Prioritizing Equity video series: The Root Cause

In the May 28, 2020, Prioritizing Equity webinar, Aletha Maybank, MD, MPH, chief health equity officer at the AMA, speaks with a panel of health equity advocates and trailblazers on their work to address the root causes of health inequity and the social determinants of health.

Panelists

- **Camara Jones, MD, MPH, PhD**—2019-2020 Evelyn Green Davis Fellow, Radcliffe Institute for Advanced Study, Harvard University
- **Brian Smedley, PhD**—Chief of psychology in the Public Interest Directorate, American Psychological Association
- **Zinzi Bailey, ScD, MSPH**—Assistant scientist, Jay Weiss Institute for Health Equity, Sylvester Comprehensive Cancer Center; managing director, Health Equity Research Solutions, LLC
- **Joia Crear-Perry, MD**—President, National Birth Equity Collaborative
- **Jonathan Metzl, MD, PhD**—Frederick B. Rentschler II Professor of Sociology and Medicine, Health, and Society, Director, Center for Medicine, Health, and Society, Professor of Psychiatry
- **Whitney Pirtle, PhD**—Assistant professor of sociology associated faculty critical race and ethnic studies University of California Merced

Moderator

- **Aletha Maybank, MD, MPH**—Chief health equity officer, senior vice president, Center for Health Equity, American Medical Association

Transcript

May 28, 2020

Dr. Maybank: Good afternoon, everyone. Welcome to the next addition, or this edition, of Prioritizing Equity. I am Dr. Aletha Maybank, chief health equity officer and group vice president at the American Medical Association, and I am very excited about today's panel, and I hope you all are, too.

I just want to give a few reminders of just some resources that we have. If you haven't gotten a chance, please visit our health equity resource center for COVID-19 on our AMA website. Last week, we did host a conversation elevating native voices and their experience with COVID-19. We'll drop the link in the chat. We'll be dropping links in the chat as we go throughout as folks mention any resources.

Next week, we'll have another session elevating the experience of Asian-American and Pacific Islander voices in medicine and in health, as well. We're here today because, to really look toward how do we advance health equity, we know that we must acknowledge history, the past, the present time and really what brought us here today.

And so, each of the panelists that are with us has significantly contributed not only to the health field, but to larger society overall by making injustice visible, naming root causes, systems and structures that consistently prevent racially marginalized people from having the conditions, resources, power and opportunities to achieve optimal health.

From my experience about naming racism, and this is really what this is about, is naming racism and the root cause, and the fundamental cause of why health inequities exist, I worked under and with Dr. Mary Bassett, who made it very intentional when she came back as a commissioner in New York City that we had to name racism and we had to be accountable as leaders to continually name it and also accountable to the people who were building the systems and the structures to make sure that they were also having those considerations, too.

Now that I've transitioned myself, more so in the healthcare side of it, I was in public health for 14 years, a really long time, and I love public health. I have many public health colleagues on the phone, on this call today. But now, I'm more rooted in the health care piece of this. I do see that there are definitely differences in understanding and fully embracing why we need to name racism and why the evidence shows us that is the fundamental cause of why these inequities exist.

I've heard a range of comments that there is a lack of evidence. Disbelief that this is even a root cause. I've heard conviction that race is biological and genetic, even to this day amongst the

community, the health care community. I really wanted to pull together the leaders that are on the panel today to just talk about all that they've done, but also what we need to do, as well.

I'm just going to ask, and just start off, the simple question of where are you in this world and how are you doing today? Dr. Jones, I'm going to start with you. Just remember, there are how many of you? Six of you. We have an hour. I know we can do this. Just got to keep it slightly brief, but go ahead.

Dr. Jones: Where I am right now is hurt. I'm hurt, not just by the COVID-19 disproportionate deaths of black and brown and indigenous people, but I'm hurt by the police brutality. I'm hurt by self-appointed guardians of neighborhoods and hurt by all of the unnecessary death, and the fact that this society does not value the lives, the intellect, the contributions of black people.

Where I am right now, is I'm hurt.

Dr. Maybank: Thank you for that. Where are you physically in this country, as well?

Dr. Jones: Oh.

Dr. Maybank: But I loved it.

Dr. Jones: I was like, where am I? Well, I'm moving. I'm in Cambridge, Massachusetts right now. I've been here for nine months, as a Radcliffe fellow.

Dr. Maybank: Okay.

Dr. Jones: Moving to Atlanta on Sunday. Going to put on my mask, my shield and get on a plane and pray.

Dr. Maybank: Okay. Thank you. All right. Dr. Joia Crear-Perry.

Dr. Crear-Perry: Hi. Thank you, Aletha. You know I love you to pieces. I am physically in Washington, D.C. right now. I'm always, emotionally, in Louisiana, in New Orleans, where my rest of my family, my parents, one of my children and my staff and everyone is. I am blessed that I can work from home, and that I have the opportunity. I feel like, as a Hurricane Katrina survivor, I'm always in the middle of pandemics or emergencies reminded that it is a blessing and an honor to be able to sit at home and to be able to work from home. Many of our colleagues and our peers are not able to do that. That's where I am.

Dr. Maybank: Thank you. Dr. Brian Smedley.

Dr. Smedley: Thanks, Aletha, and thanks for pulling this great panel together. It's wonderful to see so many thought leaders around the Hollywood Squares, as they say. I'm physically in Silver Spring,

feeling the same as Dr. Crear-Perry, feeling very blessed to be able to work at home. I share Dr. Jones's sentiments about the troubling times that we're in. It's painful. Painful to live through these challenges during this pandemic.

