

Prioritizing Equity video series: Police Brutality & COVID-19

Police brutality, racism and COVID-19 have uniquely, and detrimentally, impacted the health of Black communities. In the latest installment of our YouTube Prioritizing Equity series, health equity leaders discuss how physicians and others can address root causes of inequity by naming racism.

Moderator

- **Aletha Maybank, MD, MPH**, chief health equity officer, group vice president, Center for Health Equity, American Medical Association

Panel

- **Atheendar Venkataramani, MD, PhD**, assistant professor in the Department of Medical Ethics and Health Policy at Perelman School of Medicine and board-certified general internist at the University of Pennsylvania Presbyterian Medical Center
- **Edwin G. Lindo, JD**, lecturer, Department of Family Medicine at University of Washington and associate director critical teach and equity at Center for Leadership and Innovation in Medical Education
- **Rhea Boyd, MD, MPH**, pediatrician and child health advocate at Palo Alto Medical Foundation and UCSF Benioff Children's Hospital Oakland
- **Roger A. Mitchell Jr., MD, FASCP**, chief medical examiner of the Nation's Capital
- **Rupa Marya, MD**, associate professor of medicine at UCSF and faculty director of the Do No Harm Coalition, an organization of over 450 health workers committed to structural change to address health problems

Transcript

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Dr. Maybank: Good afternoon, everyone. Welcome to our next edition of Prioritizing Equity: Police

Brutality and COVID-19. I am Dr. Aletha Maybank, I am chief health equity officer at the American Medical Association over the Center for Health Equity. Our mission is really to strengthen and amplify and sustain AMA work to eliminate health inequities, which we know are rooted in historical and contemporary injustices as well as discrimination. We do this by, one, centering and embedding equity in our practice processes, action, innovation, organizational performance and outcomes. We work to build alliances and share power via meaningful engagement. We work to ensure equitable opportunities and conditions and innovation for marginalized and minoritized people and communities. We're working to push upstream to address all determinants of health. And then lastly, working towards creating pathways for truth, reconciliation and healing for AMA's past.

So I first want to recognize and acknowledge the land in which we are all sitting on and the Indigenous people who have been here for thousands of years before us, whose land was dispossessed at the same time, able to thrive and survive till this day. We acknowledge their contributions to this world and this land. And then also acknowledge the Africans that were forced to this land and enslaved for free labor for the sake of capitalism and how we still thrive and survive until this day. And really acknowledging all our ancestors that have come before us that allow us to be in these spaces.

I just want to highlight also for those who don't know, we have a health equity resource center on our AMA website that we've been building out, trying to strengthen. We're definitely open to more ideas. And last week, if you didn't get an opportunity, please check out the great conversation that we had on the root causes and really of racism as a fundamental cause of why health inequities exist pre-COVID, during COVID and after COVID. And we had a great panel discussion at that time. So today, we are here to talk about the recent, not just the recent public killings, but really the persistent and generational realities of forced injury and early death at the hands and by the hands of law enforcement of Black bodies, historically. And in this context of COVID-19.

I will say that I'm surprised that I still can ask why are doctors and health care workers in this space, why are we interested or concerned about this? I just want to handle this now so we don't have to really focus on that too much in the conversation. Of course, people can bring it up if they want to. But the short answer is really people are dying, and that's our business, right? They're either dying through a slow violence, if look at structural racism and COVID-19, or by violence. And usually if deaths and injury are outcomes of any disease, we in the health space have a responsibility to understand why and to act. That is our job and our deeper passion for most of us to protect and promote the health of people. Evidence and experience tells us that exposure of symptoms of structural racism, such as neglect and disinvestment from our neighborhoods, forced overcrowding in houses, stolen opportunities to build wealth, segregated and inequitable health care systems, as well as over-policing of Black and Brown bodies.

And that's not just by the law enforcement system, there's over policing within our own health care

system as well, and limited forms of freedoms as it relates to reproduction. All of this causes harm to our emotional, mental, physical well-being across generations. So sustained exposure to racism in all of its forms, increases our stress hormones such as cortisol, which causes havoc on our physical bodies. And while we know race is a construct, a social construct and has no biological and genetic basis, racism can actually literally change our patterns of how genes are expressed. So whether we're talking about more people dying of COVID or at the hands of police, racism is ultimately the disease. So I'm really pleased and so excited today to have on the panel one, and I'm just asking you to just raise your hand just a little bit like this, just in case folks can't see the names there, but just raise your hand. Dr. Rupa Marya. I never realized how to pronounce your last name.

Dr. Marya: Marya.

Dr. Maybank: Marya. Who is associate professor of Medicine at UCSF, and faculty director of the Do No Harm Coalition, an organization of over 450 health care workers committed to structural change to address health problems. Thank you. Mr. Edwin Lindo, Lindo, raise your hand, who is a lawyer. He is a lecturer, Department of Family Medicine at the University of Washington and associate director of Critical Teach and Equity at the Center for Leadership and Innovation in Medical Education. All right. And then we have Dr. Atheendar Venkataramani. Hopefully I got that right. Great. Who is assistant professor in the Department of Medical Ethics and Health Policy at the Perelman School of Medicine and a board certified general internist at the University of Pennsylvania Presbyterian Medical Center. Thank you. Dr. Roger Mitchell who is chief medical examiner of the nation's capitol and a friend and a long time colleague. I think that's one thing I'm sure that will elevate, as we go through this, the importance of us being able to communicate and talk with each other as leaders in this space and colleagues. One, just for coping and sharing, but also getting ideas and innovation of how to move forward.

