Prioritizing Equity Spotlight series: Collecting history(IES) for restorative justice in medicine

This Prioritizing Equity Spotlight session is sponsored by the Robert Wood Johnson Foundation and the American Medical Association Foundation.

This panel discusses restorative justice as a collaborative, decision-making framework to accept and acknowledge medicine’s past harmful behaviors, rebuild trust and ensure healing. We see tremendous opportunities in our present history for alignment and change in medicine and our country to name, embed and advance racial and social justice.

This session amplifies and integrates often “invisible-ized” narratives of historically marginalized physicians and patients to repair and cultivate a healing journey for those who have been harmed. This valuable approach prioritizes the personal connection and humanistic values that attracted most health care workers to the field—it embraces community power and active accountability to preserve the safety and dignity of all.

Panel

- **Rupa Marya, MD**—author and associate professor of medicine at the University of California, San Francisco, and a co-founder of the Do No Harm Coalition
- **Abigail Echo-Hawk**—member of the Pawnee Nation, executive vice president of the Seattle Indian Health Board and the director of the Urban Indian Health Institute, a tribal epidemiology center.
- **Harriet Washington**—writer, editor, and ethicist. Author of “The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present”
- **Samuel Kelton Roberts, Jr., PhD**—author and associate professor of history, sociomedical sciences, and African American and African Diaspora studies.
Moderators

- Jelani Cobb—author, educator at Columbia University Graduate School of Journalism
- Aletha Maybank, MD, MPH—chief health equity officer, senior vice president, Center for Health Equity, American Medical Association

Transcript

Steve: Our next session, “Prioritizing Equity: Collecting History(ies) for Restorative Justice in Medicine,” is sponsored by the American Medical Association. The AMA is the largest and only national association that convenes over 190 state and specialty medical societies and other critical stakeholders. As a physician’s powerful ally in patient care, the AMA represents physicians with a unified voice in courts and legislative bodies across the nation, removing obstacles that interfere with patient care, leading the charge to prevent chronic disease and confront public health crises, and driving the future of medicine to tackle the biggest challenges in health care, and training the leaders of tomorrow. For more information on the AMA and the Center for Health Equity, please visit www.ama-assn.org. Please welcome Dr. Aletha Maybank, chief health equity officer and group vice president at the American Medical Association, who will be introducing this session.

Dr. Maybank: Thank you, Steve. Hello and welcome to American Medical Association's Prioritizing Equity series at Modern Healthcare's Equity Symposium. This series brings together leaders and thought partners and conversation about key equity topics that are facing medicine and health care today. So today's session, entitled “Collecting History(ies) for Restorative Justice in Medicine,” builds upon AMA's recently released roadmap to embed racial justice and health equity, and its fifth strategic approach to foster truth, reconciliation, racial healing, and transformation. We, as physicians, health care and professionals, need to develop a critical consciousness as well as actions that seek truth and acknowledge the historical harms that powerful organizations have both intentionally and unintentionally made invisible, including us at the AMA. I've heard a lot over the last month questioning if this is the work of the present time, when sentiments of, "Let history be history," and statements that, "This is not the work of medicine, health care systems and physicians."

I am reminded of New York Times bestselling author, Isabel Wilkerson's words in her groundbreaking work “Caste: The Origins of Our Discontents” quote, "Many people may rightly say I had nothing to do with how all this started. I have nothing to do with the sins of my past. My ancestors never attacked Indigenous people, never owned slaves. And yes, not one of us was here when the house was built. Our immediate ancestors may not have done anything or had anything to do with it, but we’re here, the current occupants of a property with stress cracks and bowed walls and fissures built into the
foundation. We are their heirs to whatever is right or wrong with it. We did not erect the uneven pillars or joists, but they are ours to deal with now." End quote.

Our distinguished moderator and conversationalists today will explore, what does it mean to reckon with past injustices in medicine? Why capturing and telling the history of medicine is integral to advance equity? And what restorative justice in medicine can look, feel and be like. So, it is my honor and pleasure to introduce our moderator, Dr. Jelani Cobb. Dr. Cobb is an author, he's a long-time staff writer at The New Yorker, wrote remarkable series and articles about race, injustice and the police. He teaches at Columbia University Graduate School of Journalism and has won many, many awards. I want to thank Dr. Cobb for joining us. And before we begin, I want to give thanks to the American Medical Association Foundation and the Robert Wood Johnson Foundation for supporting this work and making this session and others in this series possible. So now, please join me in welcoming Dr. Jelani Cobb and I turn it over to you.