We all know that, historically, pandemics and epidemics bring out the worst in people, particularly when we have leaders who will foment division, fear, and hate, which is exactly the opposite of what we need at this time. This time, we're physically distancing but our communities need to come together in solidarity to build more equitable, inclusive communities. That's the way we get out on the other side of the pandemic.

I actually have a little bit of optimism that America will finally hold up a mirror and understand how destructive hate is to all of us.

Dr. Maybank: Thank you. All right. Dr. Zinzi Bailey.

Dr. Bailey: Hi, there. I am coming to you, physically, from Miami, Florida. I come with a heavy heart, really internalizing all of the events that have been publicized. This, and other weeks, and feeling a little bit weary about having to continually deal with this in very individualized ways when we need movement, and we need to mobilize, and we need change. Thank you.

Dr. Maybank: Absolutely. Thank you. Dr. Jonathan Metzl?

Dr. Metzl: Thank you so much. I'm so honored to be part of this incredible panel. I'm in Brooklyn, New York today, telecommuting back and forth to Nashville. I just was at a meeting there about 15 minutes ago, as it were.

I am like many people. On one hand, I'm feeling honestly empowered that voices like ours and a coalition like this is coalescing in the fight of really not just a pandemic, but almost a genocidal pandemic on top of a pandemic. Really, that our work has never been more important. I'm also similarly angry and frustrated, because pandemic and crisis moments like this really are moments where you see where you are as a society, as a nation. It really is almost an existential choice.

There was a moment when all of these disparities started to show up that we could have and should have said, "This is us. Not they're dying, but we're dying. America is dying right now." The fact that our leaders and our society didn't do that. They basically said, "That's them and here is us." I think it's going to have profound, profound structural implications going forward.

I'm thinking, for example, of all the other historical moments where you get to decide which path you're going to go on. I'm thinking, for example, do voices work about black reconstruction, the period after Reconstruction, and the notion that to create a more equitable South, think of how different our country would have been.

You can go on and on. Periods after the war or after things like that. This is really an existential moment that's going to shape our country for the next century and beyond. We have a chance to see the inequities and address them and right them, or we can make them more inequitable in ways that I think are going to have profound negative consequences, of course, for minoritized communities, but also for the kind of country that the United States becomes.

Dr. Maybank: Thank you, Jonathan. And, Dr. Whitney Pirtle?

Dr. Pirtle: Thank you, Dr. Maybank, for having me here today and for checking in on all of us. It's been a heavy week for me during this pandemic, but this week especially, as a black woman in America, a wife, a mother raising two sons. I've been trying to practice self-care and caring for my children. I'm just happy to be here, sharing this space with you all, talking about equity because that does give me hope. I'm happy to be a part of this conversation.

And, I'm in Merced, California. That's the San Joaquin Valley. The central valley of California.

Dr. Maybank: Oh, fantastic. We're covering the country, somewhat, for the most part. All right. Great. What we're going to start off—I'm going to ask you—this is a test a little bit, but two to three words of how would you describe the root cause of health inequities during COVID and pre-COVID? It's an obvious answer, but I'm just trying to do something.

And then, I want you to say why. What are your two to three words on how you would describe the root cause of health inequities, and why? Anybody's able to jump in and start.

Dr. Jones: I'll start—

Dr. Crear-Perry: Racism, classism and gender oppression. And why? Because they are the root causes of most all inequities in the United States of America. You can add some others across the globe, like tribalism, casteism, religious fundamentalism, and my state of Louisiana is a big one, and other parts of the country. That is still the same.

Dr. Maybank: Thank you.

Dr. Jones: I would say racism and other systems of structured inequity. I say racism and other because racism's foundational in our nation's history, and yet many people in this country are in denial of its continued existence and profoundly negative impacts on the health and well-being of the whole nation. I prioritize, among all of the things that are really happening, racism.

Dr. Maybank: Thank you. And, Dr. Jones, I'm going to come back to you, for you to define racism.

Dr. Jones: Okay.

Dr. Maybank: In its ways, and then also all of you to talk about the health impacts, as well. While we're in our community, and we hear it, there are a lot of folks who don't hear it and don't really, fully understand it. I'm going to come back to you to lead us off in that conversation.

Jonathan, your two to three words?

Dr. Metzl: I would certainly say a pre-existing condition of structural racism would be the first that comes to mind. And then, ableism and ageism. When did it be okay to sacrifice our elders and why aren't we mobilizing in that way, as well? I think that really what we're seeing is a mirror of the structures that we didn't build, or did build, before this pandemic, and the opportunities we didn't allow in a particular way.

I just think that, really, what we're seeing is a reflection of the society that is us.

Dr. Maybank: Thank you. Whitney?

Dr. Pirtle: Yeah, I join the chorus and I think I would say intersecting systems of oppression would be my three words. I think—Patricia Hill Collins refers to these as reciprocally constructing phenomena that shape our experiences and shape health equity. Later on, I will talk about racial capitalism as one of those intersecting systems, but I think disability, gender, nation, state, legality, all of those things work together to shape the disadvantage that we're seeing right now.

Dr. Maybank: Thank you. Zinzi?

Dr. Bailey: Well, of course many of the ones that I'd thought of have been said. One that I have not heard yet is colonialism. I think that it sets off a lot of these different components, where there's an element of patriarchy, racism, xenophobia, ableism. There's a number of different elements of these systems of oppression that are, that made themselves known and multiplied and reproduced to create these systems.

Dr. Maybank: Thank you. And, Brian?

Dr. Smedley: Yeah. Everybody's said it already. I guess one way to sum it in three words is destructive social hierarchies and all of those -isms that we've got to tackle. It's so interesting, there's so much talk about American exceptionalism. Well, we're certainly exceptional now. Highest number of people dying from COVID-19. And while destructive social hierarchies are found around the globe, they're particularly pernicious here. My hypothesis is that that's why we're number one in deaths around the globe.

