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Speaker Legend:

DP: Dereck Paul, MS
LN: LaShyra "Lash" Nolen
RK: Rohan Khazanchi
EL: Edwin Lindo, JD

Transcription results:

DP: 00:11 [music] This is Dereck Paul. And welcome to the Antiracism in Medicine Series of the Clinical Problem Solvers Podcast, where, as always, our goal is to equip our listeners at all levels of training with the consciousness and the tools to practice antiracism in their health professions careers. Today's episode is titled Dismantling Race-based Medicine, Part One - Historical and Ethical Perspectives. And I am just beyond excited to be cohosting this episode with two of my colleagues and Antiracism in Medicine team members, people I admire a lot, learn a tremendous amount from every day, LaShyra "Lash" Nolen and Rohan Khazanchi. So I'll hand it over to Lash and Rohan to introduce themselves and today's guest, who many of you will know already, a critical race theory scholar, Professor Edwin Lindo.

LN: 01:05 Amazing. Dereck, it's so great to be here with you, Rohan. Always a pleasure. Just to introduce myself, My name is LaShyra Nolen. Most folks know me as Lash, and I'm an LA native, now at Harvard Medical School in my second year, where I'm serving as our student council president. I'm very passionate about this work. That's why I'm so blessed and excited to be a part of this team. I write about these issues a lot, speak on them often on panels, and doing different presentations, and I'm just stoked for our conversation.

RK: 01:37 Yeah, totally echo everything Lash said. I'm really excited to be here, even more excited that Professor Lindo is joining us today. My name's Rohan Khazanchi. I'm currently an MD/MPH student, getting my MD down at University of Nebraska Medical Center in Omaha and doing my MPH this year at the University of Minnesota School of Public Health in Minneapolis and completely echo what Lash said. I think we're all here because we care about these issues. These are our passions; these are our professional interests and the ways that we spend our personal lives outside the classroom too.

RK: 02:07 So I want to introduce the series that we're starting with today's episode. This is episode number one in a three-part series on dismantling race-based medicine. And our goal for the series is to answer fundamental questions: What is and isn't race? How have the ways our medical community defines race changed over time? And most importantly, how should we think about these issues in the context of ongoing discourse about racism in medicine and beyond? So today, we're going to take a deep

dive into the history of how racial categories have been defined in America. We'll talk about why it's important to distinguish between concepts like race ethnicity, ancestry, and genetics. And we'll think about how the medical field's dark history of scientific racism plays into the broader struggle for racial and health equity.

LN: 02:49

And I am so excited to introduce our esteemed guest Professor Lindo. Edwin Lindo, JD, is a critical race theory scholar and educator, who is an acting assistant professor in the Department of Family Medicine at the University of Washington School of Medicine, assistant dean for Social and Health Justice, Office of Healthcare. Edwin teaches, presents, and writes on issues of racism within medicinal society. He's also the creator of The Praxis Podcast, which I'm so lucky to have been a guest on. It's a vibe, y'all. Please check it out. And you can reach Edwin on Twitter via @edwinlindo.

DP: 03:29

Edwin, thank you for being here with us. I get the honor of asking our first question. I'm going to start off with a question that I think seems sort of easy, but it actually is more difficult, and that is, what is race? It's something that we are all-- it's part of our lives from the moment we're born. Honestly, before the moment we're born, it's playing into our lives. But sometimes, folks are a little later in life before they start thinking about it critically so if you're new to this conversation, someone's having one of your students, and they ask you, "What is race? How do you think about it?"

EL: 04:10

Yeah. I tell folks, when we start talking about race, we start talking about racism. In many instances, it's like doing quantum physics because at its core, it doesn't actually make sense. And what I mean by that is we have something-- and so I'll get into the definition. You have folks like Dorothy Roberts and other critical race theory scholars that have guided us towards an enlightening definition of race being a socially, politically constructed taxonomy. And I use this definition a lot and I go on to say, "And it's based on perceived skin color and, oftentimes, culture, with no scientific or biological determinacy of the physiology, used for the purposes of allocating resources," right? If we get to the core of why race was created, it was for the purposes of allocating and or extracting resources from Melanated Black people when they were stolen and brought to this continent. If that's the beginning, then we really have to wrestle with that beginning, with the impetus of it. Now we are in 2020, and folks that [inaudible], and people always just [inaudible]. Well, great, we should just get rid of the concept of race, and we'll be a unified human race. And you'd say, "Wouldn't that be nice?"

