CORNELL CENTER FOR HEALTH EQUITY (CCHEq)

**Systemic Racism & Health Equity Webinar**

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# Systemic Racism & Health Equity Webinar

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DR. JEFF NIEDERDEPPE: Greetings everyone. We want to thank you for attending today's webinar on Systemic Racism and Health Equity, hosted by the Cornell Center for Health Equity.

My name is Jeff Niederdeppe, and I'm a professor of communication at Cornell University in Ithaca, and one of three directors of the Cornell Center for Health Equity. I'm excited to be part of today's vital conversation.

Before we begin, I want to introduce Dr. Monika Safford, professor of medicine at Weill Cornell Medicine in New York City and co-director of the center. Dr. Safford will share some concluding remarks at the end of the webinar. I'd also like to introduce Dr. Jamila Michener, a professor of government at Cornell University in Ithaca, and co-director of the center.

I now turn things over to Dr. Michener, who will moderate today's discussion.

DR. JAMILA MICHENER: All right, thank you, Jeff. I appreciate that introduction.

So, thus far, one of the most exciting parts of my new role as co-director of the center, The Cornell Center for Health Equity, honestly has been my part in planning this webinar. As I, you know, along with my co-directors conceived of, developed and brainstormed ideas, it was difficult for us to imagine a topic that was more imperative, more obviously urgent and more pressing than a conversation about systemic racism and health equity. As COVID-19 is, even as we speak, ravaging black, brown and native communities, this is a discussion that is as important as ever. What COVID-19 has done is it's revealed processes and patterns that were already there, but by revealing them more blatantly has also, I think, challenged us to confront and address them more directly. And the conversation that we're having today is a part of that.

When I sat down and started making my list of dream panelists, I thought what are the chances that I'm going to get all of these incredible people to come to the table and share with us their insights and really drop knowledge from their extensive and­­­ impressive body of work? And the speakers who are on this panel today were literally the top three people on the list, and we are lucky enough that they were able to say yes and to be here with us today. I, unfortunately, won't spend too much time on bios because we want to maximize the time that we can hear from those speakers, but we will put information about them and links to their bios in the chat. And, so if you are interested in learning more about and accessing their work, which I highly recommend, you can do so.

So, our first panelist today is Rachel Hardeman, who is an associate professor in the Division of Health Policy and Management at the University of Minnesota School of Public Health. Our next panelist is Courtney Cogburn, who's an associate professor of social work at Columbia University. And our final panelist is Whitney Pirtle, who is an assistant professor of sociology at the University of California Merced. All three of our panelists have honestly been leading voices, not just over the last few months, as many people who previously weren't thinking about health equity became aware of the issue, but long before that. And so I'm grateful to have them with us here today and happy to jump right into conversation.

If you're on this and you're a part of this conversation, as we're talking, feel free to tweet about this. #healthequity2020 is the hashtag that we're going to be using to tweet, so you can listen to our conversation here, but also join us via Twitter if you see fit.

Okay, so I want to start with a question that's really broad, but I think is important because it helps us to kind of set the terms and the ground of the discussion here, and I think that's a very important place to begin. So, we're here, obviously, to discuss systemic racism and health equity. I think that it's important just to have a sense of what those things mean, and so I'd like to ask each speaker to just tell us what those words mean to you and give us a sense of the crucial issues, ideas and frameworks that come to mind when you hear me say systemic racism and health equity.

Rachel, can we start with you?

DR. RACHEL HARDEMAN: Sure. First, I want to thank you, Jamila, for having me and to the Center for Health Equity for putting this panel together. I'm really excited to be here. And when I was reflecting on this, I think for me, part of it is we've heard the words over the past few months that we're in this unprecedented moment in our country, this unprecedented time in our country, and I think that may be true for some of us, but for those who-those of us living in black and brown bodies, many of the daily headlines of the disproportionate impact of Covid on black and brown communities, impact of racism in our daily lives, the fact that black moms are four times more likely to die during pregnancy and childbirth, or childbirth, the death of a black community member at the hands of police are not new news. It's not unprecedented. It's business as usual, unfortunately. And, really, that is due to systemic or sexual racism, so that confluence of institutions, of culture, history, ideology, those practices that are generating and perpetuating inequity among black and brown communities, and it certainly is the common denominator, right, of the violence that is cutting lives short in our country. And, like other epidemics, structural or systemic racism is causing widespread suffering, not only for black people and other communities of color, but I would argue for our society as a whole. We can't all thrive unless we are all thriving. It's certainly a threat to the physical, emotional and social well-being of all of us.

