussions is the relationship between policing and the health care systems, specifically, whether that's you know the security we have in our hospitals or our relationship with Child Protective Services or the criminal justice system. I think it's, in some ways, a younger conversation than what we've been having because it's not in that in that in that mainstream conversation. And I just want to keep it open-ended, and just what are your thoughts about that? And I know some of your work is based on that right now too.

RH: 39:52

I can start with a few thoughts. So I think you're right, we're certainly seeing an uptick of police presence in hospitals and police use and hospital in health care settings to "protect and serve" right? And we know from plenty of research and lived experience that that's not how that plays out and that it's often folks from black and brown communities in marginalized communities that are having that interaction with police and security, some form of security or protection and health care systems and that it doesn't usually end well. But I think it is a newer conversation and one that warrants a lot of discussion. So health care systems just like every other large system, the criminal justice system, the policing system, and child protective services, as you mentioned, they're all steeped in a deep history of structural racism and it's manifesting itself in so many different ways throughout that process. And so some of the work, again, that I've done with Dr. Cyril Long has shown us that folks who have a negative encounter with police are more likely to distrust healthcare systems or medical institutions, right, because these systems seem to all very much operate in ways that are harmful and destructive to the black body. And so we need to be thinking about how those intersect, right, and how when we're working in one area, it's going to impact the other.

RB: 41:37

Absolutely. This is such a critical, critical point because often when we talk about policing and the violence of policing, we think it only lives out there outside of the walls of our healthcare institutions, and it absolutely lives inside in a few ways. So one of those ways is, as you highlighted, that police and security line the doors of many emergency rooms. They are just a phone call away from any hospital bed, and they are deployed to control patients, often their physical manifestations of what could be their symptoms or even disputes between patients and their families that might happen inside the hospital. Another way though that happens that we as pediatricians - and I include myself in this - kind of extend a carceral gaze into folks' lives. As Rachel said through Child Protective Services, that when we refer families - because we're mandated reporters to Child Protective Services - what that often does is just extend their exposure to forms of policing, forms of people who are going to come into their homes and essentially police, how they parent their kid. Knowing that most of those referrals, 80 percent of which are across country, are for neglect, are for folks who actually have material needs in their household that keep them from perhaps parenting or providing for their kids in the ways that they need to. Those families also, along with families who actually physically maltreat or abuse their kids, get referred to the same policing structure. And the risk is the same on the other end that they may be separated from their kid, which is the biggest root of what causes health inequities from policing that you separate families, that you separate kids from caregivers. And that's what triggers that toxic stress response. So I absolutely think those problems live inside healthcare that we demamipend on those problems

sometimes for our own responsibilities in kids' lives being mandated reporters. And that one of the ways that we need to address that is to move towards abolition. I think we, in healthcare, have got to call for police free hospitals and police free schools for kids. And we have to do it because-- I've also often been quoting Harvard historian Leo Wright Rigour on this, "Black people don't have sanctuary." There is nowhere black people can go to not be inside a carceral gaze or at risk of experiencing police brutality. And hospitals and our kids' schools are those places. And we, in healthcare, have to be building that sanctuary for folks as they're human right but also as a health intervention for people.

RH: 44:19 And just to put the period on the end of that beautifully stated sentence, that's exactly what we wrote in [inaudible] was that our fifth point was protect and serve and that healthcare systems have to play a role in protecting and advocating for patients. If there's going to be any institution that protects and serves, it should start with our healthcare delivery systems.

RB: 44:45 And then one thing I'll add to that, because there are these really beautiful movements like Care Not Cops that are saying, "If we're going to divest from policing knowing that these aren't anchors of public safety for many of our communities particularly, black and indigenous communities. That we should then, invest that money that we divest from leasing into care infrastructures. But I always say, when I say that, that is not just care infrastructures as they are currently conceptualized, deconstructed, and live in people's lives. I'm not saying, take money from the police and invest it in academic medical centers or invest it in hospitals, right? We're talking about also transforming the ways that we care for folks and who we include in our workforce as a part of redress for our own contributions to the racial wealth gap because we exclude non-white folks from even working in our industry.

RH: 45:37 Right. So this is our opportunity, right, to reimagine?

RB: 45:41 Correct.