EL: 05:35

Race, from the beginning, was something that was created. I know we're going to talk more about that. And it was created by folks that will name very clearly. But we have to sit with the reality that medicine has grafted the social-political endeavor of race to what is believed to be a physiological determinant, a biological identity. And the truth is that's just not accurate. And we know it's not accurate, and we'll talk more about that. But it's now our job to start ungrafting, removing that graft, and saying, "Actually, there's a huge difference." One is the social construction, and social meaning, it's not just the white scientists that created the concept of race, but it's also us engaging with each other. That's why I don't think we need to get rid of race because it helps us identify with each other, understand what solidarity looks like, understand different struggles, understand culture, food, ceremonies, traditions, religious beliefs. And that's beautiful. We can embrace those differences. And race helps us identify those. What it doesn't help with is identify how we are biologically different, yet people can't disassociate the two. And I think it's our job to say, "It's okay that someone identifies as black. Someone else identifies as Brown. Someone identifies as Asian. That's beautiful." It's unhelpful when folks start trying to identify how those different categories are physiologically different from each other. So long answer but that's what-- and how I see race.

LN: 08:15 Yeah. Thank you for that. And that whole statement was a word. And now I'm just wondering if you could talk a little bit more about the history behind that. And we often hear people say that race is a social construct. And I'm wondering if you could also touch a bit more about, what do we mean when we say that?

EL: 08:36 Yeah.

LN: 08:36 And talking a little bit about about how history and where we're at now kind of comes together to create this moment.

EL: 08:42 Yeah. I mean, race is only a social political construct. Now that delves into a deeper question that, I don't know as a society, we're equipped yet to wrestle with but there are some people that say, "Well if it's a socially, politically-- a political construct that was created by white folks, then why are we still holding onto it? Why do we still identify with the colors that Johann Blumenbach and Carl Linnaeus created?" That's a different conversation, and I think it's a needed one. It's a different conversation because-- I'm going to start from the assumption that race is beneficial in the social endeavor and social project, again, like I mentioned, to identify and engage with each other. But when we get to the question of what it means, it means that the project-- I keep calling it a project because it isn't something that finishes, right? Race is changing, at least, the way people view it, mixed race, multiple races or single race folks. What does the identity mean? I think it depends on the consciousness that we're bringing forward to this conversation. But we are the ones that give value to the concepts. And it could be a positive one or it could be, as we've seen throughout time, an incredibly negative concept. And the reason I say in my definition that it was used for the purpose of allocating resources is that you have Johann Blumenbach, Carl Linnaeus in 1767 writing the book Systema Naturae, and he literally created taxonomy. There's an apex of the taxonomy, and there's folks who are at the bottom of it. And if you look at that taxonomy, you see how resources throughout history in this country have been allocated, black and native folks not getting many of them. European and Asian folks, Asian folks getting slightly more. White folks perceived as the most intelligent. You have Carl Linnaeus that says that they are intelligent, they are witty or - sorry - they are smart, they are imaginative, and they are governed by laws. That was the categories, the definitions associated with the color to perpetuate this racial taxonomy. And it's not an accident. What I mean by that is there was a vested interest in whiteness as a property right to ensure that certain racial categories were at the apex of this taxonomy and certain groups were at the bottom of it. What we need to sit with is, how do we ensure that our social relationships around race are not the conversations that we have in the biological round? Because they're not the same. And so you ask about the history. I am a believer that medicine is the reason we see the racism that we witness today and here's a lot of physicians who are listening, a lot of clinicians that hear me when I give my talks and they say, "Edwin, how dare you critique medicine, you're not even an MD?" And I say you don't have to be an MD, to understand how racism works. And in observing it, what I've seen is that from the beginning, from Portuguese, the Portuguese coming to West Africa using the term negro, stealing, and forcibly taking slaves into chattel slavery. You have the British, and you have the Dutch and a number of other European countries that further endeavored in this project of slavery in chattel slavery. And I always ask the question like, why, why did this happen? And when you land the United States in the 1619, project-- or not project, but in 1619, when the first slaves were sold in an auction block, guess what you had doctors that were at that auction that were hired by slave owners, and they were effectively they were the physical checkup for those slaves, because they were paid to ask a question, are these people equipped to do the manual labor that we're expecting them to do? And to know that medicine played an

integral role there and then pulled it even further. I said, "Not only is our job to ensure that this laser fit, it is also our job to ensure that we create a scientific concept of race that makes sure that these people, meaning black folks, are in a place that we get to control them." And I'll talk more about it. But it is a conditioning of medicine. People say, "Well, Edwin, it was political, it was legal, it economic." And I say yeah, but all those things couldn't have existed until science and medicine let the world know that we were physiologically different people, right." Segregation doesn't exist unless white people think that black people are physiologically different, that they are inferior. And where do you think they got that idea from? They got it from science, they got it from doctors, and we have evidence to prove it.