And I think one of the things that is coming to light and that people are starting to recognize is that we, particularly if I'm in a school of public health and I'm trained as a health services researcher with a public health framework. And so, we talk a lot about the social determinants of health and the conditions and the environments in which people live, work, play, worship, age and that they're important indicators for health and well-being. And what we have failed to sort of make the connection with is that these determinants are deeply rooted in structural racism. So, where one is born, where they live, where they work, where they play, is rooted in legacies of segregation and white flight. It's rooted in practices of gentrification, environmental racism, local zoning ordinances, all of which aggregate and confine black and brown folks to communities and areas that are disproportionately exposed to things like toxins and pollutants. We're seeing this being even more relevant as we, and I know we'll talk about COVID-19 specifically in a bit, but we're certainly seeing that the harm of living in certain communities is even further exacerbated as we grapple with the respiratory impact of COVID-19.

I think we also have to understand that our historical notions about race have shaped the way we do our science, the way we do our research, the way we practice medicine, and many more things, the policy decisions we're making. For example, the experimentation on black communities and the segregation of care on the basis of race are deeply embedded in the U.S. healthcare system, and disparate health outcomes, and those systematic inequities between black Americans and white Americans, in terms of wealth, well-being, quality of life. We have to see them as extensions of the historical context in which black lives have been systematically devalued.

And I think that the systemic devaluation of black lives sends a message to our society that black people are not loved. And my colleagues, Dr. Rhea Boyd and Dr. Eduardo Medina, and myself, we wrote an article that was published in the New England Journal of Medicine recently. And we included two important phrases; one of them was "I can't breathe," the words that George Floyd uttered multiple times in that excruciating eight minutes and 46 seconds when he was under the knee of a former Minneapolis police officer, and the other words were the late author, Toni Morrison, from her book, The Love, which was, "And he was loved." And we included those words because, while we know that racial health inequities are devastating and avoidable and they are unjust, I think what we don't often think about is that they're also an afront to the love of black people. And this fact must be a core part of how we value, how we deliver, and measure the work we do, the policies we make, the care we provide moving forward.

And so, my hope is that when we talk about health equity and systemic or structural racism today, and moving forward, that we have that in the back of our mind that, well, of course we're working towards equity and that everyone, and black people in particular, deserve equity, that more than that we deserve love. As Dr. Boyd says, that's the bar, right? That anything less belies the value and dignity of black lives.

So, I look forward to our conversation today. I again, I'm excited to be here and to participate and engage and hope that we have some great questions from the audience. Thanks.

DR. MICHENER: I love this because it's so rare, for example, to really talk about something like love when we're talking about these topics. We can be hyper scientific and we're all scientists, but really that big picture.

Courtney, do you want to give us a sense next of what those words, health equity and systemic racism, mean to you?

DR. COURTNEY COGBURN: Sure. Thank you, Dr. Hardeman, for those comments. I think the beauty of a panel like this is that we're often aligned in how we think about and frame some of these issues. So, I don't need to repeat any of what you just said and just say ditto and amplify.

What I'll add to that are some pieces that are pretty sanguine to me in my work, which is really trying to figure out how, why there's such resistance or disability in people understanding the realities of health inequities. And it feels like, in spite of the massive bodies of rigorous research in this area, so many people still don't get and so many people are still surprised by our patterns of COVID, and so there's a translation issue, either in framing or access of the information in terms of the general public that I think is important for us to engage. The framing of systemic racism, when I think about that language in particular, the framing of systemic racism really in conjunction, embedded in social determinants of health. So, anything we think we understand about social determinants of health is, structural racism is embedded in all of that. And so that's one way to try and help people. Do you understand the gravity of the problem? Do you understand the scope of the issue? It's not at the point of care. It's not just this or that, it's all of it and really trying to think about points of improvement in terms of our ability to communicate to audiences, particularly outside of health research, to be more effective in our messaging, because that's critical for voting, how people make legislation and policy decisions, what they support and what they don't support, what they think is necessary in terms of moving forward and what's not. I know myself and several of you have been engaged in the conversation around COVID-19, because when we first started having this data emerge, it was being discussed in a very individualistic frame, right? Black people, brown people take care of your grandma and your Abuela, make better choices, make better decisions, a complete mis-framing of what was actually happening and then the experts come in and try to help reframe. But we have to do that every time. Why do we have to keep doing that?

