Prioritizing Equity video series: How the past informs the present

As our AMA Equity Plan reveals, achieving health equity and embedding racial justice requires action and accountability. In this May 17, 2021, Prioritizing Equity panel, leaders in health and higher education discuss why acknowledging historical harms is critical to bringing lasting change to health care.

Learn more about the details of the AMA Equity Plan.

Panel

- Clarence C. Gravlee, PhD—Associate professor, Department of Anthropology, University of Florida
- Robert E. Fullilove, EdD—Associate dean, Community and Minority Affairs and professor, Clinical Sociomedical Sciences, Columbia University Irving Medical Center

Moderator

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

Transcript

May 17, 2021

Dr. Maybank: Hello everyone. And welcome to Prioritizing Equity today. I am Chief Health Equity Officer Aletha Maybank, at the American Medical Association. And thank you for joining the series and continuing to track along as we've had wonderful conversations with many wonderful leaders and scholars across the country over the last year. And today's conversation, and I want to move quickly in today's conversation because I'm very excited about it. We're really going to discuss the important of uncovering our history, our narratives and our truths and the importance of that to really advance
equity, that we can’t ignore the past. We can’t ignore the context of how these inequities have come about in this country. And we have to examine even the historical harms and the challenges of white supremacy and structural racism. Moving forward in this pandemic, before this pandemic we needed to do that, but during the pandemic and clearly after that as well.

And so to help us dive into this conversation, I am pleased to welcome two dynamic voices and leaders in this work today one, Dr. Clarence and Lance. But we’ll say Dr. Lance Gravlee, who is associate professor at the department of anthropology at the University of Florida. And Dr. Robert Fullilove, also known as Dr. Bob, and I'll have a story for him about him in a little while. Associate dean, community and minority affairs and professor of clinical sociomedical sciences at Columbia University Irving Medical Center. So welcome both of you. Thank you for joining me today. So I'll start with, I usually always start with a basic question of just how you are doing and where you are.

Dr. Bob, we'll start with you. And for those who don't know, Dr. Bob was my professor when I was at the Columbia Mailman School of Public Health. He wrote my letters of recommendation, some of my first ones to get into the health department in the New York City Department of Health, and just an honor to always be in contact and connection with him. So, Dr. Bob.

**Dr. Fullilove:** Thank you so much for having me speaking to you from Washington Heights. I am at 169th Street, between Broadway and Fort Washington, for those of you who know Manhattan. That means that I'm right around the corner from the Columbia University Irving Medical Center, where I have been a member of the faculty since January of 1990, glad to be here.

**Dr. Maybank:** And how are you doing today?

**Dr. Fullilove:** Doing very well. I just got back from a long trip. It's always good to see New York in fine fettle. I'm anxious to do some work with my students later on today, but I'm very happy to be here with you right now.

**Dr. Maybank:** Awesome. Dr. Gravlee. Where are you?

**Dr. Gravlee:** Well, thanks again for having me as part of this conversation. So I'm here at my home in Gainesville, Florida where the University of Florida is located and very happy to be in this conversation. And one of the nice things about being an academic is there's a certain seasonality to my year and we've just finished our semester, submitted my grades on Monday. So I'm looking forward to a summer where I have space to think and to write, and to continue some of these conversations. So it's a good space to be in.

**Dr. Maybank:** Awesome. Fantastic. Thanks for sharing. So we're going to jump into this and I'm going to start right off with for folks who probably many are aware of the JAMA podcast that was now, it was actually two days ago … it was two months ago that it really drew a lot of attention. The podcast that had two physician speaking and basically saying some of it that structural racism didn't
exist or that we shouldn’t be using those terms. And it's caused lots of uproar across the country and generated a lot of attention and rightfully so. And so Dr. Gravlee, this is where honestly I first learned of you, and it was through Dr. Nancy Krieger who shared a piece that you wrote. And I really like to discuss that piece and have that be kind of the foundation of our conversation today. And so the piece was, "How Whiteness Works: JAMA and the Refusals of White Supremacy." So what prompted you to write that piece in response to the podcast?