Dr. Maybank: Absolutely. Moving—Dr. Jones, I'm going to come back to you. I met Dr. Jones over 14 years ago. I was founding director of Office of Minority Health in Long Island, in Suffolk County. I don't

know where the conference was. I think I heard her talk, and I said I have to track her down, and I followed her through the conference. She was very generous to sit with me, and I think you even gave me your business card at that time. I was just very excited because I had not heard many folks talk so explicitly about foundational causes and racism.

For those that don't know, she's former president of APHA and also part of starting the campaign to end racism. Can you frame for us, especially for the folks on the Zoom looking in, what is structural racism? What is racism? What does it do? You talk a lot about assigning value. Can you just lay that out for us right now?

Dr. Jones: Sure. I'm going to give you a one sentence definition of racism and then just take another half a minute to break it down.

Dr. Maybank: Sure.

Dr. Jones: Racism is a system of structuring opportunity and assigning value based on the social interpretation of how one looks, which is what we call race, that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities and zaps the strength of the whole society through the waste of human resources.

Just to pick up the various things. First of all, I say it's a system, so it's not an individual character flaw, not a personal moral failing, not even a psychiatric illness, as some people have suggested. It is a system of power. It's a system of doing what? It's a system of doing two things: It structures opportunity and it assigns value. On what basis is the opportunity structured? On what basis is the value assigned? It's based on so-called race, which is the social interpretation of how one looks.

In a race-conscious society, race is not biology. It is not culture. Ethnicity is culture, but race is not culture. It is not genes. It is so—we map the human genome. It is not social class, even though because of structural racism, we do see some kind of disproportionate association between social class and so-called race, but that is because of racism. It is the social interpretation of how one looks in a race-conscious society. That's what race is.

Racism is the system that operates on that so-called race to do the three things. The unfair disadvantage is mostly what we recognize, but every unfair disadvantage has its reciprocal unfair advantage. We hardly ever talk about honored white privilege. It makes some people, especially some white people, uncomfortable. I used to say, "shake it off" because I do a lot of storytelling. I was like, "Okay, I'm going to tell you some stories that's going to make this all right."

Now, I don't say, "If you feel uncomfortable, shake it off." I say, "If you feel uncomfortable, you need to lean in. For all of us, the edge of our comfort is our growing edge."

The third impact of racism, the fact that it zaps the strength of the whole society, so many examples of that but I don't have a whole hour to talk, I'm about done, is the most important thing for us to lift up especially right now. This is what we're seeing. With a premature reopening, because some people thought, "Oh, it's disproportionately affecting people of color, so we're safe. Right? Let's reopen. We can't sacrifice the economy for those people." Right? The we, them that Jonathan was talking about, is going to zap the strength of the whole society.

We're going to have one big glob. We're not going to have a little New York, New Jersey and California, Washington. It's going to be the whole country boiling in just about a minute. Okay, done.

Dr. Maybank: Absolutely. Does anybody want to add anything or say anything? Anything boiling? You're more than welcome to chime in.

Dr. Crear-Perry: I just want to say, just like you, I had that honor of meeting Dr. Jones years ago, and I follow her around. She's usually the big keynote, and I'm the afternoon delight.

One day, she was giving her definitions. I don't think you've changed your written definitions, but I changed it based upon what you said, in that when you added for internalized racism, the definition around the belief, not only that for black people or for people of color, that we see ourselves inside of this racist society, but also for the non-stigmatized, as you put it, or for white folks, not seeing how racism impacts them.

I do think it's especially important for this conversation for us to talk about how racism is harming everyone. It's not only just harming black people, but for white folks too, this belief in a hierarchy has many, many impacts on their health, on their wealth, and so it's killing the United States and the world.

Dr. Maybank: That's a great transition to Jonathan. Jonathan is a professor at Vanderbilt University. You just got a promotion to a new, fantastic position. You can say what that is. I'm not remembering off the top of my head. But is also author of Dying Of Whiteness. Can you speak to exactly what Joia had just framed out?

Dr. Metzl: Yeah, absolutely. I'll say two things about that. Number one is, I just completely agree with Joia. There's this false narrative out there that fixing structural racism means just giving some stuff to minoritized communities. But when you look at the actual ways that we would fix structural racism, like universal healthcare and worker protections and childcare and elder care and making the criminal justice system more equitable for everybody, it turns out that's the kind of stuff that benefits everyone. Right? It's not some targeted—of course, that's also the myth that goes around about things like Affirmative Action.

For example, having more people educated and more people be able to rise up is actually better for the GDP of the entire society. I think, number one, is just to agree with Joia and everybody else is

saying, that this isn't just about give some stuff to people who are blah, blah, blah. It's actually this is the future; this is the existential future of our country.

There are plenty of examples of countries that haven't addressed this kind of issue, and they burn out as superpowers pretty quickly. Not just super powers, but really relevant, in a way. That's part of the issue.

And number two is, there's a tension right now because of course there's lots of individual-level racism, and I think it's important to call out every time that there's a bird-watcher that acts a certain way in Central Park. I think it's just as important to illustrate the effect of structural racism. The reason I say that is because part of the work that I do in my book, Dying Of Whiteness. Let's say, for example, the failure of red states to expand Medicaid under the Affordable Care Act.

When the pandemic hit, there was a golden chance to basically say, "We're going to expand Medicaid to every state in the country. Everybody's going to get health care." That would have had profound effects, not just in terms of people being able to go to the doctor when they get sick, which they happen to tend to do during a pandemic, but also about the economic impacts, because people that don't have Medicaid are much more likely to pay more for their medications. They're much more likely to accrue medical bankruptcy.