And then lastly, but certainly not least, Dr. Rhea Boyd, who is a pediatrician and child and community health advocate, and director of Equity and Justice at the California Children's Trust. So thanks to all the panel for joining us today on this. I'm first going to ask you each to go around and share. I want to know literally where you were at in this country in terms of location, but also how you are doing. Rupa, we talked earlier this week and you asked me, so where's my heart? How's my heart doing? That was really powerful for me. So, let's see. Who could start? Dr. Boyd, would you start for us?

Dr. Boyd: Yes. Hi? First, I just want to say thank you so much for having me on this powerhouse panel, and really for having the AMA elevate the critical importance of this topic. It's so important we are talking in health care about this right now. I am in the Bay Area. I've been here for the last decade. I trained at UCSF. Shout out, Rupa. I mean, I think the word I've been using so often is these are trying times. I feel tried. I feel pushed. People are pushing us. And I think it's what it feels like often to walk this world with black skin, people are always trying you. But right now, 1 in 2,000 of every African American has died of COVID, and we have to watch Ahmaud Arbery get lynched, and

we have to watch George Floyd be publicly executed, and we know what happened to Breonna Taylor, and we know what happened to Tony McDade. And those are the only most recent names that we all have been saying collectively.

I feel tired. I feel exhausted. But I also feel immensely grateful that somebody like you is at the AMA who can elevate this conversation for us to have.

Dr. Maybank: Thank you. Mr. Lindo?

Lindo: Yeah. It's tough to sit in this time right now. I think this is a time that many of us have anticipated, but also a time that makes you realize that for White folks, especially the White folks watching, that this may be the first time that your consciousness comes to a head, and you say, "There's something wrong happening society." But what we have to sit with is that typically that consciousness has to come at the expense of a Black or Brown body. And that's what hurts, is that I no longer want Black and Brown bodies to be the token that puts into the machine of consciousness. I want it to not happen at all. So I've been sitting with that, and I've been wrestling with how does my young Afro-Latina daughter maneuver this space? And I'll share a story that I've shared with some already, but I want you to feel how real this is for a lot of folks.

I was riding her to daycare in the bicycle and before I put her in the back of the seat, she heard the police sirens that were driving by, and she looked at me a little scared and she said, "Papi, are they coming for you?" And that's what we have to live with on a regular basis. I have to explain to my three-year-old daughter that, "No, they're not coming from me." But she's already been trained by the society that someone that looks like me and Dr. Mitchell, like Dr. V, Rhea, Rupa, Aletha, that it's a constant target and fear of walking into the street. So it is an articulated feeling, but moreso of just trying to figure out how we thrive and survive during this time.

Dr. Maybank: Thank you. Dr. Venkadi, Venkat, sorry, Venkataramani?

Dr. Venkataramani: All right. So we're in Philadelphia in Center City, about a 10 minute walk away from what are mostly very peaceful and powerful protests. My wife and I are with our 21-month-old son who you might hear in the background. Generally, we're just really saddened to see—both of us are attending physicians at Presbyterian, which serves predominantly a Black American community. So we've been on the front lines of the COVID-19 pandemic, and we've seen directly how that burden has fallen on one group of people in a very profound way. There's that. And with all of these events, I think we're thinking a lot about how we operate in the world, how our decisions either reinforce or work against the institutions that seem to produce these outcomes over and over. And in that sadness and in that contemplation, we're also very motivated as both scientists and physicians to see if we can do the best possible work we can to hopefully over time inform a broader conversation that leads policy makers to make true change. So that's where we are.

Dr. Maybank: Thank you. Dr. Rupa?

Dr. Marya: Hi. So my name is Rupa Marya. I am sitting in occupied Chochenyo Ohlone territory, now known as Oakland. The territory of Huichin. I was born and raised in Ramaytush Ohlone territory around the other side of the Bay in Mountain View. I just want to honor my ancestors and the ancestors of this land for giving me the safety and protection and love that I need to do this really important work. I am feeling energized and exhausted at the same time, which reminds me a lot like residency training. So just the constant—actually, as I'm on this livestream, I'm getting hit up by our friends in the Anti-Police Terror Project for medical support. So I feel like it is time to recognize and to call upon all of our institutions of medicine to denounce police violence as a public health threat. I met Edwin Lindo in 2016 when he was sitting out in front of the mission police department on a hunger strike, and I offered my services as a physician to accompany community in this righteous protest against police violence, racist police violence in San Francisco.

