

RTS:// When will anti-Black sentiments in the U S across our various systems, from education to criminal justice to healthcare, move from the tolerated to the unacceptable.

INTRO:

FROM THE USC LEONARD DAVIS SCHOOL OF GERONTOLOGY, THIS IS LESSONS IN LIFESPAN HEALTH, A PODCAST ABOUT THE SCIENCE – AND SCIENTISTS – IMPROVING HOW WE LIVE AND AGE.

I'M PROFESSOR GEORGE SHANNON, KEVIN XU CHAIR IN GERONTOLOGY

ON TODAY'S EPISODE, HOW RACISM IS A THREAT TO PUBLIC HEALTH. PROFESSOR REGGIE TUCKER SEELEY, THE EDWARD L. SCHNEIDER CHAIR IN GERONTOLOGY DISCUSSES THIS ISSUE WITH HIS COLLEAGUE, PROFESSOR JHUMKA GUPTA OF GEORGE MASON UNIVERSITY.

RTS: This is Reggie Tucker Seeley, and welcome to the lifespan health podcast. I'm very excited to talk about experiences of racism and hate and the implications for health across the life course with my good friend and colleague Dr. Jhumka Gupta. I want to note that Dr. Gupta and I have known each other for almost 15 years. We were doctoral students together in the department of social and behavioral sciences at the Harvard T H Chan school of public health. Welcome Dr. Jhumka Gupta.

JG: Hello everyone. This is Dr. Jhumka Gupta and I'm excited to chat today, especially given the recent increased attention on issues such as health disparities during the COVID-19 pandemic and systemic racism and police brutality, particularly in the aftermath of the murders of Brianna Taylor and George Floyd.

RTS: Yeah. I think the confluence of these issues is providing us with a critical moment, uh, to talk not only about health disparities, generally, and racial and ethnic disparities specifically, but also as expanding the conversation about what public health calls upstream or structural factors or the factors that create and shape the context where our health is created and our health behaviors are actually implemented

JG: This time is very reminiscent of our conversation exactly four years ago. When you and I started talking about writing a popular press piece about racism and public health.

RTS: Yeah. Um, do you remember what the motivation was for us to write that, 2016 article? Uh, well first we should state that the title of that article was, *To promote public health fight hate where we live, learn, work, and play*, and it was published online @huffpost.com//.

It was the summer of 2016 and the actor Jesse Williams was awarded that Black entertainment, television, humanitarian award. And he gave a fiery speech about police brutality and the killing of young Tamir Rice, a 12 year old African American boy who was killed in Cleveland, Ohio by Timothy Loehmann, a 26 year old white police officer and Rice was playing with a toy gun. in a

Cleveland park. Jesse Williams speech went viral and it was all over the internet. And it sparked a lot of discussions about racism and police brutality generally. And I think anti-Black hate specifically.//

JG: Exactly. We realize that these very critical issues were being discussed more and more in high profile spaces, such as the BET awards, but what was missing was the discussion of health implications. At the same time, it was a presidential election year and the hateful rhetoric of the Trump campaign was only getting worse. And the rhetoric was targeting Black communities, Black and Brown immigrants, refugees, women, and girls, and other communities such as LGBTQ, Muslim, and disabled communities. And for those of us who are trained in and do research in examining health inequities, we could just see the crisis coming. So we wrote the Huffington Post piece to number one, bring the public health lens into the conversation around social injustices by really laying out the decades of literature on how racism and discrimination impact health inequities and 2) to mobilize the public health field to not only study the etiological role of racism and producing patterns of health inequities, but also consider the need to respond to this hateful rhetoric in all spheres of life, outside of academia in our everyday lives. That is why we invoked the Robert Wood Johnson Foundation culture of health framework on how health happens, where we live, learn, work, and play, and therefore hate must be confronted where we live, learn, work and play as well. And implicit in this framework is that structure matters. // So an example of those structural forces is a red lining, where due to federal policy groups of Black or Brown people were sorted into specific neighborhoods and kept out of other neighborhoods based solely on their race.

RTS: Yeah. And, and here we are four years later, the names may have changed, but the issues related to systemic racism and police brutality and the implications of those to our health are still relevant.