Partially the reason that hasn't happened is, of course, because there are these racialized scripts about government dependence and lazy minorities and all these kinds of things. The research that I do shows that it also shortens the lifespan of White Americans, as well.

In other words, in order to teach people what they deserve and not be too dependent on the government, well, you're paying that for that with your own economy, with your own lifespan and factors like that. In a way, the failure to grasp a concept that's not a zero sum formulation of race that has a winner and a loser, but instead to basically say we need to build structures that rise us all up.

The failure to grasp that narrative, I think, is going to have profound implications if we don't reverse this pretty quickly.

Dr. Maybank: Thanks. Now, Brian. I'm going go to you, Dr. Smedley. I apologize if I call some people first names and some people last names. It's because I know some of y'all, and Dr. Jones, I will always call you Dr. Jones, no matter what. Just so that's clear.

Brian, you were lead author of the landmark publication in 2003. All of us are very familiar with it. Somebody signed it for me. It's something that I carry around all the time. The publication of Unequal Treatment.

Can you just talk a little bit about that time period of when that was written? And then the evolution, where we are now, and is that book as relevant, the publication as relevant, and what's missing? What's the next level of unequal treatment that many of us look towards, many of us refer to? We're now in 2020. What's next, as it relates to that?

Dr. Smedley: Yeah. Thank you, Aletha. That just teed up—I could, we could talk for the whole day about what's next. First, let me just say, the author of Unequal Treatment was the committee. A distinguished committee, led by Dr. Alan Nelson, who was a former AMA president. Fascinating that Dr. Nelson himself—

Dr. Maybank: I didn't know.

Dr. Smedley: Yeah. His practice was in Utah. He came to this issue, I would doubt, with much personal experience, but that's what was important. By the end of that process of a, at that time, it was called the [indistinguishable] of medicine.

At the end of that process, to have 18 distinguished leaders, some of whom were skeptical, about whether it was in fact true that patients of color receive a lower quality of healthcare, even when access-related factors are controlled, such as insurance status or income.

By the end of that process, Dr. Nelson was one of the leading proponents that we absolutely must eliminate disparities in care. He fully grasped that racism is at the root of this challenge.

Dr. Maybank: Wow.

Dr. Smedley: Unequal Treatment was—the study committee went through that. The second thing I want to say about Unequal Treatment is that it's important that people acknowledge the important contributions that people like Dr. Camara Jones to that report. Right? It wasn't just the study committee. Dr. Jones had a lot to help in shaping the context of the report.

For example, one of the things that absolutely needed to be said is that while these disparities in care are pervasive and troubling, they are not the cause of racial and ethnic health inequities. The causes are found in structural and institutional forms of racism, as well as internalized in interpersonal forms of racism.

We have piles of research showing that racism is a pathogen. It's a toxin. Thanks to her help, the committee was able to make that statement. It shocked the medical profession at that time, because clearly, doctors, nurses, other health professionals are highly-trained, committed to their patients. Very few would openly espouse racist beliefs. But the reality is, if you've been socialized in the United States of America, you have the imprint of a deeply racist society in your unconscious.

The concept of implicit bias becomes important. We also have to talk about explicit bias, because we know both are operative in the clinical encounter.

Dr. Maybank: Mm-hmm.

Dr. Smedley: While Unequal Treatment remains something I'm incredibly proud of, one of the things that disturbed me is the fact that people began to focus in on the health care and the clinical encounter itself, as if that was the be all and end all of advancing health equity.

Unfortunately, we've got a lot of educating to do about the fact that health is produced outside of the clinical counter. It's produced in our society. If we have a society that, by deliberate policy and practice, separated people into different neighborhoods, the consequences of, which are still being felt today. If we have a housing market that continues to discriminate against people of color, reinforcing patterns of segregation, if those very patterns of segregation are at the root of school segregation, and we have made zero progress. In fact, we've gone backwards since the 1954 Brown v Board of Education decision in terms of desegregating our schools.

These are the issues that we need to turn our attention to. While I'm very, very pleased that the report garnered attention and focused in on the role of bias in the clinical encounter, what that attention tended to obscure the structural and institutional forms of racism that produce health inequities in the first place.

Dr. Maybank: Thank you. This is a great segue to Dr. Zinzi Bailey, who I had the pleasure of working with a couple of years ago. Very proud of her and proud of where she's gone in all the publications and important publications at I See, I Saw, the Data for Black Lives report that just came out.

And then also, you are lead author in the structural racism paper that was published in Lancet in 2017, along with Nancy Krieger, Jasmine Graves and Dr. Bassett, Mary Bassett. Can you talk about that paper? We have the lead in now to structural racism. What did that paper lead to for you, but also, do you think for the field?

Dr. Bailey: That Lancet paper on structural racism was really conceived out of the understanding that racism has a life outside of specific individuals or communities. Right? It's baked into our educational, healthcare, political and our health department systems. I wrote this while I was still an employee of the New York City Department of Health and Mental Hygiene.

I think it was important for us to explicitly name and recognize that there was racism baked into our system, and it was accepted as normal. It wasn't just oh, it's baked in and we recognize, and we can do these things. It's accepted as normal. We can really have well-meaning liberal types, even people of color who could be perpetuating racism on a structural level, while aiming to quote, unquote reduce disparities. Right?

Therefore, for us, it was essential to name and define structural racism and demonstrate the mechanisms by which it operates to drive health inequities. Structural racism has been called an invisible evil, because it's pervasive, impacting different systems and sectors, and also making us color blind to white supremacy.

In this paper, we defined structural racism as all the ways that societies foster racial and ethnic discrimination through as mutually reinforcing inequitable systems that Brian just mentioned, around the education is propped up by segregation, which props up over policing, which props up—we could go on and on.