At that time, I approached my own institution, UCSF, to ask them to denounce police violence as a public health threat. And they said, "Oh, well, that's far too political. You can do your work as a faculty member, but we as an institution cannot take such a political stand." And my words to that after more years and more dead Black and Brown people and Indigenous people at the hands of law enforcement violence is that to couch our work along a political spectrum is to allow it to be silenced. This is not political. The work of our moral work to do no harm, to protect the health of communities, it's deeply moral work, and this is why we took these oaths as doctors. It becomes conflated into a political struggle, and there is a political aspect to this in that this is a fight that's been going on for 600 years of colonial terror around the world.

So it's not to ignore this sociopolitical background, but also to really situate the dialogue, to demand that the dialogue is really situated in the health and wellness of our bodies and the bodies of all people. So I feel excited that the AMA and you, Aletha, are leading this dialogue, and I feel very grateful to be invited.

Dr. Maybank: Thank you. And Dr. Mitchell, Roger?

Dr. Mitchell: Thanks. Thank you, Aletha. This is—to be here and to have this conversation is one that we all wish that we could not have, or should not have. I'm here in Washington, DC, in the nation's capitol. I'm here actually in my office. I'm a forensic pathologist, medical examiner. One of the few or handful of African American medical examiners in this country, one of lesser at a level of a chief in this country. So there's great demand on what we're doing here.

We're in the midst of COVID where we've had over, or are close to, handled close to 580 deaths since March 20, majority of which are African American. Our mothers, our fathers, our aunts, our uncles, our breadwinners that we've lost. And everyone has said it rightfully that it is a—the loss that

we're seeing in COVID is a symptom of institutional and structural racism. It is the manifestation of it, versus the actual core reason, and so we are here talking about law enforcement force and excessive force, police brutality, which is also probably the most reprehensible symptom of the disease of racism in this country. It's the most obvious. Other health conditions are more subtle. And so like, Edwin, I have children.

I have a 17-year-old son, a 13-year-old son and a 15-year-old daughter, and my daughter is an artist. She dances and she also paints. She's been painting up until now images of herself abstract and images of flowers, and women with Afros, and just very light, happy, although conscious images. Last night I walked in the door and she gave me a picture of George Floyd with the officer with his knee on his neck. My question is, now, what do we do?

I refuse to be an example to my children and to this country that we sit idly by comfortable in our physicianhood, comfortable in the places and spaces that we think we ought to be and not rocking the boat at our institutions or our government seats. Silence is complicit, and so there is no room for anyone in this work, no matter what the hue of your skin, to stand or sit silently by while people die in preventable ways. And so, I'm so happy to be here. I'm so happy to be part of this conversation, and a conversation that is just a conversation and requires the action behind it, so thank you.

Dr. Maybank: Thank you. Thank you all for sharing with tremendous vulnerability, humility, and I think it's what's required to do this work and to do it to its fullness. So, I want to—Dr. Boyd, I'm going to come to you to just, for folks who are not familiar who are watching, and we tend to be in the space, we are in the space in terms of equity and there's a lot that we know, but I've learned from transitioning from public health to health care that the context of social justice and equity is just not as deeply rooted or embedded or even as much talked about. And so, there are certain concepts that are just not really well understood and certain health impacts that are not well understood.

Are you able to just speak with us a little bit more about the health impacts and especially as it relates to children? You have been part of, really, leading and helping support the American Academy of Pediatrics put forward some really bold statements around racism, and you've been talking about that for a while, so can you speak to that so the audience can have some greater understanding?

Dr. Boyd: Absolutely. So, what we know is that in the United States about 1,000 people die every year at the hands of police. The police kill about 1,000 people a year. In terms of those racial and ethnic disparities, we know African Americans are three times more likely than their White counterparts to die during a police encounter. Data from just 2018, from the National Academy of Sciences told us that 1,000 black men and boys will be killed by police in their lifetime. This is a number I bring up a lot to pediatricians because 1 in 1,000 is also the mortality rate of measles, a deadly, highly contagious infectious disease for which we, as a health care infrastructure, have poured an enormous amount of constant resources. Right? We are trying to prevent the spread of measles in a way we have not yet even started talking about preventing police violence.

So, in terms of, what are the health effects of police violence? It's important that we know that those health effects are broad, they are intergenerational and they affect adults and children. So, police violence impacts individuals' physical health. If you are in an encounter in which force is used you have risk of injury, disability, death, as we've seen. If you just witness, if you just watch that encounter. The bystanders that you heard with those desperate pleas in that George Floyd video, for those who are able to watch it, for those of us who even watched it through our social media device or even heard about it secondhand, witnessing violence impacts for adults and children your mental health and your physical well-being.

I think we can even kick it to Dr. V on this after, but some evidence has shown that for Black Americans witnessing or hearing about police killing an unarmed Black American in your state impacts the mental health of every other Black person who lives in that state. This is not like the police killed somebody on your block or somebody in your family. This is the police killed somebody in your state. When you think about what it means that now we have the national consumption of the murder and execution of George Floyd, I wonder about the mental health of every single African American across state lines.