DP: 14:28

Wow, Edwin, I appreciate this conversation so much. And what I'm sort of hearing you say is that human beings, we kind of, we develop race as a part of an important mechanism to subjugate people. And that medicine plays a role in sort of providing the various rationales for that, that are sort of now proved not to be the case, but about these ideas of biological inferiority, superiority in this way, in that way, and that is an important piece of how you understand what it is that we're talking about here in the first place.

EL: 15:15

I'm going to if I may, quickly, I want articulate some specificity. So I wouldn't say, humans. So I focus my work in the United States. And in the United States, it's white folks, right. There haven't been black folks, or there haven't been Latino folks, there haven't been indigenous folks that use the concept of race to oppress any other group in the systematic way that white folks have done here. Right. And I think that's important because there's many white folks who say, "Oh, well, slavery existed across the globe." Yeah, but it was never actually based on the false articulation of physiological difference based on color. It was either you lost the war, it was religious persecution, but it wasn't race or something about the United States they said, oh, this is the thing. This is where we can gain and manage and hold the control of marginalization and oppression.

DP: 16:11

Absolutely. And I want to touch on one of the points that you've made here, which is that folks say to you if race is not biological and it's not based in physiology then it doesn't exist. So shouldn't we act like it doesn't exist? Shouldn't we perform colorblindness? And the problem with that because there are all of these-- because this social construct is extremely real and the implications are extremely real, the laws are extremely real, the genocides are extremely real, the enslavement is extremely real, the segregation is extremely real, and colorblindness also erases all of that. So not just in where we lose some of that richness that you're talking about, but it also does harm when we're colorblind to race.

EL: 17:20

Hugely. I mean absolutely. It's a huge impact on it to the extent that colorblindness and this is actually at the heart of critical race theory it is to critique racial liberalism that we see no color, things are fair, if you work hard enough, you'll make it, stop harping on race as you're oppressive variable that you can't control, and I push back and I say, yeah, if we actually treated everyone equal at this moment in time, and it's exactly what you're saying, it's an erasure of all the inequality and inequity that existed before this moment. And it's the same thing we're seeing with the allocation of scarce resources during the pandemic, right? We ask questions. Who gets the ventilator? Who doesn't? It's someone who has survivability that is better than the other person. Well, if you're coming with a preexisting respiratory disease, your survivability is lower, but no one is considering that you have a preexisting respiratory disease because you live on the south side of Chicago with the highest rates of asthma, and you come into the hospital predisposed to this because of racial segregation, redlining, and systemic racism. So unless we consider that then we're not

actually treating everyone equal. We're just furthering the disproportionate impact that occurred in the past, blinding ourselves, and saying my job, and doctors do this all the time, my job is to treat everyone the same, Edwin. Why would you ask me to treat them differently? I said because you already had. And Professor Kimberlé Crenshaw tells us when there is a disproportionate impact that harms people there needs to be a disproportionate impact in the solution, which means we will be treating people differently, not because of the color of their skin thinking there's a physiological difference, but because of how this country treats people who are of a darker hue. When we hold that then it's, yeah, some groups do deserve more, and it's not deserve more so that they get extra, it's literally to just bring them to the starting line.

RK: 19:34

Yeah. Everyone, I think this is really, really powerful and I hope we can dive a little bit more into how to rectify, how to repair, how to reconcile with the harms that we've created in American society because of how we've stratified focus by these phenotypes that we're rooted in medicine's perception of biology, but are just phenotypes, are our perceptions so I kind of want to dive into that a little bit because I think you started there. And I think it's important for our learners and listeners who are thinking as future physicians, as future providers of health care, but maybe don't know the history of the role medicine played. How has medicine played a key role in defining this social and political characteristic of race throughout history, thinking about folks like Linnaeus, like Morton, like Cartwright, these key examples of how medicine justified the subjugation of racial groups by attributing their race to being associated with biological inferiority?

EL: 20:39

Yeah. And it runs deep, again, going back to the early 18th century, going even before that. And I won't dig too far into it. But science and religion in the early 18th century and 17th century were like cousins. You can't read a scientific journal that didn't mention God. And so religion was used in the medical sphere, in the scientific sphere to publish to say, "Not only is this scientifically true, but the deity God has told us that these people should be subjugated to slavery, subjugated to differential treatment." But it started-- if we think of chattel slavery era, you have Samuel Cartwright's, that's created the spirometer, who said, "I'm going to measure lung capacity. And I'm going to measure lung capacity of the slaves," that he owned who have worked for weeks and days in the scorching sun, and compared their lung capacity to his, and said, "Well, there's something wrong with these folks. Their lung capacity doesn't seem to be equal to mine." Yeah. Let me work someone nearly to death, and then, asked to get their lung capacity measurement and compare it to mine when I'm just watching them. And then it becomes this false idea that there is innate physiological difference, and I mentioned this point because - guess what? - that data that he published researching his slaves was then used by life insurance companies to not give life insurance to black folks, post-slavery and reconstruction, saying, "Well, you are more likely to die because of poor lung, strength, and capacity. And therefore, we're not going to give you life insurance." We then fast forward today, and Lindy Bohm at Penn has written extensively about this, Professor Lindy Bohm, about how even to this day, we have this parameter machines that use race as a factor in calculating respiratory function. That's wild.