JG:

The topics from the 2016 Huffington post piece are not only relevant in 2020, but their urgency is only magnified. Trump has highlighted that Black and indigenous people and other people of color, which we call BiPOC in the US can seem to live an entirely different worlds compared to white people in the U S however many BiPOC people are forced to know the white world, but few whites know the BiPOC world.

RTS: And I think what the COVID-19 global pandemic, we know that across racial and ethnic groups, that there is differential access to testing, different levels of access to quality healthcare, differences in the navigation of healthcare, differences and caregiving responsibilities, and differences and financial resources to navigate and manage healthcare and caregiving. And these differences have been shown across various health outcomes and almost always Black and indigenous people and other people of color generally fare worse than their white counterparts. Because we have seen this over and over for many health outcomes, many of us health disparities researchers, often state that we are so tired of still just describing the problem, but what does an intervention look like that addresses racism and hate towards Black and Brown people? That is what this action and this space look like?

JG: Agree. There are certainly is not a shortage of research describing health disparities, but what I would like to see more supported is the health benefits of explicitly addressing racism, whether that's specific anti-racist policy, or if we are talking about implicit bias training of healthcare professionals, how does that not only change attitudes, if at all, among healthcare workers, but how does this training translate into patient health outcomes? How does this training translate into reduced feelings of being in fight or flight among BiPOC and especially Black patients or on a campus community or a specific city? What are the health impacts if at all of seeing Confederate statues being toppled down? But this is necessary, but not sufficient. What happens after the statues come down and the public statements of support?

RTS: Yeah. Um, you know, I'm, I'm reminded of a quote that I've used several times related to when does our knowledge about health disparities move us to collective action. And it's a quote by Sir Jeffrey Vickers from an article he wrote in the new England journal of medicine in 1958, he stated, "the landmarks of political economic and social history are the moments when some condition passed from the category of the given to the category of the intolerable. I believe that the history of public health might well be written as a record of successful redefining of the unacceptable." And I use this quote often. And I think the question is when will anti-Black sentiments in the US across our various systems from education to criminal justice to healthcare move from the tolerated to the unacceptable.

JG: Yes. And I think naming the anti-Black sentiment explicitly is important. And one area of anti-Black sentiment that is rarely discussed or explored is the anti-Black sentiment that exists in other racial, ethnic minority communities. And an example is Mr. Sureshbhai Patel. And he was a 57 year old grandfather from India who was visiting his family in Alabama. //And in February, 2015, he was walking in his son's neighborhood when the neighbors called the police on him //and Mr. Patel did not speak English well. And so it was reported that he didn't understand what the officers were saying to him. So the police beat him and Mr. Sureshbhai ended up being paralyzed. And this is just one example of the racism and discrimination faced by South Asians in the United States, which has only escalated since nine 11, like other Asian American communities. We are viewed as perpetual foreigners, not truly American, and especially for South Asian communities.

JG: There's a fear of us appearing as a terrorist. And we joke all the time amongst ourselves about how we are the ones who always seem to be randomly selected at the airport for a more thorough search. But the reality is this type of discrimination is dangerous. And an example of this is the Sikh Gurdwara in Oak Creek, Wisconsin in 2012, a white supremacist walked into this house of worship and killed six people and injured many others. And it's this kind of a fear of what we look like that led me to be scared of flying home with my father who had Lewy body dementia. I was truly concerned that he would not understand instructions for flying, and we would end up being questioned by security. So I share these to say that non-Black communities of color do experience racism, but also there's work to do within our communities around anti-Black racism.

JG: If you look at the number one selling beauty product in India, it's Fair and Lovely, a skin whitening cream, there's preferential treatment for lighter skin in India and it's pervasive. And when South Asians immigrate to the United States, we bring these entrenched biases with us, and it manifests as anti-Black racism. However, anyone from South Asia who immigrated to the U S after 1965 was able to do so because of the civil rights movement, specifically the immigration and nationality act, which got rid of discriminatory bands on immigrants from Latin America, Asia, and Africa, and the anti-Black racism also affects us because neighbors called the police on Mr. Patel because they thought he was "some skinny Black man." So there's also work that needs to be done in our own communities as well.