For kids, in particular, I will also say that these events of police violence disappear caregivers and caregivers are critical to the physical development and emotional development of the child body. Humans need a relationship that's nurturing with a primary caregiver to grow your brain, your heart, your lungs and all of the safety hormones in your body that keep you well. Once caregivers are taken out of your life, and we know police violence is a source of that removal, especially for Black and Brown kids, you then are at increased risk in your adult life of having chronic illness. Things like heart disease, things like diabetes, and other mental health impairments like depression.

So, just to put that in context of COVID, right? The news media has been running a lot of headlines that say what really puts Black folks at risk of dying of COVID is that you have so much chronic underlying disease. But now put that in relationship to what we know about police violence. If police violence disappears your caregiver, you are at increased risk of chronic disease. Right? So, then we have to be talking about the ways that this is a form of structural racism that is systematically affecting

African Americans, intergenerational.

Dr. Maybank: Thank you. So, I am going to go over to Dr. Venkataramani, rather, to speak about the Lancet piece that you were a part of. I apologize if you all hear anything. I'm in Brooklyn. I'm in New York. I'm in a co-op, and they are upstairs doing construction, so I apologize ahead of time. But Dr. V, can you speak to the Lancet piece that was really quite groundbreaking, but also, why did you go about doing this piece and, really, what has happened since that piece has been published?

Dr. Venkataramani: Sure thing. So, the reason we did that piece was we were very interested—my research is broadly interested in how people's opportunities for advancement in life affect their health behaviors and their health outcomes. There's a lot of different projects that we have under that broad umbrella, but we became very interested in structural racism as it's something that, embedded in institutions and in the way society operates, reproduces poor opportunities for specific segments in the population, especially Black Americans. And so, we've been doing a lot of work on that.

There was a paper by Mesic and colleagues in *The Journal of the National Medical Association* from 2018, which looked at police killings of unarmed Black Americans, in particular, and found that indices of structural racism, so the kinds of things that we typically measure that, such as residential segregation, incarceration rates and so forth map very strongly in the incidents of police killings of unarmed folks in particular. So, we decided that, or we thought that looking at police killings and their incidence and their consequences on mental health was, at least from a scientific standpoint, a way to get greater purchase on the causal relationship between structural racism and health. That's why we got into looking at police killing in the first place.

I think Dr. Boyd did a really good job explaining our study probably better than what I could explain myself. But the general idea was there isn't really a large database on police killings nationwide. I think less than 40% of departments are reporting to a federal database, which doesn't receive a lot of support, to begin with. It's fallen on activist groups and people who are crowdsourcing information to really construct the databases that we have, so mapping police violence, fatal encounters, and *The Washington Post* and *The Guardian*—*The Washington Post* has put together a database as well, so that's really what we're relying on.

Using the work that the folks at Mapping Police Violence have done, which I think is truly groundbreaking and incredibly important to our understanding of these events, along with the behavioral risk factor surveillance study, which goes on about its business regardless of what happens in the world. It's a federal random digital survey. We wanted to see whether having a police killing happen in your state of residence within a few months of being interviewed randomly was associated with worse mental health, and we found a very specific mapping doing that between killings of people who were reported to be unarmed in the Mapping Police Violence database and mental health outcomes among Black Americans only.

I think for a number of reasons that the number that we got about the mental health consequences is probably understated. The first thing is Rhea, Dr. Boyd, really mentioned this, but a lot of these events that are in our database were national. Everybody knew about them. They're shared widely, and so it's not like people in other states who had heard about that were not affected, so that would downward bias our estimates. Some of the instances were very, very local and not well-publicized, and for those, assigning someone across the state, say, in Pittsburgh to a killing that happened in Philadelphia may actually be the wrong way of assigning exposure and that would also bias our estimates.

Even with all of those statistical realities biasing our estimates downward, the total burden of mental health that we calculated from police killings was almost equivalent to the burden or poor mental health that comes from a disease like diabetes. We had picked that one on purpose because when I was a medical student in Saint Louis, I saw I think way too many diabetic foot ulcers come in late among Black Americans and require amputations. That was due to a neglect of a number of different things, including primary care, good social services and opportunities for advancement that would allow people to flourish. That kind of juxtaposition of a chronic disease that we see in the inpatient setting all the time and a spillover consequence among people who are not directly affected per se by that event, I thought was very striking and saddening for us.

I will say that naively after we wrote that paper we thought it would be one of those papers that described a historical episode and that people would forget about it. It would not be relevant after a while. So, it's even more shocking and saddening that we're discussing this paper again I think five years after we started working on it and something like two years after it was published. Hopefully, in the future, we will not be discussing this paper anymore because it was an unfortunate footnote of the past.

Dr. Maybank: Yeah, I mean, I think we're still talking about it because it's been such a part of this country for a very long time. It's getting exposed in a way that it has never been exposed, but the experience has been there for generations in this country. Roger, I'm going to come over to you. One, to kind of respond. Also, if you have anything related to impacts or data, but also just the report came out today that George Floyd's autopsy came back, and it was positive for COVID. So, I just wanted you to also just speak to, from a CME's point of view, what do you understand about his death as it relates to seeing the autopsy report as well? You've spoken out many, many times about this.