Cobb: Thank you for the introduction, Dr. Maybank, and thank you for your leadership at the AMA and for creating the space for these important conversations. It's a pleasure to be here today and to be able to be in dialogue with this group of amazing leaders about this topic, one that's at the forefront of medicine and deeply connects to my own work of uncovering historical truths of this country, rooted in racism, and the vision that's necessary for the betterment of the country. As was stated earlier, there's an urgency to this work. It's work that no institution or individual can do alone. The panelists today bring forth unique perspectives and experiences in this work of historical narratives and restorative justice for health. As a collective, they've contributed to groundbreaking books, publications, reports and commentary on this topic, and it is the first time that they've been brought together as a group.

We have a lot of ground to cover, so I'll start by introducing our panelists. Abigail Echo-Hawk, MA, is a member of the Pawnee Nation and is the executive vice president of the Seattle Indian Health Board and the director of the Urban Indian Health Institute, a tribal epidemiology center. She works to support the health and well-being of urban Indian communities and tribal nations across the United States. She's been recognized as a national leader in decolonizing data for Indigenous people, by Indigenous people.

Dr. Rupa Marya is an associate professor of medicine at the University of California, San Francisco, and a co-founder of the Do No Harm Coalition. Her work sits at the nexus of climate health and racial justice, and she works to decolonize food and medicine. Dr. Marya is the co-author with Raj Patel of the book, “Inflamed: Deep Medicine and the Anatomy of Injustice.”

We also have with us Samuel Kelton Roberts, Dr. Samuel Kelton Roberts, who is an associate professor of history, sociomedical sciences, and African American and African Diaspora Studies. He's also the former director of the Columbia University Institute for Research in African American Studies. His widely acclaimed book, “Infectious Fear: Politics, Disease, and the Health Effects of Segregation,” is an exploration of the political economy of race and the modern American health state between the
late 19th century and the mid-20th century, a period which encompasses the overlapping and mutually informed eras of Jim Crow segregation and modern American public health practice.

We're also fortunate to have with us Harriet Washington, who is a prolific science writer, editor and ethicist who's the author of many books, including the seminal “Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present,” which won a National Book Critics Circle Award and the PEN Oakland Award, as well as the American Library Association Black Caucus Nonfiction Award. She has authored five other well-received books, including “A Terrible Thing to Waste: Environmental Racism and Its Assault on the American Mind,” as well as more recently, “Carte Blanche,”… a book which I had the pleasure of interviewing her about recently: “…The Erosion of Informed Consent in Medical Research,” and that was published by Columbia Global Reports.

I’m grateful to have the opportunity to be in conversation with all of you, and I'll start with the first question, which is directed to the group. And if we can answer that question in the same order that we were introduced, we can go from there. This is a moment in time. I'd like to get your thoughts on the historical and present-day significance of not only medicine but the American Medical Association, in intentionally naming the critical practice of shedding light on harm caused by their institution. What does this signify for medicine at large?

Echo-Hawk: Thank you so much for the introduction and for this question. And I sit here reflecting on the fact that in the last three weeks, I've lost three family members to things that happened within the Native community that don't have to be happening to my community, that have been going on not only for decades but for centuries, where we see American Indians and Alaska Natives having some of the lowest life expectancy in the United States. And this year, I've lost 10 family members, whether that be to suicide, to accidents, to COVID-19. And when we look at this new, what is almost being seen as a new recognition of racism that is embedded within the medical care systems, I look back at the work of those whose footsteps I follow who have been screaming this from the rooftops for decades, for centuries, if we look at the history of my people.