And that, those kinds of mutually reinforcing systems then reinforce discriminatory beliefs, values, and distribution of resources. We can see that through history, through culture, through our institutions. That definition and discussions that followed, under the leadership of Dr. Marie Bassett, and you at the Center for Health Equity, it allowed us to question how we presented and used data in the course of our work and to what degree were we biased, or are the biased underlying assumptions about what explains group differences, driving our programming and policy and what we were seeking to pursue, what we were investing money in.

The way data is used is often, it often feeds preexisting biases and prejudices. Essentially, there's these deeply-held beliefs being socialized in a structurally racist society that then stigmatize certain communities and lay emphasis on personal responsibility and quote, unquote culture and lifestyles.

We end up often scrutinizing sick individuals and neglecting to scrutinize sick societies or sick policies. Right? And so, if we support, as public health professionals, certain policies or mirror the approach from other sectors, or even pursue these biological arguments for inequities, we become complicit in the perpetuation of health inequities.

We could argue that structural racism, in its pervasiveness, prevents us from actually seeing these inequities that we see, we've seen before, and with COVID, as a call to action and a call for structural change. And being able to name and demonstrate structural racism has been helpful for us to be reflective about our process, and be creative about the new ways to do our work.

Dr. Maybank: Awesome. Can you also, do you mind just talking a little bit about the data from Black Lives Report and the title of it? Data has been elevated tremendously during this response. Right? The lack of it, in many different ways, it is, it's problematic. Right? It was before, but it's even more so now, in terms of collection of race and ethnicity data.

I just thought it was a really profound report about what do we need to do moving forward, and how do we really center equity in that process? Do you mind just talking a little bit about the data piece?

Dr. Bailey: No problem. No problem. I think data is a really key component for this. Essentially, this is based in an organization, Data 4 Black Lives. It's actually a movement. Right? On April 15th, a round table was led by Yeshi Milner, one of the founders of this movement, to take the pulse of society and coordinate, organize, mobilize, our community to demand data integrity, accountability, ethics and justice surrounding the COVID-19 data.

Data 4 Black Lives sees data as protest, as accountability, as collective action and really, in short, data as a tool for social change. Recognizing that in the past and currently, data is often used as a weapon. Right? We must demand—a lot of what we were doing in this report was demanding that the use of COVID-19 data should not be weaponized like other data has been.

We need to use these data for the abolition of structures, systems, policies, narratives that have created the structural vulnerabilities in our country that have particularly disadvantaged black and indigenous people.

We called for publicly available data on COVID-19 testing, cases, hospitalizations, deaths. That's disaggregated by race, by geography, across settings that act as basically inequity amplifiers—nursing homes, homeless shelters, correctional facilities, ICE detention centers, public housing and across the essential, yet undervalued occupations.

Essentially, race on its own is not a risk factor. Racism is. Right? We need to be using that data and presenting that data in a way that contextualizes what we're seeing. People are going to go back to their biases and underlying understandings of what these differences are due to, but we have to situate these data into a call for radical reform of our criminal-legal system.

Health care for all. A robust and autonomous public health system. We need to use these data to create structural change and be aware, and fight against, militarization of public health data, and the enforcement of policy. And not use COVID data for the denial of employment, or housing, or healthcare and so on.

Really, structural racism is pervasive and deadly, and we have to use every tool in our toolbox to combat it. And data is one of them.

Dr. Maybank: Thank you, Dr. Bailey. You all are transitioning to each so well. You mentioned—I know she knows I'm coming for her now. Joia, who is president of the National Birth Equity Collaborative. It is you that I heard first really coin the term about racism not as a risk factor—I'm sorry, I said that wrong. Race is not a risk factor, but racism is. You say it how—I don't even know if that's how you exactly said it, but however you phrased it, I remember that.

I see it all over the place, in the Twitter and social media world. I just want you to speak to that. And then also, from somebody who's really in the black maternal health space. I'm sure that's not the full

words that you would use, but how can we translate what you're learning and what you're doing there to this whole experience, as well? And then also, just your experience of that tagline. Usually, she has it on a t-shirt somewhere. Today, she has Black Doctors Matter, which is great. Okay.

Dr. Crear-Perry: Yeah, Zinzi, you teed that up for me really well. We've been together a long time. I appreciate that. Yes, the reason that it was so important to me, as an OBGYN, even as a black mother, when I was in medical school, I was taught in the late 1990s, which is not that long ago, in my embryology class, that there were three races: mongoloid, caucasoid and negroid.

I, in fact, did research. When I was an OBGYN resident, I did research about preeclampsia. We talked a lot—we were putting Flagyl—a lot of folks are physicians probably on this call—so we were putting Flagyl in the water, trying to fix pre-term birth because black women's vaginas had more bacteria. Right?

All these things are things I was taught as they were medical facts. They were truths, that the reason we had health disparities, and I love listening to even Brian and Dr. Jones talk about history of how we got to here because so many of the words people use to weaponize against us so often. Right?

The reason we had health disparities was not because of structural racism, it was because we were just biologically different. We're broken. Right? We have different genes. If it wasn't our genes, it must be our epigenes. If it's not our epigenes, it must be that bacteria can find our vagina. They see, oh look, brown skin. Let me go to this vagina. Right? That's the logic that's been inside of our health care system for a long time.

I had a baby in medical school, pre-term. The only risk factor that I had as an individual was my blackness. I believe the reason I had a pre-term birth, as an OBGYN, and I was taught the reason I had a pre-term birth, is because of my blackness.

Then I went around trying to figure out, what did that mean? What about my blackness, despite having an education, despite being a child of two professionals, despite of not being obese, despite of all the things that we teach are the risk factors, that I still have a baby who weighed less than a pound? What was that about?