Another piece that's very sanguine for me in my own work is how we engage these issues as health researchers. So, we're talking about engaging the general public, but how do we do this work within our own fields and disciplines? There is a tendency within this space to sort of passively acknowledge the significance of racism, yeah, yeah, racism, and then continue business as usual, in terms of how we measure, how we model, how we analyze our data. And it's a recent writing, Reyes [phonetic] is another person who's been writing about this recently as well, is we have to change the bar and the standards how we conduct health research and simply describing patterns of difference is wholly inadequate. At some point, we have to move beyond describing difference and start to invest in doing something about the problem. So, not only do we understand the pattern difference at a population level, we also understand a lot about the mechanisms, the things that are contributing to those patterns. We're pretty clear on that as well. So, at what point do we take up the mantle of actually doing something about it? And what are the roles, what is the role of academics and scholars and researchers in taking some responsibility for that work? And it's a question that I have to keep asking myself as I conduct my research as well.

And in general, related to that question of interventions, so what do we do about this? What are our most critical next steps because we simply cannot continue to have conversations talking about the patterns of racial inequities. We're very clear, very clear about all of that. So, I think what's important for us to talk about is really start to carve out, and I'm seeing this type of discussion more and more, really start to carve out a charge, a call to arms in terms of what we need to be doing, and I think we have a sufficient basis on which to determine our next steps and we need to take more responsibility in terms of moving forward. So, I'll leave my comments there and turn it over to Whitney.

DR. MICHENER: Wow, that gives us so very much to think about. Thank you, Dr. Cogburn. Whitney, would you like to, Dr. Pirtle, would you like to give us your perspective on this?

DR. WHITNEY PIRTLE: Sure, and I agree with Courtney, I think all of us here are on the same page, which is exciting. It's exciting to share the space with all of you, and I'm glad that so many other people are now listening. They're engaging in this work, they're thinking about it, and I think the next steps would then be to do something about it.

So, as someone who is trained in sociology, we are taught to focus on systems and structures sort of from day one. And, so, my understanding of systemic racism as related to health equity is informed by critical race scholars who see racism in general as an organized system and the system works to categorize groups into different-categorize populations into different groups, but the important part of racism is that it ranks those groups, so it positions groups in a hierarchy and it distributes differential goods and services according to that hierarchy. And so, that's when you have inequities come out to play.

Racism as a system, systemic racism, means that it's involved in every aspect we have of society. So, it's taking discrimination and embedding it through all levels. So that means interpersonal discrimination, discrimination that can happen in your families. It also means discrimination that's happening in housing, it's happening in education, it's happening within all of our organizations, it's happening in media, it happens in criminal justice, and it most definitely happens in healthcare. It's also ideological and rests upon culture and is reproduced time and time again. And so, it's this huge sort of monster that we have to address at all of those levels as well.

So, I think when we're thinking about health equity, the way that racism impacts health equity, we know that racism is a system that started day on in the United States and has then relegated different groups to different sort of hierarchies and distributed different goods and services, and that one of the main cost of that is our health and our health over time. So, health equity, systemic racism and health equity has been an issue since our inception. And so we need to think about history, we need to think about culture, we need to think about the institutions that we have built up and think about ways they are unjust and what we can do to build them down and build anew. When I think about health equity, I think the conversation about love, about being able to breathe, being able to live, about freedom is all tied to health equity, because all of those things that I named the media, our earnings, employment, housing, they all relate back to health. And, so, if we need to address systemic racism, we have to center health equity in that conversation. And so, I think right now Rachel's article about *Stolen Breaths* was so powerful because we know that health equity is not just about that COVID-19 that we'll talk about, but it's also about police brutality, it's also about things going on in our education system, the school to prison pipeline. Health equity should be centered and all of those things, especially if you're a race scholar, because we know structural racism structures all those same things. And so, I think I'm really moved by Camara Jones, who has been ringing the alarm about racism and health for a long time. And the first thing she talks about when addressing racism and health equity is that we need to value all humans equally. And so, I think that that's where the love comes back, that's where black lives matter comes back, that's why it's a human project that we're engaged in right now.

