Randall: You are listening to the Health Disparities podcast from the Movement is Life Caucus. Conversations about health disparities with people who are working to eliminate them. I am Dr. Randall Morgan. I am an orthopedic surgeon in Sarasota, Florida. I'm a member of the Movement is Life steering committee. And I serve as the executive director of the W. Montague Cobb/NMA Health Institute. We are attending an important two-day conference at the University of Virginia Law School and Medical School entitled Healing Hate. It is my pleasure to introduce Professor Dayna Bowen Matthew, who is the organizer of this conference. Dr. Matthew is the William L. Matheson and Robert M. Morgenthau distinguished professor of law here at the University of Virginia. Also, the F. Palmer Weber Research Professor of Civil Liberties and Human Rights and a Professor of Public Health Sciences and the Director of the University of Virginia Equities Center. Welcome to the Health Disparities podcast, Professor Matthew.

Dayna: It's my pleasure to be here Dr. Morgan, thank you for having me.

Randall: In terms of health disparities and health equity, which trends are you most concerned about at this time?

Dayna: I'm concerned most with the social determinants of health and how those are increasingly demonstrating patterns of inequality of segregation and

about right racism. So, we know now in the public health arena, that more than 40% of health outcomes are determined, not by your genetic or biological background, not by your access to healthcare, but rather by the social and environmental factors that affect where you live, work and play. Discrimination, segregation and inequality in housing, education, food sources, in the law itself, in our jobs, in wages and in every one of the social determinants of health, has got me seriously concerned. It's not only concerning because of the vast inequality, but because of the siloed way in which we're addressing it, healthcare providers and other social activists have got to come together in order to attack these problems.

Randall: After the unequal treatment in 2003, that even though a plan was laid out, that was supposed to effectively address the health disparities with multi-faceted approach, that really hasn't happened either. So, we haven't seemed to have collaborative efforts, as you mentioned, how do you think we can make a difference this time?

Dayna: Well, let me say that the opportunities that we have for making a difference this time wouldn't have been here if we didn't have the foundation laid with unequal treatment, that was an important and monumental consensus report. It focused on access to healthcare, which we thought was the problem. We thought that getting everyone access to equal quality of healthcare at three different levels as the report

suggested, the framework that you described earlier, that would be the answer. But of course, we haven't seen that and that much of a difference. Some improvements have been made. We see some improvements in cancer disparities. We see some improvements specifically in the Latinx population. This time around, I would say that one of the most important things we can do is build partnerships across disciplines and that's really what the center of this conference is about. You'll find scholars from clinical disciplines, nursing, physician assistants, physicians, of course. Then you'll find humanity, scholars, law, social studies, social work, economics, and you'll find people from the community, all sitting down together to fashion collaborative solutions and those partnerships I think will make the difference.

Randall: I think this is somewhat of a perfect storm actually with a major research university and being able to house the conference both in the law school and the medical school. So that, that helps to promote a multidisciplinary involvement just because of that. We've had our first day of the conference and we're very impressed with the input and attendance of the law students and other young scholars who are a part of the panels. So, perhaps they will lead us out of the wilderness in terms of this problem.

Dayna: Well, I do want to compliment the law students for sure. I hope we see medical students tomorrow as well. What we're learning here at the law

school is that health and justice go together. And as we begin to see that the preamble of the constitution, which says the reason we have this government, the reason we have this constitution, the reason we made this country was to establish justice. The reason we have a 14th amendment is to provide equal protection under the law. And when we see those lofty goals, not being lived out in the kinds of differences in infant mortality rates, a black mother is likely to lose her child in the first year of life, two and a half times more probable, that is, than a white mother. And that doesn't change when you control for income, socioeconomic status or education. So, what we end up finding is that a black woman who is college educated and making between $50,000 and $75,000, is going to lose her baby two and a half times more likely than a white woman in America who has an eighth grade education and who is living just above the poverty line. This is a race problem. This is an injustice problem. And so, seeing the disciplines come together to attack it, is hopeful and especially if we train students to think in these interdisciplinary ways from the start. I'm hopeful.

Randall: Thank you. Thank you. I'm hopeful as well. If you could have one call to action, what would you like our listeners to hear?

Dayna: I only get one call to action?

Randall: Well, for now, we'll have other calls afterwards but---

Dayna: I think the call to action is to see the right to the opportunity to live a healthy life as a civil right, as a matter of human rights and a matter of justice. That's the call to action to begin to defend that right, as vigorously as we would defend the right to life itself.