No one ever talked about the fact that I was working and training in a hospital that had been named Confederate General just less than 20 years before I was there, that very few black medical students had ever even graduated from this school, and the expectation every day that I was supposed to not only represent my ability as an individual student, but also my entire race. Right? That expectation lives on all of us when we're doing our work.

It was important for me when I was able to listen and do these trainings around black maternal health to help people to unpack the reason that black women are dying is not because they have black skin

or because they're kidneys have different function, or their lungs have bigger capacity, that all of those biological reasons for different outcomes were based upon racism. Their foundation, the very foundation of obstetrics and gynecology is built upon racist notions by J. Marion Simms, that black women named Lucy, Betsey and Anarcha could not feel pain.

That still plays out in how we do our work today. I love hearing, even in the original document, it said that we perceive that we were being treated differently. There's still this negative, this connotation that we don't even understand that we're being treated in a racist manner. You have to put the word perception inside of that. Right?

Dr. Maybank: Yeah.

Dr. Crear-Perry: Anyway. It was important for us to really call the importance that racism is real, and it's not an emotion, that people explicitly do believe we are broken. I was taught that I was broken because of the amount of melanin that I produce. And that there are people who are practicing medicine across the United States right now who still believe that, so they still treat patients very differently.

We think of an entire training and still some people will come back and say, "Well, they treat hypertension differently, based upon race." That becomes because of ancestry. Right? And who's doing that data, and what does that mean? How is it the impact of racism? There's so many important, it's important for us to change it to racism, because we leave it at race all we're doing is saying we need to fix black people, that our strategies, whatever we're doing, must be built on fixing them versus fixing the structures and the institutions that are harmful to us.

Dr. Maybank: Thank you for that.

Dr. Smedley: Can I jump in real quick, Aletha? I just want to say something in response.

Dr. Maybank: Oh, go ahead.

Dr. Smedley: I'm stunned. I'm so stunned and saddened, Joia, to hear that was how people were trained medical school as late as the 1990s. I think about Troy Duster, who I think said it best. I'm going to try and paraphrase what he said. The effect of race on health is biological in effect, not origin. Right? It's the lived experience of living as a person of color in the United States that has negative physiological consequences.

Dr. Maybank: Absolutely. Thanks for that, Brian. Yes, go ahead Jonathan. It's hard for me to say that. Go ahead, Jonathan, and then I want to come to Whitney.

Dr. Metzl: I think one of the important points of this is like, it's not like there are no historical precedents for addressing these problems. Right? In other words, I know, as an educator, that changing peoples' identities is very hard. You can read the most beautiful poem. Some people can come away with it, thinking I'm this way or I'm that way. You don't change peoples' identity. This isn't a call, really for everybody across the country to all of a sudden become more woke. That would be awesome.

But it's really that when you think about things that are structural, then they suggest we need structural solutions. Two examples of that, one is, for example, I'm thinking of a work about the Second World War, where the United Kingdom was under a blockade. It was being bombed. The government, at the time, made the decision, we're going to democratize access to food and to health care. Everybody has the same right, nobody's going to have to worry about getting food, even though there was a blockade.

What happened between 1941 and 1946 is, actually, life expectancy went up in the United Kingdom during a time of war. That laid the foundation for a nationalized health system that still functions in this day. It's not like it's rocket science about how to fix structures. We built these structures. They're dependent on funding and national will and all these kinds of things.

But for me, that is a better conversation to have than thinking about this as trying to change peoples' identity or sensitivity. I think, again, it leaks right into Whitney's amazing work on racial capitalism during the pandemic, which talks particularly about the financial underpinnings about why we don't make those decisions.

Dr. Maybank: Okay, so you teed it up for Whitney. Great. We built these structures, was the phrase that you used, Jonathan. Whitney, really, pleasure to meet you. It was just, I think for all of us, really, I don't know what the right word is, but it was pleasing. That's what I can say to see another researcher of color put out such a powerful and monumental piece of work that you did.

Dr. Maybank: For those who don't know, Whitney recently released Racial Capitalism: A Fundamental Cause of Vovel Coronavirus (COVID-19) and Pandemic Inequities in the United States. For the audience, can you please describe what is meant by racial capitalism? And just, I'll say also, the evolution, I think, to see the word capitalism is what's really big. I was talking to Dr. Bassett the other day and she was just telling me, sharing with me this evolution of how we talk about we address and how we name.

And so, this addition of capitalism—and not that this is a new concept. Racial capitalism is not new, but to apply it specifically and directly to health, we have not seen that frame so much. Can you please talk more about racial capitalism and what it is? And then, I want you to talk a little bit about some of the challenges. I've been following Twitter. Go ahead.

Dr. Pirtle: Yeah. Yeah, thank you so much. As I mentioned, I'm really happy to be here and join this conversation about structural racism. I did write the article relating racial capitalism to COVID-19 pandemic inequities, but I think structural racism is very much a part of that conversation.

I think the idea of racial capitalism comes out of black radical thought traditions who always had equity and liberation at the forefront of their work. That's why I think it's so important and applicable to the current situation.

Racial capitalism says that racism is an inherent structure of capitalism and capitalist pursuits. Cedric Robinson wrote about the theory in his book titled, Black Marxism, where he explained that the development, organization, and expansion of capitalist society pursued essentially racial directions. So, too, did social ideology.

His work allows us to situate current forms of racial and health inequity within a materialistic, ideological and historical framework. I think that's really important, as we've talked about today, that history is important. Racial capitalism created the modern world system. It's a global phenomenon, but it impacts the United States, too.