UE: 45:41 Well, I'm in a lecture right now. I know I'm very jealous of Rohan. He gets to sit through your lectures, Dr, Hardeman. I feel like the words of Stolen Breaths in New England Journal which now has over 120,000 views - for folks who still, for some reason, have not yet read it - are coming out into voicing this moment. And this is really an amazing discussion. I really appreciate y'all. So as we think about what to do with all this amazing information, I want to turn it back to you Dr. Hardeman because you'd mentioned back in 2016, after the death of Philando Castile, that everyone else was silent but you and your colleagues were not. And you published this piece in the New England Journal of Medicine back when racism was not in, back when every week there wasn't another amazing black author dropping street knowledge and bombs in that journal. But you and your colleagues wrote about the role of the health professional in dismantling structural racism and supporting black lives. And in that article, you note that clinicians need to master learning the way structural racism actually affects health. So as in the series with this episode, we really hope that this is just an introduction to that conversation. And you guys have already really provided us with a lot of key steps based on that history. But I'd love to hear from your perspective, what should student trainees, educators be thinking about in this moment and addressing that point about how structural racism affects health?

RH: 47:18 Yeah. I mean, I think there's so many things and we probably don't have time to talk about all of them. But I think it starts with knowing that history, right? I mean, I was shocked that the number-- I shouldn't be shocked at the number of folks who just don't know the history of racism in the United States and the way that our country

was founded and built, and what that's meant for medicine and healthcare delivery. I mean, it's completely absent, as you all know, from much of the medical education curriculum. And so that has to be a starting place. And when we wrote that 2016 New England Journal of Medicine piece, part of it was healing for us and sitting with the pain of Philando Castile's murder. But also, in the deafening silence around us, as I described. But also, to make sure that our colleagues know that as clinicians and as health services researchers, we don't get to just sit idly by because we aren't policymakers or we aren't community organizers or community activists, but that we all have very specific roles that we can play in dismantling the systems that have allowed so many of these murders to happen among all of the other health inequities in our society. And so it's asking folks to really start to interrogate all that they've learned, all of the ways they've been socialized to think about race, and to really begin to break that down in ways that allow them to understand that racism social construct and not a biological one. And that because of that we have built a system and a society based on disadvantaging folks because of the color of their skin.

UE: 49:11 And maybe I'll pose it to you as well Dr. Boyd. What about for researchers? You had the amazing opportunity to sit before Congress via Zoom. But policymakers, how should they be thinking about this moment as well?

RB: 49:25 Yeah. On this [inaudible], people have a lot of work to do. And part of why this needs to be a professional competency is it needs to be acknowledged that if you're not doing this work, you're not doing your job. Whether that's a job as just a clinician who cares for individual patients or whether that's a policymaker or an administrator across our health care systems. This is a part of what you should be expected to know. The same way that you have to know how to solve acid-base crises, how to recognize a patient who's sick or not sick. The same way that you have to know these core components of how to be a doctor, you need to know the core components of how racism affects health to be a doctor effectively in 2020 in this country. And if you're not doing that, we all should be-- we all should be acknowledging that you're ill-equipped, then, for a leadership role, to be an administrator, and maybe even to just directly care for patients. That's how critical this competency really is. And for folks who still kind of doubt that these things are related, we also have to question how our field has situated-- how many who work in our field are situated in very particular racial and class status. Doctors are well paid. We profit off of disease. We are a field that's predominantly white at every level. We understand that having that confrontation about how racism impacts health directly implicates how you might live and move in the world, how you have your own social mobility and economic mobility in the world for you and your family. And I think that's why it's difficult for people. But it's not an excuse. And it's not enough anymore because if you want to be working in this care profession, we all have to be doing something about it. And I would hope that folks will not stand in the way. If you don't understand it, then just stand aside and recommend somebody else for that leadership position. If you aren't sure about how to treat that patient, stand aside and offer them to a clinician who really understands. First, do no harm. And while you're doing no harm, learn as much as you can. There's one thing I wanted to highlight. One of my colleagues and friends, Sidra Bonner who is a surgical resident at the University of Michigan, wrote a paper about how, in surgery, they could start to understand racial health inequities and how it affects surgical outcomes. And she wrote the paper because there was evidence to suggest earlier this year that two-thirds of surgeons, actual doctors who are operating on real human beings, don't think racial health disparities exist. And it's unconscionable at this point. You should not be able to interact with human beings in a health care setting if you don't understand these things. So hopefully making it a

professional competency in as many ways that we can and institutionalizing that will help us kind of move the needle for folks.