RTS: Wow. Jhumka. Thank you so much for sharing those stories. I think there is just so much work that needs to be done to address anti-Black sentiments in this country. And this work must be included in any of our intervention and policy efforts to address health disparities.

RTS: Yeah, and the focus of our 2016 article was on the harmful health impacts of anti-Black sentiments and hate. We discussed the hate driven social injustices can occur in the forms of racism, ableism, heterosexism, sexism, or anti-immigrant sentiment among others. And that public health research has attempted to elucidate the impact that these isms have on the public's health. You know, that is one of the aspects that really drew me to public health generally, and to the field of social epidemiology specifically. Um, one of the frameworks from this field that I think helps us to begin to really understand what we're seeing with the different impact of COVID-19 on Black and Brown communities is the fundamental causes theory or framework. And that framework suggests that resources such as money, knowledge, prestige, power, and beneficial social connections are sorted by socioeconomic position. And these resources create the social context where health behaviors are implemented and our health status is produced. And in creating this context, the resources or lack of such resources are the factors that put people at risk of risk. And we know that socioeconomic resources are disproportionately sorted by race, ethnicity, with Black and Brown and native households, having substantially fewer of these resources compared to other racial and ethnic groups.

JG: Right. And we also know that these circumstances don't just happen randomly. They were purposefully shaped by decades and decades of policies, and they won't be remedied with a one shot or, or simple solution to address health disparities and systemic racism.

RTS: Right. And so, um, I remember when I was on the faculty at Harvard, in our old department, actually, um, I taught a course called measuring and reporting health disparities. And in that course, I recall that the students were consistently surprised by the size and scope of health disparities generally, and racial and ethnic disparities specifically. Um, I would often discuss that just because we know a health disparity exists, that doesn't always facilitate action. And the question I would also ask in that class was when is a difference a disparity, and when does a disparity warrant action,

JG: Right? And we know that these are such seemingly simple, but as we know, very hard to answer questions. And sometimes we don't even know when a difference is present because

we don't have the data for all groups or the data has not been disaggregated across groups. And an example of that, um, I read from a Health Affairs article about two weeks ago, is that in San Francisco deaths from deaths among Asian Americans consistently account for nearly half of COVID-19 deaths. And this pattern is just not specific to San Francisco, but they're starting to see this pattern in other communities as well. And when we look at the COVID epidemic in New York, the places that were hardest hit Queens, Bronx are also home to a large population of immigrants from Bangladesh who are also largely working class immigrants. And they also live in close quarters. But when we see data that just says Asian, it's difficult to discern Bangladeshi immigrants in that mix. And there's a lot of concern among activists from this community about what they're hearing from people in their community about people being impacted by COVID-19 and what the data are showing or not showing.

RTS: Yeah. And I think, you know, you raise a really great or interesting challenge here that is, you know, if we don't have the data, then we don't necessarily know what those differences are across racial and ethnic groups. But I think also the challenge is that it's not necessarily, um, membership in that group that is the risk factor. It is the racism that has a substantial impact on our, on our bodies. And what we highlighted in our 2016 article was that racism can operate at the individual level and at higher levels that is in our organizations and in our society. So at the individual level, we see the maltreatment of Black people based on race that leads to feelings of being under threat. And it is in the managing of those feelings over time that can lead to wear and tear on our bodies that have shown accelerated aging and worse health outcomes among racial and ethnic minorities, generally and Black folks in particular.

An example of structural racism is seen in our neighborhoods where racial and ethnic groups have been historically sorted based on policies like red lining into specific parts of cities and the neighborhoods with primarily Black and Brown families generally have fewer resources for creating a healthy life compared to their white counterparts.// 23:21 I recently saw a TED talk that introduced a very promising strategy for helping folks to understand what experiencing racism feels like. And it's called Experiencing Racism in Virtual Reality by Dr. Courtney Cogburn from Columbia University. And she asked a very interesting question. And in that Ted talk video, she asked, what would it take for data we see to not just make us feel bad, but to act? So as we look to ensure that the attention to systemic racism and health disparities currently happening actually lead to an improvement in the lives and health outcomes for Black and Brown people, many of us have been asked for resources to support during this time.