Colonialism, we talked about that. Slavery, genocide. Those are all racial capitalist pursuits. In the United States, we can look back to our original sin. During slavery, black humans were seen as valuable for the profits that they made. As humans, they were devalued, dehumanized, disposable. But the enslaved were the quintessential essential workers. They were essential for capital, but their lives are expendable.

I think what we're seeing right now, today, is not a direct parallel, but that thinking is relevant. That black and brown workers in the fields in the San Joaquin Valley where I am, those who are at the checkout counters, those who are packaging meat in unsanitary warehouses, those who are delivering our goods, they're essential to capitalist pursuits, but have been seen as wholly expendable because we're not protecting their health and well-being.

Just this week, White House advisor, Kevin Hassett said, "That our human capital stack is ready to go back to work." The enslaved were literally human capital stack, and we're still thinking in that way. As we talked about the rush to reopen states, that has especially impacted southern states, and who is forced to go back to work, that are mainly people of color, and black Americans.

And so, I think that we can't distinguish structural racism from racial capitalism, that those two go hand in hand, because they uphold and mutually constitute what we're seeing today.

That's what I was arguing in the article, that racial capitalism is the fundamental cause of disease disparities, but COVID-19 is showing that. I argued that racially minoritized and economically-deprived groups face mutually constituted capitalist and racist systems that continue to devalue and harm lives,

so much so that it's shaping who can live and who can die.

I walked the idea of racial capitalism as a fundamental cause, thinking about it as a basic root cause, because of all of the things that we know about structural racism and how it interacts with capitalism, that it shapes multiple risk factor mechanisms, like racial residential segregation, homelessness, precarious work, medical bias.

In addition, racial capitalism and structural racism minimize the availability of flexible resources, like power and unfreedom that restricts the ability to cope with risks and mitigate these impacts. I think we have ample evidence to say that racism and socioeconomic disadvantage have persistent, significant and multi-faceted associations with poor health in the United States.

What I said in the article is that COVID-19 is just showing America who we are again.

Dr. Maybank: Right. And, this is America. You go ahead, Dr. Jones.

Dr. Jones: Now I've been stimulated by everybody. I just want to pick one. I'm going go backwards, I think.

Dr. Maybank: Go ahead.

Dr. Jones: Dr. Pirtle, I think it's important to talk about racial capitalism, because of your youth, to let you know that the argument sometimes has been is it racism or is it capitalism? Right? Even within health and public health, in health care, there have been people who have been willing to talk about social determinants of health, and poverty and adverse neighborhood conditions and even capitalism in that context, but never say the word racism, to never acknowledge that.

This framing—and when you're talking about structural racism and racial capitalism, it's important for us to not, 20 years from now, have people so interested, oh, we finally named capitalism that we lose the racial part. That is still in the United States, the thing that people do not want to name, the racism. They will name the capitalism and celebrate it.

It's a whole different kind of thing. At least they'll acknowledge the capitalism, and many people, the ones in power, celebrate it but none of those people would acknowledge the racism. You might want to respond to that, but I just want to go around in the circle and just say two more things.

Dr. Maybank: Mm-hmm. Please.

Dr. Jones: To Dr. Bailey, that work on structural racism is very important. I have, when I'm thinking about the mechanisms, I just want to throw out a very simple thing that helps me answer the question, how is racism operating here? That's a legitimate question, first of all. Racism's not a miasma cloud, you can't get a handle on it. It is, as you say, a system which has identifiable and addressable

mechanisms which are actually in our elements of decision-making.

How is racism operating here? You look at structures, policies, practices, norms and values. Where structures are the who, what, when and where of decision-making, especially who's at the table and who's not, what's on the agenda and what's not. The structures are the who, what, when, and where decision-making, policies are the written how of decision making, practices and norms are the unwritten how of decision making, and then values are the why.

I have, many times, I might be asked to come to a talk. I used to do a talk on the underrepresentation of people of color in research. I'm thinking, how is racism operating here? I go through the thing, who, what, when, where, why and how? Right? I will come out with different possible levers for intervention because our job is to name racism, number one.

Dr. Crear-Perry, you can't stay at race. We have to say the whole word, racism. Name racism. Ask how is racism operating here, so we can identify targets for action, and then to organize and strategize to act. Finally, for Dr. Smedley, when you were talking about—something you said triggered me. I can't remember which words you said that triggered me.

Dr. Smedley: I'm getting that a lot, over the years.

Dr. Jones: American exceptionalism. I think that was the specific phrase. Or, it must have been something else. I just want to say, and we do not have time for me to talk about this, because you know I can talk about this a long time.

I want to say, there are seven, what I used to call, societal barriers or cultural barriers to us achieving health equity, which I now recognize to be the values targets in a national campaign against racism. We have our structural targets of the residential segregation, the underfunding of schools, over incarceration, disproportionate incarceration and all of those mechanism that go in that.

But the values things have been mostly assumed in our culture. I'm just going to quickly name them. Our narrow focus is on the individual, which makes systems and structures invisible or irrelevant. The fact that we're ahistorical, we act as if the present were disconnected from the past, as if the current distribution of advantage and disadvantage were just a happenstance.

The third, our endorsement of the myth of a meritocracy, that if you work hard, you can make it without recognizing that yes, most people who have made it, not everybody, but most people who've made it worked hard, but there are many, many other people working just as hard or harder who will never make it because of an uneven playing field that's been structured by racism, sexism, capitalism, all these things.

The fourth, the myth of a zero-sum game, that if you gain, I lose. Right? We can talk deep on that. The fifth one, our limited future orientation, especially as manifests, and our lack of, the children and the planet are the two parts of the future that I can touch today, as I'm about to roll off. Not right now, but maybe in 40 years. Our limited future orientation, we're not investing in our children, And we're not protecting our planet.