Dr. Mitchell: I appreciate Dr. Boyd and Dr. Venkataramani speaking about data. One of the things that we've been working on, and I've been trying to elevate since I started looking at this work in 1999, with the death of Amadou Diallo, is the fact that there no real objective way of measuring how many are counting how many people are dying at the hands of law enforcement. I use the term deaths in custody because the spectrum of deaths in custody is really a phased spectrum, so during pursuit is a phase. Once you've put your hands on the person, that is considered the in-custody

phase of a death in custody, and then there's the in jail or prison, and then there's longstanding incarceration. There's different manners of death that follow the particular phase.

So, while in pursuit, we see a lot of homicides. This is what we—and in custody, and there's overlap in these phases. I talk about that in—I was the lead author on a paper that talks about how medical examiners need to be reporting and categorizing deaths in custody.

We see accidents, motor vehicle chases that lead to individuals dying. That's also important because there's policy that changes. One of the big policy papers that I talk about that happened in California. There was a policy of law enforcement that was Find and Bite for K9 units, and they saw a lot of morbidity and mortality surrounding the biting of dogs of suspects. And it was costing this particular city a lot of money, and there was a lot of deaths and morbidity surrounding it. They changed that policy to Find and Bark. It significantly decreased the amount of injuries to those individuals and decreased the cost burden on that particular city in health protocols. So that's the pursuit.

The reason why I bring this up is there's a Deaths in Custody Reporting Act H.R. 144, right? That was put out several years ago that requires every jurisdiction, law enforcement jurisdictions, to report cause and manner of death of those individuals that are deaths in custody and provides a definition that goes from pursuit all the way to incarceration. What I've been asking for years is a box on the U.S. standard death certificate.

So that physicians like myself and physicians that are in emergency rooms or physicians that are in ICUs, when they're signing death certificates, they can check a box with proper definitions that establishes individuals that died in custody, in any particular phase in custody. So that way the vital records, the National Center for Health Statistics can be an objective way for us to mine that data. And we don't have to worry about law enforcement reporting deaths in custody on themselves because they may not be privy to that death that was from an injury that subsequently died maybe even months to years later from an infection, but can be directly related back to an injury that occurred while in custody, while in jail, while in prison, while during pursuit.

So I want to kind of level set that because the majority of our viewers, our physicians, we need individuals to talk about adding a box on the U.S. standard death certificate so we can have a direct and an objective measure so we can have better numbers. The numbers we have are woefully inadequate and do not tell the whole story as it relates to age, race, gender, demographic and where these individuals live and have their being.

As far as the Floyd case. Yeah, the autopsy report came out yesterday. The cause of death is established as cardiopulmonary arrest complicating law enforcement subdual, restraint and neck compression. The manner of death is not on the medical examiner report. And I have not seen the death certificate. My assumption is that that manner of death is homicide and homicide is death at the hands of another. So although complicated, that cause of death, I would've made it much simpler. I

would've just said complications of, or I would have said asphyxia due to neck compression and just left it at that. But in and of itself, it serves of the purpose of elevating the fact that the neck compression and the restraint is the cause of death, and it does not have in the primary cause of death line, his underlying health conditions of coronary artery disease, which he had 75% stenosis of several of his arteries. And it does not have his toxicology results, which he had some tox findings.

It also has his COVID-19 status. Indeed, that he has a positive COVID-19. It also has that he has increased lung weights of over, both of them over a thousand grams. Normal lung weights range in the 500 gram each level. So he has twice the size, they're congested, which also goes to breathing up against a blocked epiglottitis or breathing up against an obstructed airway in some way. And your lungs are going to fill with edema and become heavy at autopsy. So some of that is here. Some of his bumps and scrapes and bruises are there. And so the reality of it is, is that no matter whether it's asphyxia because of the airway itself is obstructed, ripped or compromised, or whether it's the pressure that collapses the carotid arteries.

We know that there's pressure anywhere from 5 pounds of pressure to 20 pounds of pressure that can collapse the carotid arteries and that is going to stop blood to get to the head. And I think it's probably the mechanism by which Mr. Floyd died is functionally he had his blood supply cut off to his brain. And no matter what that is, it is clear that it's the actions of the law enforcement officer and the complicit nature of those that are standing around watching that had also the same authority to move the officer off the neck of Mr. Floyd that led to his death. So, yeah.

Dr. Maybank: Yeah. I just want to bring in a few other folks in this. Thank you, Roger, for that. And for all that you've just provided. Rupa and Edwin, I just want to provide some space for you all to respond to anything that you've heard and wanted to add to at this point as well.

Dr. Marya: Yeah. I first want to thank everybody for their work in this important area. As Dr. Boyd said, and I think really framed this dialogue really appropriately, that these issues have long standing impacts on communities through trauma. And we know now enough about trauma and the driving of low grade inflammation. And low grade inflammation being associated with all these diseases that plague Black and Brown folks and Indigenous folks in a more impactful way from heart disease to depression, obesity, diabetes. And I see COVID as a way, it's having this worst expression, not only because essential workers can't stay home when they economically must work, but then their bodies, the Black and Brown folks, that our bodies, are living in this state of chronic inflammation.