So, I think right now, while I'm very excited, I see the opportunities, I see the voices that are pushing forward. I also know that the word equity has become rhetoric versus actual action. And so, until we see actual action and move beyond just having conversations to seeing the true change that can happen, that is happening, that has to happen across medical systems, across organizations like the American Medical Association, we're just going to keep saying the word equity. And my relatives, my people, are going to continue to die and that's something that cannot go on any longer. It cannot happen in silence. It cannot happen in invisibility. Now is the time for meaningful change. So, I'm excited for this conversation because I know with this group of people, we're going to talk about what action can truly look like.
Dr. Marya: Thank you, Abigail. That is exactly the, you hit the nail right on the head in terms of the naming of structural determinants of health, the performative gestures of land acknowledgments, without any analysis over how the structures came to be and how the structures can then be changed. And when, in academic medicine or in medical practice, there are the naming of these things without the next step, the prescriptions on how these things can actually be changed, how systems of power can be restructured, it becomes a form of almost reifying the inevitability of these structures and medicine again becomes complicit in the ongoing violences that it has been a part of for the last several hundred years. So, understanding that these lands around the world are lands. I'm here. I was born in Ohlone territory, occupied and unceded Ohlone territory in the Bay Area as a child of Punjabi immigrants, because of the $62 trillion of wealth that were stolen from my homelands in India. So, we have all been orphaned from our homelands in different ways through these systems of violence.

And if we don't truly understand where these thought patterns and systems began, we can't make effective changes. We can't make anything more than cosmetic changes without getting at the root causes of why these things are happening the ways that they are. One only has to look at the outcomes of COVID to see how these things are playing out. Actually, in every health parameter, you'll see the same layout of how racism makes itself known in the bodies of people. So yes, this is an important historic time to push this dialogue further, but even more than that, to demand the changes. It's shocking to me in medicine that up to 40% of dermatologists, certified dermatologists, cannot diagnose common skin problems in Black skin. If that was any other reality, that you couldn't diagnose a heart attack in Black folks or you couldn't diagnose asthma, you wouldn't be certified. But however, in dermatology, up to 40% of practicing dermatologists can't recognize common conditions.

So, there's a whole reckoning that needs to happen throughout the system of ... throughout our society but especially in medicine because it is an emergency and our communities are being impacted on a daily basis.

Cobb: This is, really is a stunning, stunning fact. Dr. Roberts, would you care to respond to the question?

Dr. Roberts: Yeah and thank you. I've been looking forward to this conversation for a while, and as you said, this is our first time altogether, so this is especially, even though it's serious material, it's a treat to join you all in the conversation. I think, as a historian, the AMA, or at least medicine in general, has always been not just medically and scientifically prescriptive but also socially prescriptive, even at times when it might not have admitted that. And this was, I've been thinking more recently about kind of Peter Conrad's critique of medicalization, that to medicalize some things, to remove it from politics, to remove it from social analysis and to think of it just as an individual body. And medicine has never operated in that way. It's always been social.

I am particularly hardened to see, under the leadership of Dr. Maybank and others, that the AMA is now bearing witness to structural racism, structural inequities here in this country, and also,
apparently, reckoning with its own history. I think, as Abigail said, some of that we have to see. Will the proof be in the pudding? And I think that's for the nation at large, really. Really, it's a global conversation we've been having for the past 18, 24 months. But I think this is an interesting moment and certainly, one that I think with hard work will bear some fruit.

**Cobb:** Harriet?

**Washington:** I agree with all these insights. And I just want to say that the history of medicine has been carefully curated to lie the experiences of African Americans and Hispanic Americans and Native Americans. The colonial gaze has been predominant and unquestioned. That's the real harm today; the fact that this long history has been edited so severely in order to project negative perceptions of people of color and yet the profession has been allowed deniability. This acknowledgment is very important in my view because it is a positive act in which the institution is taking responsibility and abdicating that invisibility, and accepting and acknowledging its role, its active role in promulgating this. And it's an act. This acknowledgment is an act. Apologies are very good; their importance, beginning places but they're limited. They're words. This is an act of atonement. With atonement, you do more than talk. There's an act. You're trying to make amends. You do something to make amends. And that's what I see happening here, so I'm finding it very exciting.

**Cobb:** Thank you. And so, Abigail, I wonder if I can direct the next question to you specifically, kind of jumping off of Sam's point about medicine in a social context. You're the chief research officer for the Seattle Indian Health Board and a lifetime public health advocate. You know first-hand the impact the collected histories can have on the health of Indigenous communities that have been made vulnerable by historic practices and current injustices. What does restorative justice mean to you in your work of decolonizing health? And what has been the impact on medicine and people when history has been made so invisible for so many generations?