Dr. Gravlee: Well, I think a lot of people who heard that podcast, it was a mix of disbelief and outrage and recognizing that what the podcast represented was a much broader set of assumptions about racism and a broader set of misunderstandings about racism, particularly among white people. And it's misunderstandings that aren't just an accident. It's part of how white supremacy operates. That most white people struggled to understand what racism is, struggled to see it, struggled to recognize it and preserve a sense of themselves by denying that it exists. And so I think what really moved me was to recognize there was this 15 minute conversation that encapsulated so much of the discourse about race and racism among white people. And honestly not just among white people. I mean, you think about the last couple of weeks, we've seen our president, our vice president and a sitting senator all go on TV to deny that America is racist, to deny that racism exists.

There's this rightwing backlash that's going out of its way to deny that racism is a force in American life, right? And the podcast just encapsulated all of that in a really concise way that I think made it possible for some of these abstract ideas to seem very concrete. So that people could really start to recognize the harm that comes from this kind of denial. I think it also helped that. This semester I was teaching a graduate course on racism, medicine and health, and an undergraduate course that was new to me about whiteness. And so my head was very much in that space now. And as soon as I heard the podcast, I brought it into my classrooms and the conversations with students also really clarified for me what an important teaching example the podcast could be. And that's what really got me writing. And I basically rage wrote the first draft of the essay.

Dr. Maybank: Got it. Well, I thank you for that transparency. And it's been used by many as an educational tool, so thank you for that.

One of the nuggets that really caught my attention, there's several in there, was the question that was asked by one of the podcasts participants that said, “Is there a better word than racism?” and you responded, “There may be, how about white supremacy.” And why that hit me is because I've been saying that for a while that I feel that our discourse around dismantling racism is void of talking about white supremacy explicitly. So we've had lots of movement to name racism, but that's still not sufficient enough to get to root causes, even white supremacy still not sufficient enough to get to root causes when you think about colonization and all of that. But why is it important to name white supremacy and can you just help the audience better understand how does whiteness work?
Dr. Gravlee: We have how long again?

Dr. Maybank: It’s a long question for us, right?

Dr. Gravlee: I think that part of the essay that you’re talking about also reflects a kind of transition in my own thinking because for a lot of years been working to name racism along with lots of other people in this space, working to name racism as the driver, the root cause of racial inequities in health. But I think, particularly over the last year, I've been thinking a lot more about how the conversation about racism is, it’s difficult for a lot of white people to see themselves in that conversation.

I think that when we talk about racism, it's very easy for a lot of white people to see it as a problem that really only pertains to Black and Brown people. And the root of the problem is white supremacy.

It’s about the way that our political and economic structures for the entire history of our country have been organized in such a way to consolidate power among people who are defined as white. And as a way of excluding people who are not defined as white from opportunity, from living full lives, from being fully human and having their humanity fully recognized. And so for me, I'm thinking more and more about the need to name white supremacy to get white people involved in the conversation. Now, there’s, of course, this problem that many people hear the phrase white supremacy, and they just think about white supremacists in some kind of extreme form. We think about the sort of caricatures of a racist as being only the KKK and people flying the Confederate flag and so forth.

And really that's not what we're talking about. We're talking about the every day ways that our society's organized, our political structures, our economic structures, our social relations are structured in such a way that resources and power are consolidated among white people. And I think really getting white people to reflect on that history and that reality of the present, it's a huge task particularly because, the other part of your question, how whiteness works? I mean, one basic way that whiteness works is it makes it very difficult for white people to recognize any of this. Because it’s very easy as a white person to sort of move through the world and not think about any of it. Or to turn it off, and it can be very threatening to white people to talk about it as well. So, it's not a small task, but I think really directing attention to not just white supremacists as individuals, but really to the social structures, to the political and economic structures, to the way that our society is organized, so that it constrains the opportunities that are available to people. And it gives other people like me, a leg up that we don’t even recognize that we have. I think it's crucial to face that piece of the problem.