I guess the other thing I would like to add is that I think systemic racism is the root cause, and that's the reason we're all here today. But systemic racism upholds additional systems that are intersecting and interlocking that then amplify the implications of various oppressions. So, systemic racism also works to uphold capitalism. It is intertwined with structural sexism, ableism. There are a ton of usually reinforcing processes that do shape the health and well-being of many, and it means that, for instance, black women in the United States have multiple forms of oppression that they're often fighting and contending against. And, so structural racism is one of those things. It upholds these other systems. But I think it's important to also think about those other intersecting systems when we're working towards health equity.

DR. MICHENER: That's great. And I want to just point out that I put a link for everyone, all the panelists to access to, to Rachel's article, *Stolen Breaths*, because, or co-authored, because we've mentioned it several times now and I agree that it's both moving and it's grounding. It grounds us in the sort of realities at play here and how profoundly the conversation that we're having right now matters for so many people's lives. So, several of the panelists have already mentioned COVID-19 and I don't think any of us can forget that we're in the middle of a global pandemic, because otherwise we would all be in the same room right now and I would be getting to have some kind of dinner tonight with these amazing panelists and we'd enjoy ourselves. But instead, we're zooming right now, it's so sad we're zooming it, and that's because we're in the middle of a pandemic. And it is a global pandemic, but it is emerging as particularly acute in the United States right now and it is not an equal opportunity crisis. It is disproportionately affecting communities of color in ways that are devastating, and I just wanted to ask the panelists to speak a little bit to what the pandemic is showing us, perhaps that was already there, but not everyone was seeing it in this clear view about the relationship between racism and health equity and what we can learn about racism and health equity by watching the present crisis and how it has unfolded.

 Anyone can start.

DR. COGBURN: I think the pandemic is showing us who we are and who we have been, and in a way that's striking in only, I think, the way that the global pandemic can be. And I think that in some ways that is the silver lining of this moment, is that it has made the social inequalities in our country so starkly visible in a way that are very difficult to deny and in a way that I have found, I think in conjunction of COVID-19 and the global political movement that's happening, both things coinciding have made my job much easier. I have to spend considerably less time trying to convince people that racism matters, and I've resented that for the two decades of my career of having to start all of my conversations somehow justifying, predominantly to white audiences, that racism is a thing that we should be talking about and figuring out how to measure, not just sort of saying yeah, it's that thing out there that we can't do anything about, if they're acknowledging it at all.

So, I think the reality is that the patterns in COVID-19 in terms of rates of infection, hospitalizations or the severity of infection as well as mortality rates, that pattern, that general pattern that shows that black people, or black --, et cetera, are at greater risk of all of those things That general pattern is not surprising, but the magnitude of those differences are still starting, even to people who have conducted this work, researched and been in this space for a very long time. That's also unfortunately, working to our advantage. It is hard to deny that that's happening, but it's so important for us to acknowledge that. Look at rates for cancer, look at rates for stroke and heart disease and diabetes, and this is the exact same pattern that we observe with all those disease outcomes as well. This is not new, and if you're disturbed by COVID-19, you should be disturbed by a lot of things. Let's sit down and chat about all the ways in which these types of inequities show up across social determinants of health, but across health and disease, as well. So, I think it's important for us to be taking this moment and leveraging it and holding people accountable, but also not pretending that there are some of us who are not at all surprised about where we are.

MR. MICHENER: I think that's still important. I will just note that if you're watching and you're thinking about questions or there are questions emerging for you, feel free to start putting them into the chat. We will hear more just about COVID-19 from Drs. Pirtle and Hardeman, but after that we'll transition into Q & A. So, now is the time to start putting your questions into the chat. Drs. Pirtle and Hardeman, would, anyone, either of you like to jump in here?