**Echo-Hawk:** Yeah, this is a question I could give semester-long lectures on. It is definitely one that is deep. When I think about history, in the way that we talk about history, we automatically assign the Western concepts of history to, in other cultures and communities. Western culture and history is not mine. I am not historically underserved. I am historically resilient. I am colonially and institutionally underserved and oppressed. And so, we're even thinking about shifting the language that is used when we talk about the health disparities, the different kinds of health outcomes that we see within medical systems as it affects American Indians and Alaska Natives.

And I reflect back on a conversation I had many years ago with a tribal member. I was doing some research with a tribe on suicide outcomes and how to intervene for young people who were experiencing suicidal ideation. And during the lunch, one of the elders who was there, she came over and she grabbed my hand and she said, "Abigail, I want to tell you a story." She said, "I was one of those children who was taken from their homes for no other reason than I was Native and I was placed in a boarding school in California." She said, "I was there for about five years where I didn't
even see my parents, where they changed my name. And when I came home, I didn't even speak the language of my mother and I couldn't talk to her anymore." She said, "When I got married and I was so excited to have children," and she said, "I tried for several years to have children and I couldn't have any."

And that's when I discovered she had been sterilized against her will, unknowingly, as a young, Native woman in that boarding school, along with thousands of other Native women, who were taken, they either brought physicians to them or they took them into hospitals and they forcibly sterilized generations of Native women. And she leaned her head on my shoulder, and she had these tears running down her face and she said, "I am such a good auntie. I have so many children because I'm a good auntie," but she's like, "I would have been a good mother." She said, "I can understand why these young people experience no hope."

As we look at these impacts that have passed down generation to generation, I tried to publish that, which is, we have established history of this through Government Office of Accountability reports. We tried to publish that in a leading journal here in the United States, talking about the building of health disparities in the U.S., and you know what the reviewer sent back to me? A note that says, "Please take this out. It's inflammatory." We see that even when we try to write about the racism and the history that has existed in these medical systems that affect the health and well-being of people, not just 10 generations ago but 10 generations in the future, that we're not even be able to publish them in these journals that establish medical practice. So, we have this embedded structural racism that is impacting the ability of this auntie, this woman who wanted to be a grandmother, who saw these young people without hope as a result of these medical practices.

And I think about a story that was just told to me by one of our physicians. We had homeless Native people who had been in an accident. They put the other person in a wheelchair and they wheeled them past two major medical trauma centers in Seattle, Washington, to get to our clinic, where we then put them in an ambulance and took them back to that trauma center, with one of our staff, because they didn't trust how they were going to be treated. It has impacted the health and well-being of our people when I think about, I can always reflect on my family; it's impacted our ability on whether or not we'll live past the age of 50, whether the young people in my family will experience suicidal ideation before the age of 18 and whether or not, when they go to that medical practitioner, they are taken seriously, whether or not they are treated with racism and embedded bias, and whether or not they get the care that they receive.

This isn't what should happen. It's not what has to happen. And there is absolutely opportunity for change when we bring forward these stories into the light. Being invisible is purposeful. It's built when the history is defined by others. It marginalizes those who have been the most impacted. And until we get uncomfortable and get comfortable with being uncomfortable, we won't see the change that we're looking for.
Cobb: Thank you for that. Harriet, you’ve dedicated your life to the collection of histories of health injustices experienced by Black Americans and you, of course, wrote the book we mentioned upfront, medical apartheid, and that’s where we learned more about Dr. J. Marion Sims, who was a former AMA president and his egregious surgeries on women who were enslaved without the use of anesthesia. Can you walk us through what it was like and what it has been like, collecting these histories in medicine? And why do you feel this knowledge is critical?

Washington: Well, I know the knowledge is critical because, as Winston Churchill said, "History is written by the victors." And when scientists in the past wanted to support the system of enslavement that provided the economic basis for this country, they used medical science to do so, to promulgate images of African Americans that were quite negative, but more importantly, to establish longstanding, contemporary patterns, still exist. The belief in biological dimorphism, that Black bodies are profoundly different than white bodies. The belief in blame the victim in those -ologies of illness; African Americans' behavior and their own defective bodies is a cause of their illness. Turning a blind eye to the very dramatic abuses and torture that constituted early medicine, and in some cases, it's persisting. All these things are done and were not only abuse of African Americans but also a negative gaze that established perverted images of their personality that persist today.

I mean, it's no accident that in 2016, University of Virginia found that African Americans ... half of all medical students thought that African Americans don't feel pain the way whites do ...

Cobb: Wow.