Dr. Maybank: Absolutely. And I think it's a lifelong journey. And I usually don't to say that, but it is because I'm about the now and the urgency of now. But I had a conversation with Peggy McIntosh who is also a scholar in this space, a couple of years ago. And I recently listened to our conversation
and she just talks about the legacy of doing this work as a white woman, naming white supremacy, but white privilege and being able to educate folks around it. It's a lot of work that often also doesn't get much recognition. So Dr. Bob, you and I shortly after the piece came out, happened to be in a conversation and kind of paying it forward, a student of Dr. Bob is now with our team at the Center for Health Equity, who's now graduated. She has her MPH. And in that conversation, you highlighted to me, and this is classic Dr. Bob, who I think is a wonderful storyteller, a wonderful historian as well.

And you spoke about your father and specifically talked about a connection to a JAMA article that he wrote in 1943. And it's going to spark some more conversation, but I think about it in the context of history and oral history and these connections and repeating yourself and not knowing our history and how we have the potential to repeat ourselves. So can you talk about that story about your father and this article?

**Dr. Fullilove:** Of course. My father practiced medicine from 1934 to 1986. At his death, he was the president emeritus of the North Jersey Medical Society. So he'd been in medicine long enough to really see some pretty radical changes from the 30s to the 1980s. And the 1940s, in the midst of World War II, an article was published in the Journal of the American Medical Association that basically said, “We've got a problem with syphilis, and it's a Negro problem.”

The author of the article pointed out that if you looked at all the reasons why Black men in that era had been rejected from the draft, the number one reason was they had tested positive for syphilis, a Negro problem. And it went on to basically state that this was the result of a population that was, amongst other things, very much drawn to criminal behavior, to being antisocial, to not really fitting in.

And as a consequence, it seemed to suggest that number one, not only should Negros be understood as diseased, it was also calling attention to the fact that things had to be done to correct the problems that had been created. After all, this was World War II. We were in a fight to preserve democracy. And the idea that you'd have syphilitic men fighting in Europe or in Asia, in the second front of the war, was something that readers in that period of time were going to find to be apparent. Let's be clear. The American Medical Association in the 1940s, specifically barred African American physicians from being members. So there was a discourse, if you will, within those halls, that was basically one sided and goes all the way back to the issues of white supremacy that Dr. Gravlee so eloquently described. My father basically said in a letter basically challenging what was in that letter.

Please understand that if you look at the other reasons why Black men were rejected from service in the army, it was because they were largely illiterate. Lack of education was a second reason why they'd been rejected. They could not read. He pointed out that lack of education even back then was understood to be one of the ways in which you created a population that was poor, underserved and likely to be challenged by the problems of public health and specifically problems with diseases like syphilis. He said before we start to think about condemning a whole race, maybe we should look at what we would now describe as the social determinants of health and understand that if you dealt
with those social determinants of health, you would probably have a very different disease profile on
the part of this population. So way back in the 1940s, he sort of understood that what drives the social
factors that are so much a part of health and disease are at least as important for our understanding
in modern medicine as the nature of the diseases that a particular population is likely to have.

Dr. Maybank: Thanks. And so in looking now at present day COVID-19, that same narrative really
played out initially kind of blaming Black and Brown people for COVID-19 and then having higher
rates and higher death rates and the narrative is present there. And so, Dr. Gravlee, can you speak to
how these historical, intentional failures of acknowledging white supremacy have played out in this
time of COVID-19 and then the pandemic?

Dr. Gravlee: For sure. And that’s a marvelous story, Dr. Fullilove. I’m going to go look up that letter as
soon as we finish here, because I think it’s an important corrective to this narrative about COVID-19
being unprecedented. I mean, in many ways, of course it is. The scale of suffering has been
horrifying, but it also is following the precedent of health and disease and of medical responses to
health inequities that really characterize our entire history. Whether it’s syphilis, whether it’s
hypertension, whether it’s diabetes, there’s this very long history of health being distributed unequally
and of medical professionals misdiagnosing the problem. Because of a failure to see the way the
white supremacy is conditioning things.

So, the context of COVID-19, I think, early on in the pandemic, it became clear that people were
trying to lay blame for the COVID-19 pandemic, either in Black people’s bodies or behavior. You think
about the surgeon general talking about sort of behavioral drivers and calling on people to step up. Or
you think about Senator Bill Cassidy from Louisiana, more than a year ago, suggesting that genetic
factors were responsible for unequal death from COVID-19. Or Representative Bill Foster in a
congressional oversight committee meeting last summer speculating again about genetic reasons.