DR. HARDEMAN: I think Courtney covered almost all of what I would have said. I just, I think it certainly is not a coincidence that the two populations in our country that have bared the physical burdens of centuries of injustice, so black communities and our indigenous communities are the communities that are now contracting COVID at disproportionate rates. I think one of the things that is important to understand and think about is, I think we initially started hearing, well it's because blacks have more chronic illness and are more likely to have comorbidities. And there was sort of this failure rate to link why they have more comorbidities or why they have more chronic illness. And there wasn't a sophisticated discussion around the lack of resources and the role that structures and structural inequity had dictated the reasons for more comorbidities. And I think we're seeing that conversation shift very quickly, which is really important and a good thing, but I agree, I had-I have to spend less time doing Racism 101, which is wonderful, because I think that COVID-19 has opened the eyes of a lot of folks to what, how actually structural racism plays out. And so it's my hope now is, what do we do with that, because once you see it, you can't unsee it. The next step is then what do you do to fix it?

DR. PIRTLE: Yeah, I totally agree. I think-I even wrote that line that COVID-19 is just showing us who we are, again. Any sort of health crisis will remind us again. So, it is this reminder that's in our face and it's a sad reminder, right? It's shameful that so many people have died to remind us how unequal our society is. Recent reports say that in every 2000 black Americans-or, that number might have been shrinking-but one in every 2000 black Americans has died because of COVID-19. At the rate-that means the rate of two to three times more of white Americans and for some indigenous populations, it's almost five times that rate of whites in particular states.

So, we're talking about immense loss of life, an unequal amount of loss of life. And so, I think that COVID-19 is just showing us, it's giving us more undeniable evidence that racism is killing. And so, I think, and the writing that I've been doing about COVID-19, I'm arguing that racism, structural racism, in particular I said racial capitalism, so those mutually reinforcing systems of capitalism and racism, but I situate them as the fundamental cause of health disparities. So, this is what other medical health, sociology health, scholars have talked about as the fundamental or root cause, and so for something to be a root cause, that means that there are multiple mechanisms that link that root cause to the outcome, and so we can walk through examples with structural racism and the COVID-19 crisis.

So, some of those pathways are just stress and burden, and the undue burdens that people have. We know the Geronimus Weathering hypothesis that says that stress wears and tears at our body and it breaks down our physiology. And so, black Americans not only have the stress of the pandemic that everybody's dealing with, but also police brutality and that sort of extra level of stress and burden and financial as well, during the pandemic definitely breaks down bodies at a higher rate. There's also, a big one is residential segregation, racial residential segregation. This has been caused historically by red lining. It interacts with environmental racism, it constrains where black Americans and other people of color can live and restricts those goods and resources that they have. This not only impacts the green spaces, where people can go out and exercise during the pandemic or the foods that they might have, but also their access to quality healthcare in a close neighborhood. And a recent report showed that testing centers in black and brown communities endured higher wait times.

And so, even there, even getting testing for COVID-19 is uneven. Other reports said that black Americans are more likely to be turned away from hospitals showing symptoms, and there are a lot of anecdotal evidence. There was a black woman who worked at a hospital in Detroit for multiple years, and she was turned away four times before she passed away. And so, these are, these are large numbers, but they're also personal stories of these stolen breaths, of these lost lives that are rooted in racism and showing us the difference of COVID-19. Another way, another mechanism we can think about is the lack of resources to cope with the risks.

So, we know that there are undue or unequal amount of risks, but also, how to cope with those risks. Who has the ability to have time off, who has childcare, who has health PSAs in their own language, who has legal status and has health insurance, and can see a primary care physician, who is more likely to be arrested and in jails, and we know that those are hot spots for COVID-19. So, I think there's just so many different mechanisms that link structural racism to unequal health. But COVID-19, we can walk through every single one of those mechanisms and find an example. I think that that just reiterates Courtney's point that this is just putting it in our face, it's showing us who we are again and that we do need to make some big changes so these unequal systems aren't being replicated.