Washington: ... the exact same belief promulgated in the 19th century by American scientists making a case that African Americans were not fully human. We know about that because we're studying that. What aren't we now studying? And where are they learning this? They're not learning this in textbooks and lectures. They're learning this on hospital floors. When they see the African Americans who come in reporting profound pain, are dismissed as drug seeking and sent away without medication, and with negative notes in their charts that they're probably drug addicts. So, it's actually, it's going beyond the individual patients and subjects who are abused to taint the entire population. The communitarian issues are really profound. African Americans en masse are viewed as people who have negative psychologies, rife with pathology, pathology that is inherently genetic and hereditarian, not caused by the system. All these things can happen because the history is not accurate.

The history was devoted to promulgating negative views of African Americans, and unfortunately, those patterns that have been established are still being carried out today. We talk about the history but I always want to remind people it's not history, it's not dead. It's happening right now. And partly because we have not appropriately addressed what happened in the past. One of the things that spurred me on; I knew this was a problem back in the 1980s when I managed a poison control center for a teaching hospital, Upstate New York. I knew then, from reading patient files, that Blacks were treated differently. But things galvanized for me in 2001. I presented a paper in Lübeck, Germany, at a
history of medicine conference. And while I was there at this global conference on the history of medical experimentation in humans, I thought, "I'm going to talk to the experts here, the global experts, and find out what I need to include in this book that I'm writing about the experimental abuse of African Americans."

And there were 20 people there, most from Germany and also a few from the U.S. and Russia. They said it was a global ... there's nobody there from this Global South or Africa, right? Every one of them told me the same thing. Nothing happened to Black people except for Tuskegee. These are the global experts. And they were too adamant that nothing had happened. And that's when I knew I had to write the book, because this blindness, this myopia about the health care system's venality, from the inception of the republic, is part of the problem. Until we are willing to take off the blinders and see how the health care system has actively driven a lot of the negative outcomes we're seeing now, we can't expect anything to change. And that's why I do this work.

**Cobb:** Wow. Thank you for that. Rupa, in your recent book, “Inflamed: Deep Medicine and the Anatomy of Injustice,” you talk about the hidden relationship between our biological systems and the profound injustices of society, and you also talk about decolonizing medicine. That's not a common frame, not only in medicine but anywhere. So, I'm wondering how you and your collaborator, Raj Patel, decided to go in this direction and how it's been received by your peers.

**Dr. Marya:** Well, you only have to pay attention when you're in the hospital to start to see the patterns, or when you're working in communities around the world. And I work as a musician as well as a doctor, and it was through my work as a musician touring in communities around the world, in the Global South, in the autonomous, Indigenous communities in Mexico, across this land, that I started to notice certain patterns, over the last 20 years, of inflammatory disease. At that time, we didn't know, actually, that these were all inflammatory diseases, whether we're talking about depression and suicidality or addiction or Alzheimer's or cancer or end-stage renal disease, COPD, asthma, cardiovascular disease; all the things I treat on a day-to-day basis as a hospital medicine physician. They're all diseases where inflammation is playing a role. At that time, I started to notice that these diseases were more intensely expressed in communities that had been shaped, or societies that had been structured through systems of colonial domination, and specifically, colonial capitalist domination.

And so, what was it that was similar about the Irish and their patterns, and my people in India, and what I was seeing? Even though we call India liberated from British colonial rule, the structures that they set up are still there and sociopaths like Modi can just use those same structures to drive those same inequities. And so, through that noticing and query, as the data emerged over the last 10 years, all these diseases are linked to a chronic sterile inflammation. And so, I started to wonder with Raj Patel, what was it that was driving that inflammation? And exactly what our other panelists here are talking about; this is, when medicine focuses on individuals and as if the body itself somehow is
dysfunctional, whether it's a Black body, an Indigenous body, a Brown body, it's a form of medical
gaslighting that doesn't allow us to see that actually, the structures, the total sum of exposures that
extend actually through generations around our bodies, that are shaping the body's very normal,
evolutionarily conserved response to damage.