The sixth one is this myth of American exceptionalism, which makes us unwilling to learn from what other people are doing around the world. The seventh, the foundational one, is white supremacist ideology. The myth that there is a hierarchy of valuation in humanity, and the further insult to the myth that white people, if anybody, were going to be at the top, which makes white people feel, it makes them feel entitled. It makes people afraid at the brown end of America, which is underlying some of our politics right now, and make America white again, which is what he said. Right?

Dr. Smedley: That's it. That's it.

Dr. Jones: And it's into the dehumanization of people, which we're seeing when we're being hunted down, or strangled, or suffocated in plain sight. All of those things are a challenge that I'm sending to you guys, my contemporaries and next generation, how do we address these values targets, as well as the structural targets, in terms of policies, and all that. The values piece is so insidious that the first three of them are why we keep slipping into what I call the somnolence of racism denial.

We woke up with Hurricane Katrina. Oh, racism might be happening here. We woke up with the poisoning in the Flint water supply. We are awake now. Oh, racism might be happening here with COVID-19. But then, the risk is that the whole nation sinks back into the very comfortable, staunchly-loved somnolence of racism denial. Our job is to not let the nation go there, as Dr. Metzl said. We need to act now. This is a bifurcation point, again, for our society.

These values targets, is it going to be in the books we read to our kids? Is it going to be in the religious leaders? Somehow, we need to deal with this.

Dr. Maybank: Thank you. Zinzi had her hand up first. And just to remind you, I knew this was going to happen, we have six minutes left to the time. I want to hear from all of y'all. Go ahead, Zinzi.

Dr. Bailey: Very, very quick. And so, what you have labeled a very fancy name, I just named it as a cycle. I'm actually very weary, in fact livid, that we continue to go in this cycle of there's a perverse spectacle, there's a superficial outrage, there's calls for individual level of change, we fire a few people, there's implicit bias training, and then we go back to normal. That's every system we see it in. Right?

Normal is killing us. Structural racism is killing us. We should have a red flag whenever you hear "back to normal."

Dr. Maybank: Yeah, absolutely. Joia?

Dr. Crear-Perry: Yeah, I was only going to add, my only optimism, because you know I'm optimist at this moment, what we're starting to say now, instead of the going back to normal, meaning we're only worried about black and brown people, is now we're expanding the conversation, I hope, that will allow for people to see that you're all dying, that the country, I say, in the country, probably, we have the worst in the world. We can't have that only because black women are dying at eight times the rate in New York City. We also have it because white women are dying that shouldn't be dying, because we don't invest in universal healthcare. We don't invest in education. We don't—we are trying to, in trying to harm people of color, we are harming ourselves as a country.

That has to end, so that should be the wake up call this time, that oh, we're not just going to help those poor people, we're trying to help all of us, together.

Dr. Maybank: Jonathan, I see your mic going on and off. Go ahead.

Dr. Metzl: Oh, you know, I just couldn't agree more. So many people are trapped by this system right now. This really is a true crisis moment. I'm really hopeful that is the recognition that we come to. I also am thinking about your next panel, about the role of medicine. Right? Among other kinds of crises, this is a health crisis.

Medicine, for so long, of course, has not only of course treated the individual, and importantly so, but it's also addressed matters of race and ethnicity and inequity through a cultural competency lens that's basically said, "This problem is just one that we can only address in the exam room."

I also think this is such a profound challenge for medicine itself, to think in more structural terms, to leverage its authority right now, to really think about this is not just a crisis that we can treat our way out of with medications or even a vaccine. In a way, this really is a crisis moment for medicine, to treat the individual, and really, to treat the system.

Dr. Maybank: Thank you. Whitney, I wanted you to have an opportunity, because Dr. Jones addressed you directly. I just wanted to make sure you have an opportunity.

Dr. Pirtle: Yeah. Thank you for that. I just am a fan that everything that you have written and what you're saying here, and I agree wholly that we can't—this isn't a capitalist story. It's a capitalist society, but structural racism is part of that. We can't stop there, only thinking about capitalism.

You know, I'm thinking about where we're at right now, that racial capitalism created an unequal society and we're being told, over and over again, that black lives don't matter enough, whether it's related to killings or the pandemic. I ended my article quoting you, Dr. Jones, where you said the first step for health equity is valuing all individuals and populations equally.

That's so important. I think that's what Black Lives Matter is about, is remembering that human value. I think that's also what the black radical traditions taught us, is that people of color are fully human, first and foremost, and so that definitely is a first step in health equity. It needs to be incorporated at all of the levels, the structural, mezzo, organizational, interactional, every day experience.

Dr. Maybank: Thank you. Awesome. As we close out, Brian, would you like to say any words? We haven't heard from you in a couple minutes. But, go ahead.

Dr. Smedley: I just love this panel. Can we work together? We've got a lot of work to do, because we have to create a new normal. Again, I'm with Joia. I share optimism that, in order to survive this pandemic, we will come out with a new normal and a more just world.

Let me just hold this up, because I'm a big fan, Jonathan. Great book. Thank you for this important contribution.

Dr. Maybank: Awesome, everyone. I think—I looked at the questions. I was getting the questions as they were coming, but I think the next conversation is, people want to know, what do we do? What does that agenda of what we do and what is collective about what we need to do, moving forward, to do exactly what you all have named.

I want to thank every single one of you for being on the panel today. You all are amazing and inspirational. Thank you for your leadership and your commitment. Thanks everyone who has been watching and tuning in. This will be available, actually probably later today. If you want to share it with others, please do, because I think this was beyond a conversation. There was real pieces of education dropped in this conversation.

Again, thanks to everyone and have a great evening, everyone. Or, day, and everyone stays safe.

Dr. Pirtle: Thank you.

Dr. Bailey: Thank you.