So I see this situation as really revealing how the structures of colonialism, and by that policing is a system that was put in place during the time of colonial occupation of this land, and it remains with us. And structures of colonialism also include the way our medical institutions are organized currently. While I'm an advocate of the science and the data and many of the ways that we practice medicine, I also see that the structures that exist are also part of that project that came about at the same time as colonial expansion.

And our health, those of us who come from colonized places, our health was never a part of that agenda. Our health was entertained only in so far as a bunch of sick natives might interrupt the resource extraction of colonial projects. And so we really need to reimagine and rethink and decolonize our work as physicians and medical institutions. And this is a really important concept that I feel grateful to my Indigenous teachers from Lakota, Dakota, Nakota territory here in Ohlone territory, Salish territory, who have taken me in and educated me about the 600 years struggle for health and equity.

So I just want to situate our dialogue in that. And I believe the health outcomes that we're seeing broadly in the hospital where I have worked since 2002, where I trained and now work at UCSF, I would notice how Black folks would end up in the hospital with COPD with no history of smoking. And I would ask, "You know, well where—what do you mean? Someone in your house might smoke?"

No one smoked. Emphysema, terrible looking lungs. And over and over, I'd ask, "Well, where do you live?"

"Well, in Bayview-Hunters Point."

Bayview-Hunters Point in San Francisco, where there's still radioactive material that hasn't been cleaned up. Where the cities and medical institutions are also complicit in the coverup of the health problems that Black and Brown people predominantly experienced because of that. So there's so many structures and police violence, as Dr. Mitchell said, is the most egregious one.

I'm currently in the midst of writing a book with my coauthor, Raj Patel, around inflammation, around how we must reconceptualize our work as physicians to be able to move the needle upstream enough to be able to address these things. So I can give people insulin and send them out of the hospital. I can treat DKA. I can treat COPD exacerbations. But how do I really get involved so that I stop seeing those folks in the hospital? And that's where the work really is. And I'm excited to have a chance to share that information.

The other thing I would say is we're wrapping up an investigation of several years called the Justice Study. After I worked with Edwin on the streets in the hunger strike, the community there asked me—it was the community who was advocating for justice for Mario Woods and Mario Woods'

mother, Gwen Woods. Mario Woods was shot by SFPD. They asked me to create a study that looked at this question. If a police killing is the wounds and the medicine is justice, what happens to our health if that medicine is withheld from us? And so I'm not a researcher, so it required bringing in Dr. Sonja Mackenzie, Liz Kroboth, several other researchers to design the research tools. And then we took it to the families of those who were impacted by this violence, and they ripped up our research tools and said, "You can't ask these questions, and you have to ask these questions."

And so it became a really powerful community-led project. We are now in the final, looking over the data and just received funding to get a team together to write up our findings which are extremely relevant. But what we did see, and I'll share is that everyone was traumatized, all races by witnessing and experiencing police violence. With Black and Brown people having the most intense impacts to their health, but everyone is traumatized by this violence.

And we need to start looking really upstream at how do we change these models? How do we move the funding since funding will be so scarce now with COVID? Let's move the funding away from those things that are causing us trauma and towards things that are causing us healing. How do we support the housing, the education, the caregiving, the healthy food, the access to healthy food and safe communities. How do we fund intelligence systems that will drive great health outcomes for our communities and defund those systems that are continuing to traumatize us?

Dr. Maybank: Thank you. So building on that, Edwin, you were definitely doing lots of organizing from what I could see. And I think, because we now have 15 minutes, and I want to get to what Rupa has started and Roger as well, in terms of like solutions. What needs to happen? What do people—what do we need to do? Especially as a physician community, we're a health care community overall. I think there's a disconnect again. You know, you all are very rooted in what it means to move upstream, what it means to move the structures in historical context. But I would err that the majority of the medical community really is not there yet. And so how do we kind of translate that so that we can engage and get more physicians engaged in this space of moving upstream, but also what can they do? And not just physicians, but health care professionals overall as well? Edwin.

Lindo: Yeah. Thank you, Aletha, and thank you for being at the AMA for pressing this conversation and for what everyone else said. And for everyone that's watching, I got to tell you, if you aren't taking notes, if you aren't listening to what is being said over the past 45 minutes, you are missing out on years and years of knowledge of soul and of power that this knowledge didn't come because we read it in a book. It came because we were in close proximity to community. We're in close proximity to the people who are most affected by these issues. And for many of us, we are the ones being affected by these issues.

And so I want to break it down a bit for folks to understand. You may think, well, Edwin, I don't really care what you say, because you're not a doctor. And that's perfectly fine, but I'm going to demand your attention here. Because number one, many of you all in the medical field believe that medicine is

not political. And then we have to disabuse ourselves of that belief because medicine has been wholly and has been squarely situated in the apparatus of politics since the beginning of this institution. And I'm going to tell you how it began, because it was a physician that served as a guide and as a recruit for slave owners to find the most prosperous slave so they could sell it to the next slave owner. Medicine had a role in that. Medicine wrote the pieces in peer reviewed journals that suggested that Black bodies and Indigenous bodies were inherently flawed and that the only natural body that existed on this continent where White folks and everything else was abnormal. And guess what? We still practice that today in our medical education. I sit in medical education. I see the presentation that suggests that a risk factor for hypertension is being Black. How the heck is your melanin the risk factor for a pathological disease? What we need to do, which everyone has done here, is we must pathologize racism.