DR. COGBURN: It feels like, related to that, I think my sisters on this panel might agree with me that it feels somewhat absurd that some people are just coming to realize the significance of racism, because we've certainly been talking about it, we've certainly been writing about it, we've certainly given brown bags and grand rounds, et cetera, talking about this. So, I've been talking about this a lot and I just have to, one, to point out the absurdity of them, but welcome to the table, welcome to the party, and grapple with how well established this phenomenon has been, how well documented, how well studied and you are still, some of you are just now really coming to terms with how this functions in relation to your own work and in your own lives, and you have to think about that. You have to reflect on why it took a global pandemic and one of the largest global political movements in our history, for you to start to come to terms with the realities of what we're talking about. That's a personal reflection that's necessary in order for us to determine how to best move forward.

DR. HARDEMAN: I would add to that, too, that in addition to all the scholarship over decades, centuries, community has been saying this is a problem. This is my lived experience, but we've decided not to value that knowledge as part of the cannon or part of what's real. And so often, when I go into communities to discuss these issues or talk about my research, the folks that I'm talking to are like yeah, we know, yes. And so, I think that's an important piece of this discussion too, is whose knowledge do we value as real and how do we change that?

DR. MICHENER: I think that those reflections resonate so deeply. It makes me think about times when, like some sort of, obvious, explicit incidents of racial violence or racism happens and whether it's on campus or elsewhere, you get these emails and it's, this isn't who we are, and I always think this is exactly who we are, you know, it's exactly who we've been, as both Dr. Cogburn and Dr. Pirtle pointed out, since before the inception of this nation, right? And really following on what Dr. Hardeman said, you know this if you're embedded in community, engaging with the people who are going through it, right? I never feel as uninteresting as when I present my research on the ground in communities. Folks just be looking like, okay, and I'm like, wait, this is revolutionary and they're like, but I've been seeing this, I've been feeling it, I've been experiencing it, and so it really is a matter of whose voices are centered, right? Whose experiences are naturalized and normalized and accepted as a part of a set of experiences that are worthy of believing and of acknowledging. And it's only in the context where black and brown and native voices are marginalized, that we can be like coming to revelations right now about race, but I think, like many of the panelists have pointed out, okay, like, we're there, we're coming to those revelations.

And so how can we make the most of this moment is one of the kind of questions that I'm sure we'll get to consider as we move forward here, but it's certainly is one that we have a renewed opportunity to pursue, given everything that's happening at the moment.

Okay. I think it's a great time to… ops, I muted myself by accident-to pivot and to think about some of the questions that are coming in from the audience. We're getting actually more and more now. And so, I think we'll have lots of opportunities to discuss a lot here. I do want to point out I also added for the attendees a link to Dr. Pirtle's article about some of the root causes of COVID-19, because she was talking about that issue and it struck me as she was talking that her own research speaks to this and tells us about this. I want you, the audience, to be able to access the knowledge, not just that's available here, because we're lucky enough to have these panelists with us, but the knowledge that they're producing and putting into the world, which delves even deeper and I think illuminates even more. So for folks who care to learn you have access to those directly.

Okay. So, I'll jump in with the first question. I think that this question is sort of touching on some of the things that have emerged in the conversation, but the question is really around what kind of research can help to move us from observation to action? I think this is something in particular that Dr. Cogburn pointed out for us. We've been measuring, we've been assessing, we've been observing, we've been documenting for quite some time. It's not to say that that work is no longer important, but as we orient towards action, what's the kind of work that's going to get us there? And the next part of the question says, so many of the solutions are about policy more than about research studies. Does this imply that researchers should embrace activism? And so any, any of the panelists can answer. But maybe we'll start there.

DR. COGBURN: To the point about research and translating into action, I think that's complicated because we start to grapple with cultural systems of academic institutions and what types of work we value and prioritize and how tenure is granted and how people keep their jobs, and those sorts of things. And when we rely on those kinds of systems, then we rely on a need for people who are trying to keep their jobs to rely on data that already exists, and because of that, the kinds of data that we have and that's readily accessible that will allow us to publish quickly, are the same data that people have been using for quite some time to try and describe and talk about these issues or measures that are reliable, that we know work and help us to document these issues, and so we use those again and again. It is much more difficult to create new measures or to start to think about measuring points of intervention and how affective those are. That's much riskier work and you put yourself in a precarious position by pursuing the gaps that actually exist, rather than sort of staying close to what's already been done.