And one of the questions is, you know, to support what, what specifically are folks or organizations looking to get help with? Um, there have been increased discussions on social media and popular media about anti-racism books and discussions about book clubs focused on systemic racism, but similar to our discussion about health disparities, what happens after knowledge is gained. So in our 2016 Huffington Post article, we talked about the American Public Health Association's national campaign against racism with the goal being to begin a conversation where racism is explicitly named as a threat to the health and wellbeing of all society, but in public health research, what this can mean is not just naming differences across

racial and ethnic groups and health outcomes in our research studies, but actually contextualizing with history about why those differences exist.

JG: Right? And one of our goals from our 2016 Huffington post article was for our field, public health to actually name the issue. And an example we see of this is the declaration from Montgomery County in Maryland, where I grew up and currently live, where they declared that racism is a public health issue. And so we're seeing this conversation move from public health, academic journals and conferences to policy circles. And I had the opportunity to actually ask my council member Will Jawando about what the motivation was for this resolution. And a quote from him is: "racism is present in every aspect of American life. Montgomery County is leading the way as one of the first jurisdictions to pass this type of legislation. As a full council, we have established a track record of promoting racial equity, social justice, and inclusion throughout county government. The resolution declared racism is a public health crisis elevates this issue and is the next step in creating legislation to promote racial equity and eliminate health disparities in Montgomery County."

RTS: Wow, well, that is a really great start for Montgomery County in Maryland, and I'm eager to see how these statements about racism as a public health issue. And right now we're seeing a lot of statements, you know, affirming that Black Lives Matter from organizations. I'm eager to see how all of those statements lead to action and improvements and the lives of Black and Brown people. You know, given that we're in academia. Um, I'm also curious to see how those statements lead to action in academia. So there was recently an article on medium.com titled, "White Academia: Do Better. Higher education has a problem. It's called White supremacy." [by Professor Jasmine Roberts, The Ohio State University]. And in that article, the author states, "as academics, we occupy some of the most privileged spaces in the world. We have access to groundbreaking research included in top tier journals. We are scholars. We are educators. We are researchers. We have PhD degrees, medical degrees, and master's degrees. Academics are highly intelligent, and yet we cannot somehow figure out how to engage in anti-racist scholarship for personal and professional growth." I had thought that quote was worth reading in its entirety because I think it captures so well how perplexing it is that we as academics seem to be struggling with how much or how best to address systemic racism within our own ranks.

JG: That quote definitely captures a frustration very well because we are often operating from very different frameworks and life experiences. And just like in public health, there tends to be an overemphasis on individual attitudes and behavior change, as opposed to structural change. Institutions tend to move too quickly to let's increase the confidence of BiPOC faculty instead of really pushing themselves to understand that it may not necessarily be a candidates confidence per se, but the fact that their reviewer may unfairly question accomplishments of a BiPOC candidates.

RTS: Well, I think we're struggling with, with many challenges here. Um, I think, you know, we're trying to manage a global pandemic, the economic consequences of that pandemic, coming to terms with the history of police brutality and systemic racism upon which this country was built. I, again, I have another quote, I think, which helps me to understand why this

is so hard. Um, so in my research and policy work, I focus a lot on making sure that we all share the same definition for a topic, um, for whatever topic I'm working on. And I've seen the importance of this in terms of health disparities. And when we don't share the same definition that we might attempt to intervene on different things, but thinking we're all on the same page about the thing we're intervening on. So this quote is from Martin Luther King in his 1967 book, *Where Do We Go From Here: Chaos or Community?*

And he states, "there is not even a common language when the term equality is used Negro and white have a fundamentally different definition. Negroes have proceeded from a premise. That equality means what it says, and they have taken white Americans at their word when they talked of it as an objective, but most whites in America in 1967, including many persons of goodwill proceed from a premise that equality is a loose expression for improvement. White America is not even psychologically organized to close the gap. Essentially it seeks only to make it less painful and less obvious, but in most respects to retain it." And that quote was from 1967. And I think it is, it remains quite relevant today.