EL: 22:56

Let's back up a little bit more before Samuel Cartwright. You mentioned Samuel Morton. You mentioned Samuel Cartwright or Samuel Morton. And there's even just [inaudible]. But these were folks who were partly genesisists, physicians who studied at Penn and Harvard and were professors who believed that people of different races were of a different origin. And that's why they, in their mind, were able to rationalize that one group was inferior versus another. And you had evolution, a concept that existed that they didn't agree with from much of the time. And Darwin was like, "No,

you got to believe this because the evidence shows it." And their response is, "Well, I don't know. I don't know if your evolutionary theory is true. But what do we know about species of a different kind? They're unable to do what?" They are not able to procreate. You can't make anything if you are of a different species we see the history. You had white slave owners that were having children by women on the plantation, Black women. That completely destroyed this concept. But again, they knew that. They knew it. So they were willfully making up these things to maintain the power that they had. They finally accepted Darwinian evolutionary theory and said, "Yes, we'll accept it." However, Europeans are still evolutionarily-wise leaps and bounds beyond Black folks and Native folks. They even say in published pieces, that Black folks are Native folks are just one step above the chimpanzee in the evolutionary chain, and that Europeans are, at least, four evolutionary chains away. And therefore, we should hold the construct in the systems that we currently have. Again, a rationalization, we fast-forward into the early 1900s and you had Eugenicists, you had social anthropologists that were pathologizing Black folks at the ends of reconstruction, suggesting that Black people had a predisposition to crime, to violent crime. In the 1920s and 30s, when this was at the forefront, you had Nazi Germany bringing over researchers to study how we, the United States, were doing such a good job of subjugating black people, that they used those tactics to do the same things to Jewish people in Germany. That's how terrible this country has been, has continued to be. And yet we don't feel we have to still make the argument for it.

EL: 25:57

I'm getting tired of having to go up to argue with people that racism is not just something that I made up, but it happens every time in 2020. And the response, "Well, Edwin, what about heart disease or what about this comorbidity? It is just, it has higher rates in black people?" Yes, it has higher rates in black people because we've subjugated black people through the arms of racism, and strangled a community intentionally. And then, you want to talk about gaslighting and then tell them, "There's something wrong about you that we can't figure out." There's other things against it, but I'll stop there.

LN: 26:47

No, 100%, I think that everything you're talking about is the experience that a lot of us have when we're sitting in lectures, and we talk about all of these disparities, whether that's hypertension, diabetes, and they give us this graph. And clearly, we see Latinx, Black, and indigenous folks who are dying disproportionately from these diseases that are preventable, but there's no context given. And it kind of makes you feel like this is inherently wrong with this group. And I think a lot of our colleagues who don't get this education, they leave thinking exactly that. So, I mean, you go into this a little bit, but I'm wondering what are some ways that this is an example of this willful knowledge that these things are happening, but then choosing to ignore it in order to really maintain power?

EL: 27:41

Yeah, that's the interesting thing about the scientific method in science, is that it believes that it is apolitical. But the history and the data shows us that there is nothing apolitical about medicine. It has been political since day one for the purposes of holding power, maintaining power, excluding people from the spaces of power. And I do think when you talk about science, it is the same in law. People say, "Oh, Edwin, I'm not racist. This is just what the law tells us we have to do," The same in science. "Well, I went through the scientific method, Edwin. And I can't be racist because I use this objective truth." I said, "But the scientific method is only as good as the variables that you input into it." And if you aren't being critical of what you're imagining, the questions you're asking, what you're researching, who you're researching, how you're doing that research, then the biases, the history, the legacies - they seep in whether you wanted them to or not. And speaking of your colleagues or classmates, there's always someone who is like, "Well, I'll play the devil's advocate