Randall: And I think that Martin Luther King would have felt the same way in terms of his feelings about the injustices and the lack of health and compassion, health being among the highest of those injustices. The start of the conference focuses on the health justice movement. Can you tell us about that concept and perhaps several of the important speakers here at the conference and how they contribute to the health justice movement?

Dayna: Certainly, the conference has centered around a health justice frame that Professor Angela Harris and Aysha Pamukcu have written about in a forthcoming article in the UCLA Law Review. And the idea reinvigorates civil rights litigation, civil rights advocacy and civil rights organization in the community as a way to defend and pursue health equity and health justice. Now, I love this concept and framework because its roots go deep into the civil rights movement itself and that's where the conference really did begin. After Angela spoke, there were several scholars including Craig Konnoth from the University of Colorado, Alex Tesis from Loyola, Chicago

and so many others who came and spoke about the history of the civil rights movement. Now during the civil rights movement Cameron Webb, for example, a JDMD who's here at the university reminded us that we wouldn't have had a title six of the civil rights act if it were not for physicians and dentists pursuing a litigation strategy to press for the civil rights of their patients in court. So, that's an example of the history being brought forward to the health justice movement that Angela Harris described today.

Randall: Has a new paradigm for civil rights emerged?

Dayna: I think it has. I would say it's re-emerged, to be honest with you, Dr. Morgan. When you take the concept of the social determinants of health and you look at one of the key social determinants, let's take housing for example, and you observe how racial segregation in residential patterns have been formed historically, red lining and that inequitable treatment of sales and leases through racial covenants and restrictions, all of that past is not dead. All of that past is not even past, as we learned about today. That past is brought forward so that the same patterns of inequality have reappeared so that red lined areas, historically, are today the places where infant mortality, asthma rates, death to diabetes, death due to premature death due to diabetes or heart disease are the highest in those areas. We heard from Angela about a nine-mile difference separating one

area in Chicago from another area in Chicago but a 30 year disparity in life expectancy. While the red line districts, that were historically residentially segregated, remain segregated today and replicate those patterns of inequity in the form of terrible health disparities.

Randall: Chicago has been one of the prime examples of disparate healthcare through neighborhoods. And there's been a lot of work that was done at Rush as well. I think Dr. Angston, I'm not sure, but who has looked at various neighborhoods and that's the most extreme, the Englewood to Streeterville.

Dayna: That's what the name of the neighborhoods where yes, that's right.

Randall: As it turns out, I spent my part of my childhood in Inglewood with my aunts and uncles and then I spent my training at Streeterville at Northwestern. So, of course, I didn't know anything about health disparities and hope I'm on the good side of the longevity. I think that the fact that these patterns continue to exist in our major urban areas, and we've been so hampered in terms of making things occur, perhaps this merger of the law along with healthcare will give us a much better sense of urgency.

Dayna: I think that's true. Let's be clear also that it's not just Chicago where these disparities exist. But there are two neighborhoods, six miles away,

Westover Hills and six miles down the road, 20-year life expectancy disparities. And you'll find those all over the country. The urgency that you speak of was really highlighted I thought today, nicely in the panel that talked about environmental justice. So, as Angela Harris' health justice paradigm tells us these structural inequalities. These are not inequalities, at just an individual level, but they're systemic and they're structural. They travel through person, they travel through place and they travel through power. So, we're talking about place at the moment, residential segregation. Well, if you remember Vernice Miller-Travis, and she's from the Metropolitan Group and Marianne Engelman-Lado from Yale University, they both talked about the fact that if you want to find landfills, power plants, the health hazards of superfund sites, if you want to find the dangers associated with highways and the terrible pollution that they spew, in Colorado, if you want to find the pollution, you find the neighborhoods where people of color live. That's not just true in Colorado but they showed us all around the country, that's also true. They talked about the I95 corridor going down the East and West side of Virginia. And where does the I95 corridor go? It goes through minority neighborhoods, historically black neighborhoods. Pipelines, like the Atlantic Coast Pipeline, compressor stations like that, which is going to be located in Union Hill in Buckingham County. These health hazards travel not only through history but through place and they affect communities of color and their health disparately. So yes, I think there is an urgency, a sense of

urgency, and part of it is because the law and the medical side are uniting but I think it's also because social scientists are bringing the data. I think it's because communities at grassroots level are organizing and we're all coming together to build these partnerships, these collaborations.