And of course, there isn’t a shred of evidence to suggest that genetics has anything to do with it at all.
But this is also one of the important precedents is that there’s a long history of misattributing health
inequities to genetic factors when there isn’t any evidence to support that at all.

Most of my empirical work has focused on hypertension in the African diaspora, and it actually kicked
off with a JAMA article in 1970 in which Dr. Boyle published a paper showing an association between
dark skin color and high blood pressure in Charleston. And he interpreted dark skin color as a marker
of African genetic admixture. And of course, the alternative hypothesis is that in a racist society in
which skin color is a marker of your life chances, darker skinned African Americans are more likely to
experience racial discrimination and to live in poverty and to face other social stressors rooted in
systemic racism that leave a mark on our bodies, including sustained elevated blood pressure.

So in my empirical work in Puerto Rico and in the mainland U.S., one of the things that my colleagues
and I have tried to do is to challenge that idea that first appeared in JAMA and kicked off a program of
research in this area. Where we test on the one hand the biological parameter of skin pigmentation,
or more recently, genetic ancestry against social stressors based on how people are perceived and how they're defined, the way that they're treated. And we've showed in a number of studies over and over again, that once you take account of the meaning that we attribute to skin color, then skin color itself and genetic ancestry aren't predictive of blood pressure. It's really about the way that skin color operates as an index for where people are positioned in systems of power and how that conditions the way that they're treated in the way that they play out.

And so now you bring that forward to the context of COVID-19, where we know that hypertension among other things, increases the likelihood that if people are infected with SARS-CoV-2, that they're going to develop more severe complications. But you also think about the structure of our society that disproportionately exposes people to the virus in the first place because of race-based residential segregation, because of the racialized nature of the American workforce, which makes it easier for some people to avoid exposure to shelter in place to work from home. You think about the racialized structure of our legal system and of mass incarceration which again means that the risk of being exposed to the virus in the first place depends on where you sit in these systems of power. And now you play it forward to the aftermath of COVID-19 as well.

You think about the social and economic fallout of the pandemic, massive unemployment, school closures, delayed health care. All of those consequences are, again, going to disproportionately affect people who lack power, Black and Brown people, who are at higher risk for infection in the first place, for hypertension, cardio-metabolic disease. And so now we see this synergy among all of these problems that runs the risk of making it all worse unless we focus on those problems and base our policy and base our responses on delivering services where the need is greatest. And that has to be a response that recognizes the way that white supremacy structures people's chances of good and poor health.

Dr. Maybank: Absolutely. And so it's a perfect segue for my question for Dr. Bob. In the work that you have done around mass incarceration, so strong form of white supremacy and structural racism, can you kind of continue this conversation and speak to the kind of overlay, the intersection of mass incarceration and COVID-19, and also what this means for public policy potentially moving forward.

Dr. Fullilove: Yeah. I have always tried to link where we are at this moment in our history and mass incarceration with one of the historical trends that goes back to the 1930s, redlining. Redlining was the way in which, as a nation, we decided during a depression to invest in urban areas. We decided as a nation that if you looked around, there were some neighborhoods that were more worthy of investment by the banks, than others. What were the neighborhoods that were least likely to get that kind of investment? Those that were heavily populated by folks of color, but most especially Black people.

Redlining is something that you will see present in almost all major urban areas in the United States. We are still a rigidly segregated society. We might have integration in schools and in the workplaces,
but basically where we live. And I think the 2020 census will bear this out, is that in many, many, many areas, it is clear that Black people, white people and Latinx people live in separate communities, they are not together.

Redlined communities in the 30s persist to this day. Those are the areas that have the highest rates of poverty, but they're also the ones that have the highest rates of police presence. They are the ones that have the highest rates of crime, crime and poverty go together. That means if you live in one of these neighborhoods, you're more likely to come under the surveillance of the police. In New York City that was stop-and-frisk. And as a result of increased police presence, you're more likely to be arrested.