here. What about hypertension, right? They tell us that black people's response to channel blocker versus ACE inhibitors is different." And I'm like, "Yeah, well, what about the data that tells us if you use a dual therapy and you add a diuretic, that difference disappears. So clearly, it's not race. It's something else that we don't know, but we don't actually want to dig into it." There is something innate in this country that it wants to hold the fundamental, physiological difference. And some people say, "Well, it's because our minds were tribal and we want to hold differences, and it's just tribalism, Edwin." And I'm like, "No, it's not. There's people around the world throughout history that have lived without subjugating other people. That exists. It's a thing." What we're talking about is the property of whiteness. And this is the second time I've used that term, so I want to explain it to folks. There's an amazing critical race theory scholar named Professor Cheryl Harris, who wrote the piece called Whiteness as Property. And she outlines and explains that the property rights, in legal terms, is an expectation. That's all it is. It's an expectation to be able to do something. So with your land, if you own land, you have an expectation to put a fence up. You have expectation to own the air rights, the soil rights, to move soil, to sell part of the land, to put a sign up. You have an expectation to do a whole lot. Now, if we place that and transpose it onto whiteness, white folks have an expectation to walk into a bank and get a loan. They have expectation to walk through a store, corner store, and not get followed. They have expectation to not get pulled over and killed by police. They have expectation that they can go into any neighborhood they want to. But if they have that property right, that means it's at the exclusion of someone else's rights because when I walk into a store, I keep my hands in my pocket. When I see blue and red lights, I make sure I slow down, or I try to not bring attention to myself. If I am stopped, I've been explained by my dad that you keep your hands on the wheels. You put your hands on the side of the door and roll the window down. Why is this? Because I don't have the property right that white folks expect. How do we deconstruct that white folks shouldn't have a property right. That that property right is the privilege of whiteness. And in that privilege is actually at the exclusion, at the denigration, and dehumanizing of other communities even when they say they don't want to be doing that. But it has to start from the beginning of, "I don't actually think you are physiologically different than me," because if we can't get over that hump, then we don't actually get to solidarity. Right? Solidarity exists because you think that my liberation is attached to yours, but you can't think that if you believe that we are of a different kind. And so I struggle when people are like, "Oh, that's the Black struggle. That's the Latino struggle. That's the native struggle." I feel that conversation unfortunately adheres to the construct that these are different people. Yes, there's different experiences; there's different maneuvering through the world. But solidarity means that their freedom, their justice is attached to mine, and that's why I will fight. I will fight incredibly hard for it.

DP: 32:40

Edwin, oh, man. We should've had you on the podcast right away because I think this is absolutely fundamental conversation that we're having. And the point that you're making about needing to deconstruct these false beliefs about about being physiologically and biologically different as, sort of, being foundational to so much of the rest of what happens. And I think what I'm understanding as we're having this conversation is that, actually, the racism in medicine isn't just a piece of the conversation, it is, in some ways, at the base of the conversation. And what we're doing is extremely important for that reason. I also just have to appreciate you for talking too, about your own personal experience walking through this world, walking through this society, walking through the US. Because I think sometimes even as we get deep into these conversations whether it's on the data side or the philosophical side, sometimes it's like, "I know these things to be true because I've lived them in my own body." And sometimes you're out here trying to explain this to folks or convince

them with data when I know this to be true through my own lived experience, not just the ways that-- I may not have those property rights, but also, I've seen the way this social construct plays out and different people relate to me in different ways and different spaces. And from being myself I know that I am just as much as, just from being me. So I just appreciate you bringing that in.

DP: 34:58

And I also wanted to make a pitch for a book. I think there are so many-- we've already mentioned many great scholars. Isabel Wilkerson has a new book *Caste* and she references and borrows from a lot of other folks who are scholars in the area, but I really like it because it's a very personal book that talks about her walking through the world. And she talks about some of these things that you've mentioned already about how preventing interracial relationships and marriages were so key to keeping racial caste systems. She talks about the things you mentioned in terms of the rise of the Third Reich in Nazi Germany borrowing from some things that were already happening in the US because there were so effective at disenfranchising and subjugating people. And she actually looks at caste systems in India and she looks at how these ideas are related and not related. And I like edge cases because they sometimes help me understand what it is that we're saying. And one of the things that she says that I think was really interesting point to me and was about the way that sometimes the success of one person can actually be important to reinforcing the fact that racism doesn't exist, right? "Look at that person," whether it's-- Barack Obama is probably the biggest example, "There's no racism." And I think that happens too, in medicine a lot both within the conversations on racism in medical education and the conversations that we have around racial disparities. She references some interesting data about how racism plays out when you switch your social context. And maybe you're a person who's now living and working in a predominantly white institution or sort of environment and how racism works on and whether it's the body in that way. So just want to make-- I think that's a-- these are important things for us to think about, and so, people have the privilege of not thinking about them. And so, if you're there, I would just encourage folks to sit down and do the work and put some time into those sources that we're going to share. We're going to share so much of your work after this and also some of the other scholars that are doing some of this important thinking.