Racism is the risk factor. Racism is the killer, and we have to address it head on.

Number two, politically, even the lab scientists, you get to choose what your research looks like. Dr. Rupa has chosen to take research that addresses and examines and interrogates racism. Many folks choose not to do that, that is a political choice. But that also means that politics is also involved in the grant that is provided to that nonpolitical research. We must change the way grants are provided, because guess what? I get on the NIH grant, and I look at the list, and I do not see one that says, "examine and interrogate racism on a daily basis so we can deconstruct it." We need that.

Two, that progress has and only has been made in the streets. Our feet on the ground, in community, hand in hand demanding justice. We have not seen anything that has ever changed in this country, because we're sitting at home. Right now there are thousands of people that are getting in the streets, risking their lives of the transmission of COVID-19, because they're telling us that, "I know that the risk is higher for my Black and Brown sisters to get shot and killed by police than me contracting COVID-19, and I'm willing to take that risk." That has to be powerful.

As a critical race theory scholar, and what I bring to my institution, University of Washington School of Medicine, in saying, "We have to fundamentally and create a seismic shift of how we're learning about medicine, but also interrogating our own institution." I'm going to call out the AMA, it's beautiful we're having this conversation, but at the exact same time, the AMA has a blemished past around racial inequity. Now is the time that the AMA, that UW Medicine, that UCSF, that UPenn, that the cities and counties throughout this country step up and say, "You know what? The impossible is no longer impossible." We are going to make that transformation or change of bringing justice.

What does that look like? Well, just yesterday every dean within UW Health Sciences Service, we're talking about pharmacy, public health, social work, medicine, nursing and dental have agreed to the demands on a protest that we're organizing on Saturday that has now had solidarity protests taking place in San Francisco, and Oakland, and Chicago. These demands are that elected officials must declare that racism and police violence is a public health emergency, number one. Number two, we

must end policing that is violent against marginalized populations, particularly our Black community. That we must redirect funds from law enforcement agencies to community based programs for harm prevention, intervention, and transformative justice. That we must stop and reverse militarization of law enforcement, we must eliminate legislative and union contract provisions that shield the police from accountability, that we must declare records of all investigations of law enforcement brutality with associated materials as public property and ensure public accessibility to those records. We must immediately end the violence against protesters that are in the streets because we stand in solidarity with them.

Every medical institution must demand now and must declare their positions on police violence on Black folks. That means that we also must consider the theory of abolition. It is not a wild, crazy idea that sits in the fringes of a theoretical book. Actually it sits squarely in the pedagogy of providing health care to our community. If we are actually here to provide for the common good of folks, then that means we will care what happens to them when they walk outside of our clinic. Abolition means that we are defunding police so we can fund the things that people actually need. I guarantee you, and I will put my career on it, that if we gave people homes, if we gave people food and we gave people education and jobs, 75% of the crimes would never happen. The exploitative nature of capitalism as we know it today does not allow for that. It wants that criminalization. Why? Because the 13th amendment tells us that slavery is abolished except there is an incredible caveat there, and if you aren't aware of it, the caveat is "except if you are duly convicted of a crime."

Why are we over policing in our communities? Because we're filling up those two million beds that are sitting throughout our country of the highest prison population in the world. We have two million slaves, property of the state, working for Fortune 500 Companies, for pennies on the dollar, and we're doing nothing about it, yet we say we are against slavery. Abolition is not a crazy idea. I see most White folks already living it. Most wealthy, White neighborhoods do not have police roaming in their backyards. Most wealthy, White communities don't have police sitting in their car on the corner waiting for a crime to occur. Guess what? If you look for it, you will find it. The data shows us that drug use among black and white folks is identical, yet why are there more Black people being arrested for drug offenses? Violent crimes, similar statistic.

I would ask that we imagine a future that is not even possible in the current conditions of reality that we see now. Now, that justice, real justice, is actually imagining something, imagining a place of justice that we've never seen before. That's why this work is so hard. When many people say, "Edwin, how dare you say we should get rid of the police. What's going to happen to all of the violent folks?" Let me tell you this. The violence is the police.

The fact that being a young Black man, the leading cause of death is to be shot by police is infuriating to me, and it should be infuriating to you. It's our time. It's our time to not just write the letter and make the statement, it is our time right now, as Kimberlé Crenshaw told us, that when the disproportionality

of harm is so great, that means the disproportionality of justice must be greater. Yeah, there's going to be people that deserve more justice than others, because that harm has been too much. I'm imploring every one of you all that are watching to take a stand, get in the streets safely and demand that our intuitions do something that is never done before, and that's actually center Black bodies.