Once you arrested, you're more likely to be tried. And once tried, you're much more likely to go to prison. Fast forward to 2020, 2021 where the highest concentrations of COVID-19 are in jail and prison facilities. In state of New York, that's a population that's more than 80% Black and Hispanic. But this is also a population that because of our nation's hatred for anything having to do with crime and criminality, those are the populations that we struggled to test.

They're the populations that we struggled to vaccinate. You might recall that in the state of New York, the governor had a plan. I'm going to vaccinate prison staff, but I'm going to leave the folks who are incarcerated alone. The governor had to be reminded by the courts of the 14th Amendment, which guarantees equal treatment under the law. You can't arbitrarily designate somebody as not worthy of a vaccination, simply because they have been convicted of a crime. And through the actions of a jury are now doing time some place. The idea that everything that Dr. Gravlee described, our notion that somehow or other populations that are not part of the mainstream, populations that are characterized by their being non-white, by their “other” reason, are the populations that are most likely to be ignored or most likely to be exposed to the problems that are created by a virus like COVID-19.

And the problems that are associated with that disease are the ones that are going to be the hardest for us to regulate because we simply do not as a nation have the habit of treating them as equals. As a consequence, we are looking at settings where the highest concentrations of this virus and our most important struggles to maintain some control over this virus will depend largely on whether or not we can abandon these attitudes and make it very clear that the health of all of us depends on the health of even those who are the lesser amongst us, those who are incarcerated. Nowhere are the issues that I think Dr. Gravlee raised more pertinent and more, I think, relevant for the conversation we're having now, then to understand how white supremacy has led us to a point where we aren't able to act in our own best interest.

In epidemiology, isn't it clear, you never leave a reservoir of infection untouched. We were willing to do that simply because we didn't like, had negative attitudes towards the folk who were behind bars. That as a consequence, we deliberately created a situation where we expose ourselves to contact with this virus, simply because we are too blind to the necessity of doing what we know public health
tells us is right. Nowhere, again are the problems of this conversation more apparent, I think, than in the manner in which mass incarceration has suffered, has been a part of the problem of COVID-19.

Dr. Maybank: Thank you. And thank you both of you for that. To try to transition, because we're almost to the end of the show. So we're in a moment of time. And we've had moments of time before and thinking about history again and how we're acknowledging and remembering history, trying not to repeat history, making sure folks understand the harms of history and the current present time. What are these ways that are going to be important to really document the history so that it doesn't repeat itself? And we don't have another podcast or another article, or the need to write another article that your father did in 1943. What are the tools that we can use?

Dr. Bob, you do a lot around kind of oral history and I've spoken about that work in advancing health equity. Can you speak a little bit about that and how we can use that as a tool? And then Dr. Gravlee, I'm going to ask you also to specifically about the podcast itself. What do we do with it? As we move forward that we don't make the history invisible, but we also preserve it at the same time. But Dr. Bob, can you speak about kind of the tools that we can use?

Dr. Fullilove: More than anything else I think the good news, if one can imagine it of COVID-19, is the reset button has been pressed. There is no going back to January 2020. Now that we're completely aware of the fact that we're all at the same level, asking the question, "What will we do to make sure that we don't have the damage that this pandemic cost?" That gives us an opportunity to focus specifically on health disparities, because of the way in which is Dr. Gravlee mentioned, they are driving this pandemic.

We need to see this as an opportunity to not only do a rebuilding of the infrastructure of this nation's roads and highways. We need to think about the reconstruction of its medical system of care. If we're clear that eliminating health disparities is a way of lessening the damage of a future pandemic, we should begin there. We already have a blueprint on how to do that. The work that you are doing with the Center on Equity focuses our attention, both in terms of policy as well as in terms of action on the places where we need to do the work.

If segregation is a major cause of so much of what has driven this pandemic, why not start thinking about how we de-segregate everything about the way in which public health and medicine operate and use that as a template to rebuild a nation so that it becomes pandemic-proof in the future, if that's at all possible.

Dr. Maybank: Pandemic-proof, appreciate that. Dr. Gravlee?