EL: 37:48

Yeah, I want to highlight two points because I have this conversation. And oftentimes, it's white folks, many non-black folks, many Latino folks like myself, who are struggling. I have colleagues that are Latino that-- they're like, "Edwin, I get you, but I don't really get it." And so, there's two things. One is to get clarity on how useless or race is in the biological endeavor of studying the physiology is that race changes the moment I change any nation states boundaries. That is, if I go to South Africa, my race is different than here in the United States. I go to the Middle East to a country; my race is different. If I go to South America, my race is different. I go from mestizo to colored to Latino to Central American to indigenous. If that is the construct of race, how is it that we're using it in science? Because even as a society, don't agree that there's a universal language of race. Yet, we're going to take data points to say that someone's kidney responds differently to a white person's kidney and use race as the holding variable. Now, some people say, "Well, then I'll stop using race in my data." No, that's not what I'm saying. What I'm saying is, we need to be precise in the way that we use race. That is, if we're going to study race, we should understand how race has affected health by the concept of racism causing that impact. So we should be studying racism as the risk factor that is harming our communities. That's point number one. Number two is, I was hearing you, Dereck, and I still remember the conversations if someone's like, "Well, Edwin, prove to me that what you're saying is true." For a couple years now, I've decided to say, "You know what? How about you

prove to me that I'm biologically different? I need you to go do the research. I want you to go dig into those papers because you're really just responding to what you heard in class. And that was like two-and-a-half slides. And more often than not, those slides are based on UpToDate. And if you go to UpToDate, and you look at those peer-reviewed journals, and you dig into it, these folks have no idea what they're talking about when it comes to race." Yet, we're taking racial understandings of humanity based on scientists that have never had to study race. And they think they know what it is they're talking about. But I asked him, "How many of you have defined race in your publications?" 98% of them say, "No, I never have." "Great. So if you haven't defined it, then how the heck we know we're talking about the same thing?" Because there's Latinos who are in the Caribbean. There are Latinos who are in Central America and South America. There are black folks who are Caribbean, West African, South African, Canadian. Who are we talking about? Because you're unclear, and your lack of clarity is actually going to kill people. So we need to be intensely clear in what it is that we're talking about. And so, I think if someone were to say, "Well, what would you encourage for looks to do, I say, "Let's assume the position that science, when it comes to race, has been wrong. And let's start building from there."

RK: 41:21

Yeah. Edwin, I think that's so excellent. And one other observation I'd make, you're talking about how across geographic space race is defined differently. I think across time, race is defined differently too. And one of the examples that I often talk about is, our own US Census has changed our racial categories repeatedly throughout history. Every ten years seems like we get a new set of boxes to put people in. And I think that's so important because it shows that race is dynamic, right? Where you are on the world, where you are in US history determines, maybe, what your race is and speaks again to this point that the racism, the experiences that people have because of their race are the risk factors, not race itself. And the burden of proof falling on us to prove this in spite of little evidence that proves the contrary, I absolutely think your point here is very strong that as scientists and as clinicians, we need to be clear about what exactly we're talking about when we're defining these problems. And the other thing I'll add is coming back to this point of-- this has to start with, "You are not physiologically different than me." Something we talk about as a podcast team all the time is this starts in med ed. This starts with medical education, how we teach the future positions of our country.

RK: 42:36

So I want to have one more teaching point, maybe, and have you kind of break something down for us. I think a lot of folks can understand this notion that structural racism and structural determinants of health, that kind of lie upstream of the way social determinants are distributed, right? These risk factors that we understand for chronic diseases, that's maybe more believable for folks, right? Policy shapes the way resources that are distributed across modern society. As a result, certain groups are disadvantaged. Others are advantaged. But another myth that I think is harder to debunk for some folks is, "Oh, what about sickle cell? What about cystic fibrosis? What about diseases that seem to be linked to race because of ancestry or because of genetics?" So the question that I would ask you to, maybe, answer for our listeners is, "Is race a good proxy for ancestry? Is race a good proxy for genetics? And can we kind of conclude based on the fact that the prevalence of sickle cell is greater in black populations, or the prevalence of cystic fibrosis is greater in white populations, that race is linked to these diseases?"