Dr. Maybank: Thank you, Edwin, for that. Dr. Boyd, yes, I can see you clapping, I can see you snapping throughout all of this. We only have about six minutes left, so I want to give you space and time in terms of probably about three or four minutes, three minutes, and then just close out with everyone. Just speak to that as well in terms of physicians and what they can do, especially as a physician, understanding where physicians are at as a whole, as a community, and what should our next steps be?

Dr. Boyd: Yes. I just got to go back and say what Edwin just said to a primary medical audience was so critical, and I hope the students, the trainees and the practitioners really heard that. I hope you pause this recording and you go back to what he just said. That is critical. Before I talk about what we can do, I also need to say very clearly, to underscore what he's saying, protests saves lives. The fact that people are in the streets, and there is civil unrest right now is why the AMA is having this whole live stream. Protests saves lives. Civil unrest is what has brought the civil liberties that pushed the Black liberation movement, the queer liberation movement, and the women's liberation movement. We as a country have required Black folks to get in the streets, and often we've required them to be brutalized in the streets.

Remember the visibility that was necessary during the Civil Rights Movement. Dr. King brought the eyes of America and the eyes of the world to what was happening in the South, and it was only when that was visible to everybody that we made a change. This unrest is critical and the very first thing that doctors can do is what Dr. Marya is doing. We've got to support the folks that are in the streets. Sign up as medics, bring medical supplies. I challenge health care institutions to donate the wealth of medical supplies that you have so that clinicians don't have to pay for their own when they arrive. I think we have to be supportive in our language and supportive in the resources that we're willing to provide to ensure that this unrest can be met with the changes that are necessary so that people can go home safely and know that they're going to be all right.

I'll also say, just more practical advice to clinicians, we need to start talking to patients about this. If you haven't talked to your patient about whether this is occurring, and you haven't recorded that in their medical chart, it's another way in which we are not contributing to the knowledge and wealth of data that identifies police violence as a health issue. We are not recording it as a health issue, so consider recording that. We have few resources right now to refer patients to to address police violence because we haven't recorded it in that way. Start recording it, and then think about the resources that exist in the community that are already doing this work. Just because you learned about this when George Floyd was murdered does not mean that this has not been the work of

abolitionists for centuries. You need to take a step back, and let the folks who are either in your organization or already in your community who have been doing this work lead you in how you can then address it for your patients individually and as a population.

I'll also say one smidge of a piece to parents. I think a number of reporters have been asking me, "How should parents talk to their kids about this?" I think for Black folks, this is a critical conversation that parents are having to keep their kids safe. This conversation happens early. We know Black kids are adultified, or considered older than they are, as young as age five for girls, as young as age 10 for boys. These conversations happen in our homes early. They're primarily centered around our kids knowing their rights and knowing how to keep themselves safe in the encounter. The fact that Black parents have to have that conversation is devastating, because we're essentially educating children to deescalate and encounter with a professional that all of our tax dollars pay for, but we have that conversation. For White parents, it's critical that we have those conversations too. The data from the 1940s that showed us that pre-school aged children, three-year-olds, as Edwin said at the beginning of this, three-year-olds understand race. If three-year-olds understand race, then White children understand too. We need to frame for them what's happening.

A helpful way to do it starting with kids is to model empathy, to show as a parent that you are concerned about racial groups outside of your own, and then to show your child how to stand up for them. What does that look like in your classroom and in your community? Stand with people on the streets. If we require people to be on the streets, to get justice, placing White bodies alongside Black and Brown bodies is a part of the surrendering advantage it will take to eliminate racism and its impact on our health and lives.

Dr. Maybank: Thank you, Dr. Boyd. We're at the very end. One, I want to thank all of you. Your brilliance, your power, your humanity, vulnerability, truth, all of it. It's so critical and so needed. It inspires me. If y'all don't realize, it really does. It pushes me every single day, especially in being at the AMA. I must say, Edwin highlighted, we as a historically White institution, as most historically White institutions have, our history and our legacy of exclusion and racism, and it's extremely critical that we name it. I will give credit, though, to the existing leadership and the current leadership right now who has given me this space and allowed for me to have this space to lead these conversations, because their recognition that we are in a moment, and not even just a moment now, but we are in a moment for AMA and that we need to shift and making sure that we're embracing and being inclusive and understanding and acknowledging and dismantling and all of that.

I want to recognize the leadership for allowing me to do this. For all of those who are out there in the streets, we still encourage you to wear your masks, and your hand sanitizer, and all those things that we know are really important in preventing the spread of COVID at this time. Really, thank you all for being in the streets again, for fighting, and continuing, and pushing this arc of justice as we all have heard. Thank you for all of the folks who have tuned in today. This will be available really pretty soon,

probably by the end of the day. It is available to be shared. Transcript will actually be created as well. I really just wish everyone good health and safety and for all of us peace at some point in time in our lives as well as joy. Thank you all for coming today.

Dr. Marya: Thank you. Thank you for having us.

Lindo: Thank you, Dr. Maybank.

Dr. Boyd: Thank you so much.

Dr. Maybank: Thank you.

Dr. Mitchell: Thank you so much.

Dr. Maybank: Thank you.

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