So I think there are two fundamental sins that this country has really never reconciled. Um, that is the enslavement of Africans and the decimation of native American tribes.

Um, and, but there have been efforts to attempt to rectify those types of fundamental sins in other countries through efforts called restorative justice. So there was, um, a truth and reconciliation effort in South Africa and the Truth and Reconciliation Commission in South Africa was created to investigate gross human rights violations that were perpetuated during the period of the apartheid regime from 1960 to 1994, including abductions, killings, and torture. And there was also, um, a truth and reconciliation campaign in Canada that provided those directly or indirectly affected by the legacy of the Indian residential school system with an opportunity to share their stories and experiences and reconciliation there is an ongoing individual and collective process. Now, I'm not sure what the health outcomes of the respective groups look like in those countries after those efforts, but it does require an honest look at history and an explicit recognition of the initial and the generational harms that systemic discrimination, meaning discrimination in policy, big P policy like legislation or little P policy like policy in organizations has caused segments of the population.

RTS: Absolutely. And, you know, in order to engage in this process, these very important processes, we have to have a more honest and truthful description of our history. And, um, as you alluded to, especially from perspectives that have historically been erased, and this is not only relevant for the telling of our general history, but also in what we know about the history of our respective professions, how do we know about how much do we really know about the racist and anti-Black roots of our respective professions, for instance, in global health, where much of my work is there's been recent discussion on how Black Lives Matter can apply on a global level. And there's been discussions happening by scholars in the global health field for some time about the need to decolonize global health and thinking about power and just the idea that global health and specifically tropical medicine, really the origins were really to keep

white people healthy in these countries as opposed to improving the health in that specific setting. And so we need to think about where the power lies, who is listened to. And part of this is really going beyond cultural competency, which is a term that we use a lot in public health. And recently APHA (American Public Health Association) has recommended cultural humility as the competency for the MPH in global health. But I think we need to even go beyond that and think about including anti-racism in these competencies, both for global health, as well as for immigrant health here in the United States.

JG: You know, this conversation is reminding me of a, of a course that you and I took when we were students with noted social epidemiologist, Dr. Nancy Krieger at the Harvard school of public health. Um, and that course focused on theories of disease distribution. Um, and that course showed us the different theories that have been, that have historically been used to explain the distribution of disease over time. And I think that course has really shaped so much of my thinking about who gets sick, why they get sick, how we describe risk factors for disease and make sense of the distribution of disease in populations and how the answer to all of those questions is rooted in the context of the time and in the history of the time. So there are several folks working on the front lines to address systemic racism and the need for a more moral or ethical approach to equality. Um, and one of the examples of that is Reverend Barber and the Poor People's Campaign. Um, one of their fundamental principles is they recognize the centrality of systemic racism in maintaining economic oppression. And it must be named, detailed and exposed empirically, morally and spiritually. Poverty and economic inequality cannot be understood apart from a society built on white supremacy.

Right? And another important book that is out right now was written by civil rights activist and lawyer, Valarie Kaur in her book, um, "See No Stranger: A Memoir and Manifesto of Revolutionary Love". And what she does is really traces, um, the aftermath of 9-11 into how we got here today. And a key message was that how we failed to grieve as a nation after 9-11. And we saw so many divisions, um, deepen after that era and how we must really act with revolutionary love towards each other. So protest is a form of love; policy to advance marginalized communities is an act of love, and how that really needs to be the ethic of our country right now.

RTS: So Jhumka, we've talked about a lot of topics today and, you know, trying to talk about them at the, you know, with the confluence of the COVID pandemic, um, the economic consequences of that pandemic, um, systemic racism and police brutality. And while we don't necessarily have the answers, the purpose today was for us to go beyond what the data says and what, and what will sustain this current momentum. So do you have one recommendation for how to address health disparities and tackle systemic racism?