EL: 43:39

That's a great question. I'll answer it simply. And then I'll answer in a more complex way. No, they're not linked. The example I always give is, if we put white folks in the exact same situation that they put black folks in, they would have all the comorbidities that we're witnessing in the research because it's about the conditions that existed and that were created to maintain power, right? If it was white folks that

lived in most of the African continent, heading into South India and Eastern Europe, yet they would be the ones that have the highest rates of sickle cell trait. But they're not. And the reason there's a high concentration of black folks in the United States is because we stole them. We stole people from their land and brought them here. And we concentrated the populations in this country. But there is white Eastern Europeans that have high rates of sickle cell trait. I know, and white individuals that I've taught, who came to me and said, "Edwin, I went to my primary doc. When I was a child, my parents were like, "There's something wrong, and we think our child has sickle cell." And the doc was like, "No, he doesn't. He's white," and wouldn't do the test. And so they had to find another provider. This innate belief a physiological difference is killing people black and white and everyone in between because of the lack of precision. You're asking the question about genetics and ancestry. I think if we're going to be precise in medicine we have to focus on geography, where are people from because geography explains a whole lot, explains the environment, it explains nutrition, it explains the weather, it explains the evolutionary process, regardless of the race if we're actually trying to find out what the genetic differences are, but when I start seeing journals that say, oh, black people have a greater concentration of this [ileal?] and therefore their kidney is going to respond differently, and I'm like that doesn't even sound right because if it's true then that means all black people should have that ileal if race is the variable, but if only some black people have the ileal then it's not because of race. It's something else. What is the thing that those people with the same ileals have in common? Our eyes see race. Oh, well, they seem to be black. But there must be something. Maybe they're from a similar geographic region. Maybe it was the food that was eaten. Maybe it was the genetic response like sickle cell trait, which was a genetic evolution to malaria, right? The malaria belt across that region I just mentioned is the reason those folks in those regions have sickle cell trait. Put the malaria belt in any other part of the world you would see the same response. So if we detach ourselves-- and I always ask the question, I asked particularly our white colleagues like why are you so attached to try to prove that I have a different bodily function than you do. What does that bring you? Does that add any value to this relationship? Does it add value to science? Because I haven't seen the value. Because more often than not it's an inclination to get to the point of where there seems to be a difference in outcomes and we have many of our colleagues, and I forgot her name, if you know it, please shout it out, but where they call it the racial disparity complex, industrial complex where, oh, let's study all the racial disparities that exist among comorbidities. Yeah. We know they're there. I want to know the question of how do we prevent them. How do we deconstruct racism causing these disparities? But then going back to asking colleagues how does this benefit the relationship of you trying to prove that I'm physically or physiologically different than you are and it's hard for a good response to come. Sometimes it's, well, Edwin, I'm trying to do this to better science so we can provide better healthcare to these communities. I said if that was true then you're not listening to the community because the community is saying we need jobs, housing, healthcare, and the police to stop killing us. Oh, I can't control that, Edwin. That's political. Oh, that's interesting. But you want to control genetics. And you want to control other variables that are-- you want to control race, which is almost humanly impossible to do because it's not something you can. So going back to the genetic part, people who publish these disparity papers, oh, black people, indigenous people, or Latinx folks have higher rates of X, and then towards the end of the discussion it's but we don't know why, so we're gonna assume that it's genetic. And I'm like is there a class that folks take that they say if you don't know the answer let's just assume genetics because I'm going to say I'm going to disabuse us of that, class, and tell you, if you don't know the answer, we're going to assume racism. Because I think if we

start from there then we can actually get to an interesting place. And I know it works because I had my research colleagues in the Department of Family Medicine when I gave a talk, and I said that same thing. And the vice chair came out to me. He was like, "Edwin, so you're telling me, if it's not genetic, and it's not physiological, it's something else." And I'm like, "Yeah." He's like, "and we don't know what that thing is yet?" And I said, "I mean, we do, but yeah." He's like, "And if we find that thing we could help solve the issues of these communities?" And I said, "Yeah". And I said, "And let's assume it's racism." And he's like, "Okay, I got to do some work for that because I don't know how that one works." But it's the logic steps that I think we've been conditioned with. And we have to-- we do have to disabuse ourself and start from a place of, maybe I don't know what I'm talking about. Maybe it's not genetics.

RK: 50:15

Yeah. I think that's spot on. And I'll just throw one other framing for this exact same point that cognitive shortcuts are causing us problems in our clinical practice. We miss diagnoses. And they're causing us problems in research because we miss the real root cause. I was on a panel with Dr. Michelle Morris and she said we're just doing a copy paste. We're just saying, oh yeah, it's race. We'll drop that into the risk factor in my head, and it's a shortcut that we use as clinicians, but it affects our decision making. So I absolutely think these are really important points, and I'll throw it to [Lash?] for the last word.