Dr. Gravlee: Well, so I know you want me to speak directly about the podcast, but before I do that, I just want to come back for a moment to Dr. Fullilove's comments about the importance of redlining and the structures that were set in place that caused harm.
And here's another place where I think we need to revisit the concept of white supremacy to recognize that not only did those structures cause harm and put some people at risk, but they also created advantage for others. So from the period of the 1930s, that Dr. Fullilove was talking about, over the next four decades. The U.S. federal government backed about $120 billion worth of home loans. But because of the way redlining operated, eligibility for those loans was conditioned on race. And that means that 98% of that $120 billion went to people who were defined as white. And so, it's not just a matter of recognizing the way that these structures have caused harm, but also the ways that it has created advantage that has insulated white people from those harms. And there is no way for us to confront the harms without also recognizing those unjust benefits that white people have accrued from these structures. So I think we have to keep both of those things in mind.

Dr. Maybank: I appreciate that, thank you. And I really follow.

Dr. Gravlee: No, I mean, I'm saying this as much as a reminder to myself.

Dr. Maybank: No, I get that. And I really appreciate that frame and narrative, but do you want to just speak to the podcast part as well?

Dr. Gravlee: I do. I feel there are so many things I want to say right now. Just one last one, because before I do that, just because all of the places to intervene that Dr. Fullilove was talking about. I've never been in class with you. So I can't call you Dr. Bob here. I recognize that something your students say. But all of those places to intervene are important, but I also think that we should not shy away from the really big picture and the really big solutions that if we really wanted to make our society pandemic-proof, it requires a much grander reckoning with our history. And I'm reminded here of a piece that Eugene Richardson and colleagues published in Social Science & Medicine a few months ago in which they estimated that if we had actually paid reparations for American descendants of slavery, as we should have, then the transmission rate for SARS-CoV-2 are not rate. They estimate would have decreased by between 31% and 68%.

And that means that not only would fewer Black and Brown people have died from SARS coronavirus, but fewer white people would have as well. And this gets to a point that Camara Jones has made often when she just talks about racism as a system, how it saps the strength of the entire society. It's not good for white people either. And it's also not good for white people to be so dehumanized that we could callously look at incarcerated people and say, “No, we don't need to provide vaccines or testing there either.” What has that done to white people's humanity? If we reach that point where we cannot see others as fully human and treat them with that respect. So I don't want to shy away from those bigger ambitions of dismantling that system and redressing the historical harms.

Dr. Maybank: All right. Appreciate that. Thank you.
Dr. Gravlee: Now, the podcast, what specifically would you to address about the podcast?

Dr. Maybank: It's for both of you, some of the conversations go in many directions, and I've appreciated where it has landed. Some of the feedback that we have received is about what to do with it. And I think this is the question of history that to your point, that has harmed as well as created advantage. What do we do with it? One of the opportunities that presented itself, this was last year, our CEO, Jim Madara after reading some of the historical context of the exclusion of Black physicians, and more specifically understanding the role of the father of AMA or who's considered the father of AMA, Nathan Davis. He removed the bust from the 46th floor in the American Medical Association, understanding that harm and his intention behind doing it and move the bust to the archives of the AMA for educational purposes, moving forward.

And we've seen that movement in many ways across the country. It's important, but we also don't want to lose the context of the history itself and being able to acknowledge the harms as well as the advantage that it calls. And so I was thinking about the podcast, but it's not just the podcast, it's other structures that I think as we move forward in this way of advancing equity, we have actually our strategic plan coming out the week of this podcast being aired. And the last part of our strategic plan talks about truth, reconciliation and healing. And as we get into that space of starting to name our past historical harms and advantages, what do we do with some of that history that we need to reconcile? What do we do to share, this is a longer conversation. So I don't want to go too much in depth with that, but more just high level thoughts from your context from both of you.

Dr. Gravlee: Yeah, my view I think that your question already contains the answer in the sense that we have to do both things. We can't hide from the history. And so I think the idea of leaving the podcast as completely inaccessible to people.

Although it comes from a good place, may not be the solution because then JAMA evades accountability. We lose the opportunity to analyze and understand, use it as a teaching moment. I come back to my motivation for writing that essay in the first place. It was to see it as a teachable moment. I think it needs to be a teachable moment, but it has to be balanced against the fact that the podcast also caused harm. It was an insidious conversation that was a form of gaslighting, really, of telling people who had experienced racism that they hadn't.