Randall: I would agree wholeheartedly with that assessment. And it's been interesting to see the emergence of public health in this whole process because when unequal treatment first was released, the national medical association was very concerned about what physicians could do to begin to solve the problem, systematically look at all of the potential solutions and how these could happen, or how the solutions could take place, and that's part of the reason why the Cobb Institute was developed to be an action arm, to push for progress. And we have found that our solutions have become much more focused upon communities and upon the public health side of things, since the place matters work and some of the other work from the joint center. So, I think this is the next iteration of bringing in the field of law. And so, I'm fascinated with where we'll get with this and I applaud you for having the vision to have this type of conference.

Dayna: May I say a word about the Cobb Institute in particular because the Cobb Institute is a co-organizer and sponsor of this project. I mean this conference would not have happened if not for the leadership of you and so many members of the board of the Cobb Institute, I'm grateful for. But

let me just point out that a key piece of the puzzle is exactly what the Cobb Institute stands for and that is research that leads to action. Physicians that take the social context of their patient's lives from a public and population perspective seriously. So much of what the Cobb Institute is doing, to not only make research a goal for the Academy to talk to itself, for us to improve our resumes or to increase our publication record. Rather what I see the Cobb Institute doing in helping in this conference and as I've gotten to know your work, generally, so many of the leaders of the Cobb Institute are doing the kind of research that makes a difference that leads to interventions. This is similar to what the Medical Committee for Civil Rights and Human Rights did in the 1960s. They started marching in order to take care of civil rights workers who were injured. That was the beginning and then they became activists. They began litigating and advocating for their patients and that's what I see the Cobb Institute doing. I'm grateful for that type of perspective. I'm grateful for that type of public health approach, to the problem of health disparities, health inequity, and health injustice.

Randall: Well, thank you and I think that Cameron Webb today in his comments spoke directly to Dr. Cobb and all of the accomplishments that he had, in particularly, his role in terms of civil rights and what people don't realize is that he was the president of the National Medical Association and the chairman of the board of the NAACP and the editor of the Journal of the

National Medical Association. At the time, he was my anatomy professor at Howard, and at the time that he was involved with both Medicare/Medicaid and also the Civil Rights Act. So, he was a phenomenal person, but I think that it's rare that you see an organization that put together or founded and it ends up emulating so closely the life of the person for whom it's named.

Dayna: I learned something about Dr. Cobb today also and that was really important to me. He advocated for the passage of Medicare and Medicaid in the 1960s when that act was being debated. And when the American Medical Association and most of the medical establishment opposed the passage of that Healthcare Insurance Act. They, the medical community, generally, was in opposition to what they call socialized medicine. Dr. Cobb and the NMA saw that this public medical insurance program was a way to universalize access to healthcare. This was important for patients. They were driven not by their own pockets, by their own need for autonomy and practice but they were driven by what was good for the health of the populations they served. And if I may, I'm going to go off script for a second. This reminds me of how important diversification in the healthcare workforce is because the AMA is the predominantly white, professional organization and they did not see the needs of patients of color to have access to healthcare. The NMA, Dr. Cobb, leaders who were in the communities of color, who were marginalized and did not have

access to healthcare, the physicians in the NMA, Dr. Cobb, chief amongst them, saw those needs and really swam against the tide of the medical community for their patient communities. That's why diversity in the healthcare workforce is so important because the perspectives of minority doctors will be different. The data is very clear that having doctors of color will increase not only what I'm interested in here, which is the policy advocacy but it will also improve patient relationships, patient satisfaction, patient adherence. So, very clearly from the individual to the structural level, this is another issue of great importance that I think the Cobb Institute stands for.

Randall: And I'm sure we'll discuss some of those points tomorrow at the medical school the second day of our conference. Is there anything else that you would like to mention, perhaps about what we could look forward to in terms of the program at the medical school tomorrow?

Dayna: I want you to know that tomorrow's opening keynote by Dr. Vivian Penn is something not to be missed. I want you to know that the panel on gun violence, though it doesn't appear to be a concern of the healthcare establishment, you're going to learn differently tomorrow. There's going to be the panel on the civil rights of children not to be disparately disciplined as a health issue tomorrow. I'm excited about all of it. We talked today briefly about the Simkins vs Moses H. Cone hospital case, that's the

watershed case that led to the Fourth Circuit decision that if it had been appealed, if it had been granted cert at the Supreme Court, could have changed one case and could have changed access in one hospital. But because on the floor of the Senate, that case's ascendancy to the Supreme Court was part of the legislative record. I believe that was a key reason that Title Six was passed.