And chronic inflammation is the body's response to damage, whether that damage is through an
environmental toxin, whether that damage is the story of being told as a young, Black boy that the
police are out to kill you because there's a 1-in-1000 lifetime risk of being killed by police in the United
States. That's a real risk. Those children need to be taught in that way but that story itself shapes the
inflammatory response. It creates a stress response in the body. And so, some of those things are
directly impacting what we're seeing in our communities, whether we're talking about the Irish who are
the longest, ongoing colonial entity in the planet, to what we're seeing in India, to what we're seeing
here in Turtle Island. So that, to me, has been very interesting. So, if we understand that colonial
capitalist cosmologies—separating ourselves from Mother Earth, separating ourselves from one
another, separating ourselves from our duties and responsibilities to everything that generates health
and wellness, we will see damage and inflammation when we separate.

So, if we want to undo those ways of understanding, we have to look back to what our ancestors were
doing and how they got it right before, 600 years before these systems of domination were put in
place. And to bring those things to the table now in everything we do, from how we work with our food
systems, to how we work with our medical systems, to how we work with our economic systems, so
that we do not have the spaces of incarceration and the spaces of warehousing humans, where
COVID is showing us how dysfunctional our society is. Who gets hurt and harmed is being told
through the story of this virus. The entire history of the last 600 years is playing out in the last 20
months through the movement of this virus. And so, it's become critical to have these conversations.

How have my colleagues responded to it? The ones who are older, male and white are not as excited
as the ones who are entering medical school, Black and Brown. So, there's a fervor and a real passion
in our young medical students, who are demanding a curriculum that addresses the history. They're
demanding, Harriet, that your book is taught. They're demanding that there's a deeper understanding
of history and the lines of power that are shaping the body's response. So, the body is not
pathological. Our bodies are doing what they're supposed to do. The world around us is pathological,
so it's time to start restructuring that world.

**Cobb:** Thank you. Sam, you have comprehensively researched the history of medicine and public
health in urban Black communities, and you've led in this space at the intersection of history and
public health. Can you share how you're receiving this broader awareness in medicine about
reckoning with history?

**Dr. Roberts:** Yeah. I think that my answer's going to dovetail or at least piggyback quite a bit on
Rupa's answer to the previous question. There is a discernible change. It's been gradual, it's been
slow, it's sometimes faltering, but I have, at least I believe I've seen a change. When I first began my career in this field, I would speak at medical schools and as Rupa said, you would have people in the audience who would be either indifferent or even outright hostile, to the idea of social determinants of health and structural racism and inequities. Now that I think back on it, these were quite often the senior members of a medical school faculty, the kind of, the white-haired white men in white coats, so to speak.

It's a bit different now. And today, I'm more likely to have questions or interest in the research questions that I've been pursuing, which is to say that, how is it that, as Rupa said, this economic system that we have, which is broadly capitalists ... there's all types of capitalism all over the world. The American variant is particularly brutal, quite often. How medicine fits into that. How this system produces bodies which will then suffer ill health because of the system. How medical education often reflects the ideologies that are produced by capitalism. Those questions are more frequent now. I think some of that is because of, well, the literature has changed. I'm coming behind Harriet's work, Keith Wailoo's work, Vanessa Northington Gamble's work and so many others who have paved that way, so to speak.

I think some of it too, is that perhaps medical schools aren't as hierarchical as they used to be. I've seen more junior faculty and as Rupa said, students who are vocal when I lecture at medical schools. And I don't teach in a medical school, by the way. I teach in a public health school. But what I think I discerned from when I do speak and my colleagues who do teach in these schools, that it's really interesting. I mean, it's the med students who I think are ... I could be wrong on this but who seem to be the vanguard of what is progressive in American medicine right now. I think some of the more critical and vocal members of the American medical profession haven't actually quite joined it yet, in certain ways. So that, I think that's been promising.

Now, how that shakes out because that's about audience reception. There's still this massive structural edifice in which we're all operating, in which people are suffering and dying, in which people are being educated, as Harriet said, to believe that Black bodies are abnormal and don't suffer physical discomfort, let alone psychic discomfort. Those are assumptions that are ossified not just in medical culture but also medical structures; structures of our health care system but also structures of our medical education system. And there, the jury is still out. I try to be hopeful. To be honest with you, sometimes I feel like to be Black in this country, if you lose all hope, then you've just, you fall into despair. So, I try to maintain my hope wherever I can but I also have to be a realist. I need to see more of what's going to happen.