And as a way of sort of placating white people's conscience to say that structural racism really isn't a thing. So that causes harm. But I do feel it's important for it to be accessible in a public way that doesn't evade accountability, that permits scrutiny, that permits analysis, and perhaps one way of balancing, that would be for JAMA or AMA to make the podcast available along with some critical analysis and commentary with the various news reports. So that people will have a context for understanding it, and don't just take it at face value.
Dr. Maybank: Thank you. Dr. Bob, close out with you.

Dr. Fullilove: Yeah, I have been a part of an effort started by Mindy Thompson Fullilove, MD, was very interested in having the nation understand that the period 1619 to 2019 would mark 400 years since the first Africans were deposited on the shores of Virginia to begin this country’s tragic history with slavery. The reason she thought it was so important has everything to do with the historical context, which has been so much a part of our conversation today.

Southern Poverty Law Center in 2018 did a survey and discovered that only 8% of American high school seniors could name slavery as the cause of the civil war. I'm very clear that part of what makes these conversations so difficult is that as a nation, we are really poor in understanding and making sense of our history, which is why pointing to 1619 to 2019 last year. Forgive me, it's now two years ago was so important.

I mean, let's be clear about one thing, I think more than anything else, the history of slavery is so poorly understood that when I asked my students in an Ivy league medical center, how many American presidents owned slaves? Almost nobody knows the answer. What could be more important in understanding how we sit with respect to the issues that have been raised in this podcast, than to understand something about our history and how it is we got to this point. History did not begin the day you were born. It began much before that. And so much of what happened on the date that you were born was framed by that, that our failure to understand it, I think, leads us to all sorts of errors, not least of which the podcast that we're talking about right now.

I've always believed that if you taught Americans more about their history, if they understood that 12 American presidents owned slaves that has so structured the nature our ability to even talk about that part of our history. That until we are able to actually do that, we will never have the kinds of conversations that give us clarity about how we got to this point that we're in right now and where we need to go with the future.

I think it's not too much to say that if we were better aware of our history, we would be a lot more conscious of the choices that are available for us for the future. I think I spoke a bit about the history of the American Medical Association and its long drive to keep African American physicians from being a part of that. My dad moved my family from New Orleans to New York specifically because, as someone who is board certified in the 40s, that move allowed him to help other African American physicians get their patients admitted to hospitals. Where a hospital membership depended entirely on being board certified. That history has so much to do with the choices that African American and other physicians of color have had to make that if we understood so much about that framing, much of what we want to do now, post COVID-19, I think, will be enlightened by an understanding of that history.

I have to believe the more we understand it, the greater the likelihood that as we move forward, we'll
do so correctly. As an old guy born in 1944. This is one of the reasons why history is so important to me. Having been around for a long time, I really see how Santayana's comment, "Those who do not learn the lessons of history are doomed to repeat it," certainly seeing that now. And that's why I hope with COVID-19, what we'll produce will be something radically different simply because we've learned the lessons of history and decided to act upon it.

**Dr. Maybank:** Thank you. Thank you to you both. I think it's COVID-19 and I think it's this greater sense of urgency to actually name racism. I hope will also help push that momentum forward to want to look and acknowledge the history as well and its work. As I mentioned I'm very excited, we're going to be releasing the week that this comes out our strategic plan to embed racial justice and advanced health equity at the American Medical Association.

So we will share that with everyone and we hope that other folks check it out and we will spend time on Prioritizing Equity moving forward. Digging into different pieces of the plan, but making sure we're connecting it to the current moment of time and also connecting it to what we all can do, to do our part and to move mountains, as I say. That I think is actually really opportunity at this moment.

So I want to thank both of my guests, Dr. Bob, Dr. Robert Fullilove and Dr. Lance Gravlee for joining me today for a wonderful conversation, your clarity is tremendous. And I'm sure part of it be you both are educators, so it's just really helpful. I think for myself, I know, but also for the audience listening in, trying to really understand these concepts and the context, and you both did a wonderful job. So really thank you both and thank you for your time. And thanks everyone for tuning in today.

**Disclaimer:** The viewpoints expressed in this video are those of the participants and/or do not necessarily reflect the views and policies of the AMA.