JG: I have one very heavy recommendation and back to Valarie Kaur's book. She talks a lot about the importance of breathing and pushing in this time. And, you know, one of the quotes from one of her talks was that, you know, what if, the era we're in right now? What if it's not the darkness of the tomb, but the darkness of the womb. And it's the idea of rebirthing our

nation. And I think one thing she says from her book, I think is highly relevant to our discussion today. And I'll read it word for word, because it's such a beautiful quote. She says, "what does it mean for us to love ourselves as a people? What does it mean for us to push as a nation. America needs to reconcile with itself and do the work of apology, to say to indent indigenous Black and Brown people. We take full ownership for what we did to say, we owe you everything to say, we see how harm runs through generations to say, we own this legacy and will not harm you again, to promise the non-repetition of harm would require nothing less than transitioning the nation as a whole. It would mean retiring the old narrative about who we are, a city on a Hill and embracing a new narrative of an America longing to be born a nation whose promise lies in the future. A nation may can only realize by doing the labor reckoning with the past, reconciling with ourselves, restructuring our institutions and letting those who have been most harmed, be the ones to lead us through the transition.

RTS: That is a really powerful quote. And I think something that's definitely needed as we think about any truth and reconciliation efforts that we'd go through in this country. Um, so I have a couple of recommendations as well. So my, my first recommendation and it's related to the discussion that we are, we are indeed having in the field of public health. Um, and that is not only to focus on differences across racial ethnic groups, or that is to think of race as a risk factor, , but to think about racism as the risk factor, um, that is to think about not just group membership as being the risk factor, but the experiences of what group membership means as the risk factor. And I think also in terms of health disparities, I think there's really an under appreciation for the challenge in moving from the process of defining, measuring, reporting and intervening on health disparities.

And I think this is especially relevant as we're thinking about, um, the differences that we're seeing in the COVID-19 pandemic. So in particular, first, if we don't have the data for specific racial and ethnic groups or other socio-demographic categories, then we can't even calculate the differences between groups, but even once we have the data, back to that, very simple but challenging question I posed earlier, when is a difference, a disparity and next, when is a difference actionable. And as we know, and many of us have experienced taking any shortcuts in the definition, measuring and reporting process can greatly impact any intervention or policy efforts focused on reducing health disparities.

So we've talked about some very heavy topics today. So, um, I've, I'd always like end these kinds of discussions, you know, on a positive. So let's talk about, these are very challenging times, and I think very hard for those of us who are members of racial and ethnic minorities. Um, so I'd like to ask, how do you address your fatigue? That is what are you doing right now as systemic racism and health disparities are on front and center in the national discourse? What are you doing right now for self care?

JG:That is a great and important question. I think, I think number one, you know, I'm very grateful to have wonderful friends and colleagues like you, that, you know, we can just chat on the phone and talk about all that's going on and all our rage and frustration. So definitely leaning into friends and I think of really, truly enjoying family time. Um, my husband is an ICU physician in the midst of COVID. So our family time has been a bit disrupted. So when we do

have some time taking full advantage of it, I exploring places in Maryland that I had never been to, even though I spent the majority of my life in the state and then really trying to enjoy the world from the perspective of a six year old, my daughter, and, you know, trying to just look at things for the first time and explore the world as she sees it.

RTS: Oh, that sounds great. Um, and I say, I say something similar to you, you know, the fact that, you know, having friends to lean on during these times is, has definitely been, been very helpful. Um, what I've also found helpful is I'm relatively new still saying I'm relatively new to Southern California. And so I have really just loved taking full advantage of Southern California weather. So getting outside as much as possible. Um, one thing I I've, you've all, you've probably, you've heard me say for sure. if I'm having a really bad day or a hard day, I'm just going outside and seeing the California sun has a way of just making me feel better. So taking full advantage of, of the, what feels like year round summer here in Southern California, um, definitely, um, is my method of self care. So Jhumka, thanks so much for joining me today for our conversation. I learned so much and it was great talking to you.

JG: Thanks so much for having me. It's always important to talk about these very challenging issues.

## **HOST TAG**

**THAT WRAPS UP THIS LESSON IN LIFESPAN HEALTH. THANKS TO REGGIE TUCKER-SEELEY AND JHUMKA GUPTA FOR THEIR TIME AND EXPERTISE AND TO ALL OF YOU FOR CHOOSING TO LISTEN.**

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