Cobb: There's another question that I want everyone to weigh in on but mindful that we have a limited amount of time here. So, it's a big question and I have to ask for succinct answers. But can each of you talk to me a little bit about, what does a framework for restorative justice look like in medicine? And we can start, once again, in the same order that we were introduced in, with Abigail.
Echo-Hawk: So, last year here in Seattle, Washington, there was a Black physician by the name of Dr. Ben Danielson who resigned from a local hospital here, citing institutional and structural racism, not only against him but Black families, children and other employees.

Cobb: Wow.

Echo-Hawk: So, I was part of an assessment committee that the hospital then brought together that was, under the direction of the assessment committee, was with former Attorney General Eric Holder and his team, did an investigation of this hospital—going through and spent many months looking at and investigating what was going on. I spent a lot of free time on that, a lot of early mornings getting to know Eric and his team. And when the findings from that study came out, the hospital initially absolutely refused to release them.

Cobb: Wow.

Echo-Hawk: They refused to release them to the community. And so, when we think about what kind of framework needs to happen, is that again, we spent time, the community spent time, people of color like myself spent time doing what we could to look at a system, to look at opportunities to not only identify but undo structural and institutional racism to improve outcomes from socioeconomic to medical practice within a large hospital system. And then the hospital freaked out and refused to release it, and then only released small portions of it, and only with great community uproar. So now, we have a community of Black and Indigenous and other people of color with one of the largest children’s hospital systems in Seattle who no longer trust it. And so, they’re now starting to have to rebuild that trust.

So, a framework could look like what I had thought they were initially going to do and that was do the investigation, look at opportunities for true change, and move forward with true community engagement to do that. But racism makes people uncomfortable. We’re going to have to get comfortable with being uncomfortable. We need to get comfortable with being uncomfortable and a true framework has to be built on community knowledge. It has to be built on the best science available, and the information that shows us where and how we need it to intervene. And we need large bureaucracies, hospital systems, organizations to get comfortable with being uncomfortable because that is what our communities deserve—the very best health outcomes. And we, as health professionals, want them to have that.

Dr. Marya: So, a very similar thing happened in Kaiser, where there was a climate survey of, what’s the vibe in Kaiser? And the report back was systemic racism over everything. And then there was, from Black CEOs and Black heads of diversity, and folks who were in the structure, in charge, orders to shut that down. Did not release it. So, it is not only that we have to get comfortable being uncomfortable, we have to get comfortable getting sued because what we’re seeing is illegal practices of how structural racism are causing deadly outcomes. If this was treating a heart attack, we get all up in arms about door-to-balloon time in medicine, door-to-balloon time to save lives. But when it deals
with racism and how that's impacting the lives of our patients, then everyone gets all uncomfortable because these are lawsuits that are going to happen because the systems are, they are racist.

And when our Black medical students shut down a class two weeks ago at UCSF, first-year medical students, they've been in the system for a few months, and they start teaching the class to the teachers who are supposed to be talking about structural determinants of health, the response from the university hasn't been wholeheartedly, "Let's just listen." Sam, as you were saying, that the most progressive voices are coming from these people who are entering medical school and going, "Oh my God, this is messed up." We should be listening to those folks and listening to the community at UCSF, their whole Hunters Point, Bayview radioactive waste situation that's going to blow up into another lawsuit. How has UCSF been complicit in continuing to sell out the health of community members? And we need to really understand that what is happening is a challenging of structures of power and that's where people get uncomfortable. And so, that kind of discomfort means certain people will lose their jobs and other people will get different kinds of jobs, and power structures will be restructured, and that is exactly what needs to happen.

And I hope it can happen in ways that can create not a zero-sum game mentality but, okay, this is for the evolution of our culture together. This will actually bring us all better health outcomes as a society. This is not about punishing but it is also about recognizing where we had been remiss and being accountable for that. And so, I see that there is ... while we do have this movement from our medical students with the Do No Harm Coalition, with White Coats for Black Lives and with these medical students coming in, we as faculty need to sit back and empower them. Just give them the microphone, say, "All right." We shouldn't ask them to change the curriculum. We shouldn't ask them to design curriculum. They're paying to be there at school. But we should bring in experts, like folks on this panel, to help us shape what that can look like. I'm sorry, I'm very passionate about this, sorry.

Cobb: True. Thank you. Sam, could you respond to that same question? Oh, you're mute.