I refer to that because George Simkins was a physician. He was a physician who represented his patients in the Supreme Court, he was headed for the Supreme Court, but in the federal courts, he was a physician who represented his patients and community, not only for hospital desegregation, but for desegregation in oh so many social determinants of health. One of my favorite stories about him is not the lawsuit he brought against Wachovia Bank, because he did, where there were discriminatory lending practices ahead of his time, realizing that income and wealth are social determinant of health. But one of my favorite lawsuits that Dr Simkins brought was against a golf course in his state of North Carolina, that was segregated and wouldn't allow blacks on the golf course. It got so bad in North Carolina that after he sued, the people of North Carolina did not only not want their golf course, they didn't want their golf course clubhouse. They burned it down rather than to segregate it. Well, his case course through the courts, they opened up the, course rebuilt the house, the golf course--

Randall: The clubhouse.

Dayna: The clubhouse, thank you. The clubhouse and who was the first person to tee off at that new golf course when it opened? Simkins was. And so, what I'm saying to you is tomorrow is going to be about invigorating the healthcare professional to become a part of the civil rights movement, again, to take the leadership that brought us desegregation and help us come out of this quagmire of injustice and disparities. We need to work together, and we need the leadership of the health community as we had it in the sixties, we need it again. And that's what we'll be talking about tomorrow.

Randall: Wonderful. I'm really looking forward to the program that we have tomorrow. And even more than that, the responsibilities that we have as physicians to be a part of the solution. It doesn't matter what your specialty is, it doesn't matter how old you are, this is something that we have to effectively work with our other professionals both in law and sociology, public health and religion ethics, all of these different fields that express the problems, the pitfalls that go on everyday life and in communities of color in particular. And I think it's important that we as physicians get back to working with the legal profession and looking at this from a civil rights point of view. And I think that's probably one of the big take home

messages that I've seen, at least for the first day of the conference. So, you've written a very provocative book, "*Just Medicine"* that I've read and you said that, and I quote, "We will continue to utterly fail in the effort to eradicate health disparities unless we enact strong evidence-based legal remedies that accurately address implicit and unintentional forms of discrimination to replace the weak, tepid and largely irrelevant legal remedies currently available."

Dayna: Implicit bias is all the rage now and people are talking about it at an individual level. I am glad that it is on the lips. I'm glad that it's in the discourse. I'm glad that it's in conversation. But the call to action in that book is not for changes at the individual level, it's changes at the structural level. So, the call to action is to recognize that we are not going to change health disparities, unless we change the context in which discriminatory healthcare is delivered. And that context has to be legally accountable. So, I have to say that, although I'm glad we've recognized what implicit bias is, I am not interested in the single doctor or the single nurse or the single physician's assistant being held accountable to think differently. I'm interested in institutions looking at the outcomes that we know are the result of discriminatory healthcare. I'm looking for patterns of discriminatory allocation of services, of discriminatory allocation of interventions, of discriminatory outcomes, to be addressed at an institutional level. We know that these are due to bias. We know that

institutions can be held accountable for creating the environment to stop it. So, that's what the book is looking for. It's looking for a change in what we heard about today was called a Sandoval Fix, a change in the law. The Supreme Court has got it wrong right now. The Supreme Court has got a focus on intent that is incorrect. And that's what the book is looking for. We're looking for accountability for discriminatory outcomes that have nothing to do with whether you meant it or not, whether you intended it or not, whether you were conscious about it or not, but those outcomes are still causing 84,000 people a year to die unnecessarily from health disparities. So, I almost don't care much whether you meant it or not. I'd like to see the law hold you accountable.

Randall: The equity center here at UVA in Charlottesville, seeks to tangibly redress racial and socioeconomic inequality. Could you share with us some of the aspects of the work that you do at the equity center and what aspects are specific to this historic city?

Dayna: I thank you so much for asking me about the equity center. It's a new and exciting work here at the University of Virginia, where president Jim Ryan has taken seriously the call to become a better citizen and a better neighbor to our community. The equity center intends to tangibly take the resources of an elite research university and invest them in changing inequality patterns in our surrounding community. We take seriously the

history that we have contributed to not only by the fact that we did not pay 5,000 laborers in order to build this institution or that we only this year, actually last year, declared that every contract and employee worker will have a living wage. But we take seriously the fact that most of our research practices have been extractive. And so, what the equity center seeks to do is to engage with the community that has been struggling for equality long before the equity center came along and engage with that community in reversing the extraction to become an investment.