MO: 52:22

Wow. I also feel like-- I feel like I'm in school and church. But this has been phenomenal. We've covered a lot and still, I think we all feel like we wish we had a few more hours to talk more. But I think ending with those thoughts is a perfect way to wrap this up. And also, just a reminder for people listening, we'll definitely have show notes. And some of the resources that we've been talking about today will be posted on the CPSolvers website. But to close we thought that, for this series in particular, we would ask each of our guests that come on to try to share some pragmatic advice with our listeners. So for our listeners who are going back to the clinical world tomorrow, the question is-- what's one thing that they can take with them and start using tomorrow? And I was just going to add one reflection from this talk for myself is-- and this is kind of a big thing, but I'm going to work tomorrow. And mine is, "How am I building sanctuaries for my patient?" So that's something that I'm going to reflect on and think about in my own clinical practice, but I'd love for you both to share.

RH: 53:42

Yeah, and that's such a good question. I mean, I think one of the things that-- and [Rhea?] started to talk about this a little bit in her final comment-- and it's something that I think is often left out of the discussions around around structural racism-- is power and who has power, and who's willing to give up their power to make health equity a reality? And so I would encourage folks-- and that might not shift exactly what you do tomorrow in clinical practice, but walking in the clinic tomorrow thinking about and critically reflecting on power and where you wield power and where you don't and where those around you and your patients have power or or not-- I think we'll start to really move some of the conversation forward about racism in the clinical setting.

RB: 54:41

I love that. I think I was going to say something really similar. We opened up talking about definitions, and I just want to provide the definition of white supremacy that I put in this paper in The Lancet, The Case for Desegregation, where I described that white supremacy is one of the processes of racial exclusion and discrimination that constructs and maintains a racial ordering of humans and resources that do various acts of violence or deprivation, justify, and enforce the racial dominance of whites. I want to end by talking about white supremacy because it's by virtue of it acting through acts of violence, as we've talked about with policing, but also through acts of deprivation through creating forms of scarcity that white supremacy also hurts white people. I think often when we have these conversations we talk very much so about disproportionality, and we should because Black folks and indigenous folks in particular-- and around other forms of policing like ICE engagement with communities, indigenous immigrant communities, and particularly undocumented communities, have certainly faced the violence of white supremacy. But it hurts white people too. It hurts everybody. This is a root of why we have decreasing life expectancy in the country. And if I was going to ask anybody what they could do tomorrow, it would be to examine ways that you either benefit, prop up, or kind of ignore how white supremacy is operating in your current work environment and maybe beyond that in your neighborhood. We need to be able to name ways that we are creating either violence or deprivation in people's lives so that certain racial and ethnic groups like white folks have more advantages than others. And once you can actually name those ways-- that's when you know exactly where to start. Once you know that, "Oh, that policy is going to try to give more to these people who live in that form of housing, and that form of housing is predominately white-- I'm against

	it." Right? And I'd say as we come up to this election there's a major way to try to undermine white supremacy in office. [inaudible].
UE: 56:49	Wow. So thank you again so much, Dr. Hardeman, Dr. Boyd, for joining us on this, our inaugural episode of the clinical problem-solvers, anti-racism, and medicine series. You both are definitely welcome back. We'll make you all t-shirts-- whatever it takes to get you back on before you guys get too big for us. But I just wanted to express our gratitude.
RH: 57:12	Thanks so much for having me.
RB: 57:14	Yeah. Thank you so much. I hope you [inaudible].
RB: 57:20	When you introduced Rachel, in my mind I heard those foghorns, and like, "[inaudible]". That's how I feel when I'm on anything with Rachel. Like, "And here's Rachel."
RB: 57:32	But she's dope. Anyways.
UE: 57:34	[crosstalk] reactions don't quite cut it. [inaudible].
RB: 57:36	People [crosstalk] see our joy [laughter].
RH: 57:39	Yeah. And the feeling's mutual. So [laughter].
MO: 57:43	But for real, though. Could we get those foghorns?