Dr. Roberts: Sorry. I think, yeah. I don't know. I can't say precisely that I know, in all the details, what's restorative justice looks like. It's a big project. I would think that a starting or founding principle is that we should question all of the assumption, all of the premises on which we have built medicine as an institution and also as a scientific pursuit. And we can just start with redoing everything. Redoing curriculum. I mean, curriculum typically starts with on the cellular level and the organ, and then the system and then maybe the body. And then in your third-year elective, you might take something about social determinants of health and thinking about medical sociology ... or sociology of medicine, rather. What if we redid that and zoomed in instead of zooming out?

What if we started with the structural, started with the social, the political or the economic and then worked our way down to the cellular level, so that the common presumption, the foundational principles, are always about thinking structurally? That the idea of “do no harm,” which is the Hippocratic Oath but, really, these connotations are much more recent than classic Greek medicine.

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That's a very individualist kind of thinking; do no harm to this patient but it doesn't really invoke or enjoin physicians to think about, as Rupa just said, their complicity as a profession in structural violence, in racial violence, institutional violence. So, all of these founding principles could be questioned. That's hardly a prescription for how you do restorative justice but that's a longer discussion. I think that's a good place to start as any.

Cobb: And so, Harriet, we will give the last word to you. You're muted. Hello?

Washington: You think I would remember by now. I started off studying literature. That was my first love. And I see that it's very, very important for us to address medical jargon, and to recognize that the language in which we describe and address medicine is like news speak. It's a language that has been formulated expressly to make it almost impossible to question many assumptions. And we have to, I think, really address this and attack it. How often do I read discussions of this topic and hear people talk about past abuses, with no evidence that they're confined to the past? How frequently do I hear someone invoke paranoia for a fear that is rooted in logic; a logical fear based on real threats. So, we have to be more careful about language and then I think we also have to pay attention to the law.

I wrote a book entitled “Deadly Monopolies,” in which I examined the patent system as the font of many of our present-day abuses. Everything from separating us from medications we need to biocolonialism, appropriating the technology and wisdom of other countries because they are poorer and they have fewer scientists and fewer good leadership. We're basically appropriating their intellectual property while we force them to respect ours. So, I think that the law is really important in terms of our American challenges. The challenge is everything from treating people differently when they walk through the door according to their race and hiding behind some kind of genetic construct for it, or a very feeble social construct, as well as pure mentology, like the belief that Black people don't feel pain. These things are very common and we need to attack them.

We need policies in both hospital systems and in federal law that address them directly. The law that established the predominance of patents over patients, the Bayh–Dole Act, was passed in 1980. It needs to be revoked. We've had patents on genes that have already been revoked, which is something else I recommended in that book. These things can be done but they're not going to be done until we codify laws and regulations and then establish consequences for not meeting the standards. Have guidelines that are very specific so there's no question about how a doctor should behave. If your resident or a doctor you're supervising is confronted by a patient who insists on being treated by a white doctor or a real doctor or an American doctor—the people I know who are in that situation tell me that they're never supported by their attendings. They'll try to placate the patient. There should be a written policy saying that when that happens, you correct the patient.

These kind of policies should be established, adhered to and there ought to be penalties for not following them through. We treat it like a quality-of-care issue, like any other important issue in health
Care. There's nothing more important than this and we need to have regulations that people have to follow or I don't think we can really expect much efficient progress. So, that's my take on that.

**Cobb:** Of course, having this conversation only kind of points out how much more we could have, how much more we could talk about, how much more we could have this conversation but, unfortunately, we're at the end of our time here. So, I just want to say thank you for participating in this discussion. And the work that you all are doing to ensure that deliberately obscured histories are brought to the forefront and that there is a movement toward justice in medicine, is remarkable and crucial. And I'm going to turn it back over to Dr. Maybank now for closing remarks. Thank you.

**Dr. Maybank:** Thank you, Dr. Cobb. Really appreciate your leading this powerful, timely and meaningful conversation. I thank Harriet, Abigail, Rupa and Samuel for your insights and your commitment, for your overall leadership, not just for this work but just as humanity overall. And for those who are listening in, we encourage you to visit our Prioritizing Equity video series just to learn more, to dive deeper. And just thank you and there will be more to come.

**Steve:** Thank you, Dr. Maybank. Thank you to our outstanding panel for sharing your insights and achievements. And thank you to our session sponsor, the American Medical Association. For more information on the AMA and the Center for Health Equity, please visit www.ama-assn.org. Thank you and enjoy the rest of this symposium.

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