So, some of the inequity that we can help with in the community is exhibited by several projects that we have going already. So, we have the Curry School of Education, which is consistently ranked as one of the Top 10 education schools in the country. We heard from Paul Harris talking about his work today with young black male athletes. But the Curry School has several initiatives, Youth Next run by Nancy Deutsch. Derek Aldridge is running Freedom Schools. These are ways in which we are reinvesting the resources of a university back into the community to close the achievement gap between black and white students here in Charlottesville. Another example is that the equity center is working with communities in Esmont, Scottsville, down in Southern Albemarle County, to look at the disparities in drinking water between wealthy communities that have access to public and municipally treated drinking water and other communities that do not, that are drinking water from wells. We're

looking at the structural disparity, both in the contamination of those water sources, at the structural discrimination that may have been responsible for who does get municipal water and who is remaining on well water, for the structural discrimination that differentiates the quality of water that people who rent get versus people who own their homes. So, these are some of the problems that the equity center is bringing research resources to bear on and hopefully leaving a tangible improvement in the inequitable health and social outcomes that our community surrounding us experiences.

Randall: And I would hope that in some of these endeavors, some of the local physician groups could be a part of the solution as well. Because I think that it's important for physicians to be connected with the solutions to the disparities related to environment and the like. Let us talk finally about some action steps. I know you had several that you wanted to share with us. We talked about one initially. Are there others that you would like to leave our audience with?

Dayna: Well, for those in the audience who are healthcare providers, I know all of you won't go to Capitol Hill necessarily for a meeting with your Senator. And all of you won't necessarily write in comments on some of the changes that the current administration is making to the civil rights laws, that advanced fair housing or the civil rights laws that advanced equal

access to transportation. But some of you will, and I encourage you to take seriously that is a part of your provision of healthcare to vulnerable communities. I'd like to also extend a call to action for educators, both in the sciences, in clinical settings and in legal settings to begin to educate our pre-professionals in interdisciplinary ways. It would be exciting to me to see medical school curricula begin to include the public health framing in a very serious way and to give young physicians in training an opportunity to look at ways that they can too, not only screen patients for social determinants, not only document in research the existence of disparities but also to become advocates for changes in laws and policies at the state, local and federal level, even if it just involved writing a letter. So screening, advocating, writing, becoming a part of a different educational paradigm, joining with others who were advocating for changes in community laws, in regulations, all of these are things that we can do together. But I think the most important thing is to realize that, although the problem is massive, if each of us takes responsibility for touching the part of our community's inequity, that is right in front of us, that's in our grasp, we can all do this together and we can make a difference that's significant.

Randall: Well, thank you. I think that is very concise and very consistent with all that you have mentioned today. Certainly, what I get from your discussion is that we have a new paradigm where we understand fully that the social

determinants of health are far more important than they were in the past. And that it's not about just the individual patient, that population health is extremely important. We understand that physician advocacy is important, that we must connect with our legislators, both on the state and local level but also on the national level. And I think that that's what I feel at this point that perhaps we may be more empowered to do that though. I think the university has the facilities to maybe help prime us to do that. But somehow we've got to get the message inside the Capitol, not just the House of Representatives, not just the Senate but all of the legislators to understand that this is a major problem that can only be solved if we work together on it and that economically we will all perish, if we don't solve the healthcare delivery problem.

Dayna: I'm going to say one other thing, it may be a little provocative but another thing we all can do is vote, not just in our own self-interest but in the interest of a society that takes equity, justice and fairness seriously. I just want to encourage everyone to take their vote seriously. Certainly, we know historically that people died to have the right to vote but I want to emphasize that today people's lives depend on how we vote. So, if the candidate you're considering is not taking health justice seriously, is not taking discrimination and housing, employment, immigration, and all of the social determinants of health seriously, then by all means vote for another candidate. Vote as though people's lives depend on it because they do.

Randall: I think that says it all and I'd like to thank you, Professor Matthew for providing us with a wealth of information. And I think that some of our audience will have to listen to this podcast more than once to get all the richness of your comments. And we hope to keep working with the University of Virginia and the Health Equity Center and Movement Is Life in any way that we can in the future. Thank you.

Dayna: Thank you for having me.

(End of recording)