LN: 50:50

Yeah, well, I can't agree more with everything that's been said today, and I just feel so blessed to be in community with these amazing scholars and folks that we have right now. Y'all, the energy is definitely here. And I think, really what it comes down to for me is, I've been listening to you-- is the same rigor that we approach all of medical school with, right? We're talking about the lungs, you're going to have a pulmonologist come. We're talking about the heart, you're going to have a cardiologist come and teach me. So when we have conversations around race, don't send faculty a one pager and then have them give this lackluster discussion or presentation about this topic when there's clearly a rigor to it that is there, and folks just aren't doing their research. So we can't continue to copy and paste. We can't continue to just say, "All right. We're going to use this proxy." So I really hope that that's where folks get out of this. And it can't stop with just reading How to Be an Antiracist. You can't SparkNotes this, right? And I think that's really what it comes down to. And all of these resources that you've given us today, Edwin, are definitely things that our learners can take away from this experience and this conversation. So before we end I just want to know, what can folks who are listening right now start doing today to start doing the work that you know we need to start doing to dismantle this idea?

EL: 52:15

Yeah, that's a good question. There's so much, but I'm thinking where to start. And I actually think we have to start at home. Meaning asking your classmates, our colleagues, what have you been taught at home that is allowing you to believe these things that so many of your other colleagues are telling you are not true? I think that's one because it starts at home and starts with the conditioning of stereotypes and the stereotypes coming from the racial definitions created by Carl Linnaeus. You mentioned research and work. I think that work is absolutely necessary. Reading the book is, as you said, not sufficient I would actually ask that before you read the book, you start asking questions, that you start digging into concepts of race that is so beyond you because it is quantum physics. It. In many ways, it doesn't make sense. And that was his intention. When you have something that doesn't make sense-- I mean, let's think about it. Racism is the real deadly consequence of a concept that is not real. That is race. It was made up. And so I get it when people like, "Well, if you just stop talking about it, then it will go away." And it's like, "No. If I stop talking about it, the majority of people in this country, which are white, will make sure that we

know that they're white." When someone's like, "Edwin, can you stop talking about race?" and I'm like, "What race are you?" They're like, "I'm white." Clearly, you are beholden to your race. Clearly, you want to hold onto it, right? We say we want to disassociate but folks who are wholly invested, especially when it comes to power. The third is it is the institutions. I have colleagues that are specialists, family docs throughout the departments at UW Medicine. And I ask them, especially the family docs, "If someone comes to you with a fractured femur, what would you do?" Well, I check everything else. I make sure they're all right but they're an emergency so I'm going to transfer them to a specialist. I'm going to get a second opinion, and I would transfer them to the surgeons, the orthopedic surgeons. I say, "Great. Why don't you just try to do it yourself?" Oh, because I wasn't trained to do that, Edwin, right? I was trained to have a holistic approach to care. I said, "Yeah that's great. Then why do you do that with race?" We talk about race. Oh yeah, I can do this. I read a book. No, I think it's now time that the institutions, our colleagues, say, "This may be out of my league. and I needed to defer to my colleagues who have been trained in this work." Last year, you were talking about this. We need the second opinions, right? We need the experts to come in who may not be physicians, who may be in sociology, who may be in history. And we start building this interdisciplinary network to address these things. The fourth thing, I may be missing the numbers, but the fourth thing I would say is we have to put racism at the center of this conversation. If you're a primary doctor, if you're a surgeon, if you're any other type of physician, if you're internal Med. When our patient comes to the door, I want us to be conditioned to ask the question in our mind and hopefully at some point out loud of how is racism causing the outcomes that I'm seeing before me and my patient. Every primary doc should be asking the question, "Have you experienced racism?" to our [inaudible] communities. And if so, what support are we going to provide them? Because the data shows us from David Williams, [Professor?] David Williams at Harvard, who tells us a black man who has a graduate degree is, on average, going to die four years sooner than a white man who never graduated from high school because of racism. That a black man who lives middle age has a level of trauma almost equal to a white man who returned from Vietnam war with PTSD because of racism. If we aren't talking about racism, then we're not actually fulfilling our mission of practicing medicine. We're only doing part of it. And I think it's now time to say we can't keep ignoring this. This is the issue, and let's address it because I would be clear that if we address racism, then it's not a prescription but collectively as a system of medicine. If we address racism, we will address the majority of comorbidities and illnesses that we see among our patients, particularly our [inaudible] patients. But we have to stop being scared. We have to stop being scared of doing it.

- DP: 57:39 I think that is a perfect place for us to end. Professor Edwin Lindo, thank you for being on the podcast with us.
- EL: 57:46 Thank you. This has been an honor. Y'all are amazing. Keep doing the work.
- LN: 57:51 Always a pleasure.
- RK: 57:56 All right. I think that's cut. This is--
- EL: 57:57 Cool. Thank you all.
- RK: 57:58 This is going to be a fantastic episode. Wow.
- EL: 58:01 Yeah [inaudible], yeah [inaudible].