So, I think there's a cultural shift that needs to happen. We can talk a lot about what types of implementation science and intervention research needs to happen. I think, drawing from the bodies of work that we already know, Whitney just highlighted like ten mechanisms where we could start and focus on, but doing that work is high risk. It may not work. It may not be publishable in the way that our publishing structures work and so we have to make a cultural shift as well. What kinds of work do we really value and what types of work do we really promote or are we only interested in people writing papers? And if we're only interested in people writing papers in ways that are accessible, we may fail to really see innovation in the ways that we need to be seeing it. So, action comes from innovation and higher risk research than is rewarded in existing academic systems. And part of that has to shift in order for us to see improvement.

DR. MICHENER: That's really insightful. And can I just add to that? It's, you know, these questions around what kind of work-is it sensible and safe and incentivized to do as a scholar? One thing I see linked to that too is, who is doing that work, right, and what the implications of that are, because when you have disproportionately scholars of color who are taking on that work to fill in the gaps to help us understand the things that we didn't understand before. And it's also work that’s devalued or undervalued, and it's also work that's harder to do because you don't already have readily accessible data. It just layers on some of the disadvantages that scholars of color face in a context where I think our voices are crucial. Right?

Okay, so we have some more audience questions. One question, I think any of the panelists can answer this. What are the systems and mechanisms of systemic racism that we should focus on collectively now? Right? So, the question is really about the prioritization of policy goals. With so many deeply ingrained problems, where do we focus?

We're not starting with the easy questions. We're getting to the tough stuff right out of the gate.

DR. PIRTLE: I will try to answer this question. I would love to hear from others. I'm going to give one of those sort of both end responses. So, I do think that if we're talking about systemic racism in one particular mechanism, I think I might encourage a focus on racial residential segregation, just because of the multitude of ways that replicates inequities in and of itself, not only regarding health, but also in education and food access and water, like all of these sort of intertwined things. So, you know, that means showing up to city council, like people did here locally just this week, and saying if you're going to do this new housing development, we want it in this part of town. And so, it starts sort of those local conversations that can go larger as well, but just holding people accountable for where they're putting their money and resources, even in your own communities.

So, I think racial residential segregation, just for all of those reasons, the ways that it impacts all of us. But I also, and this conversation right now, I mean I gave a talk with 50 eighth graders on Wednesday and they also want to know like how to get involved. And, so, I mean, we can focus our attention on one thing, but all of us are skilled in so many different ways and we're plugged in in different areas. And my son is entering the room. I think what I'm learning now, is that just like I have a particular set of skills because I'm trained as a sociologist to read and write, and so maybe that's where I'm putting my effort in, but other people have other skills. Maybe it's sewing and they're making masks and distributing to people on the street. Like there's so many different ways to be plugged in, to be sort of anti-racist in all of our individual actions that I think. So that's the both ends. We need to focus like structured policies on these mechanisms and maybe racial residential segregation. But on the everyday action level, there's just so many different ways to be plugged in. I just want to encourage people not to, like, sit back and think that they can't have an active role right now, because it's like an all hands in moment, I think.

DR. HARDEMAN: I would add to what Dr. Pirtle just said, by, related to the residential segregation because that's exactly where my mind went too, but I think it's also specifically housing and housing instability. Even now, as we grapple with COVID-19, and thinking about evictions and how to prevent evictions and how to offer rent support, that can go a long ways during this pandemic, but also, we know that housing stability has, can have significant implications for the other parts of someone's life.

The other thing I would say on the bigger picture is taking-I think we really have to be thinking about universal healthcare. We have seen our healthcare system innovate in a lot of different ways over the past few months, that, you know, a year ago, we might have said was impossible. And so the point being that we can do it, we have the capability and the resources to ensure that everyone has the appropriate amount of access to health care. And so I hope that that is one of the discussions that ends up on the table at some point.

DR. MICHENER: Okay, so much to think about there. It's actually hard for me to pivot to the next questions because I get so deeply engrossed in what you all are saying, but I'm trying folks, I'm trying. So, one question that has emerged that's sort of a practical question, I mean, the questions are at all different levels of practicality and abstraction, but this question is how can we integrate anti-racism effectively into medical and public health education to assure that doctors and public health leaders are anti-racist? And how can peer-to-peer education on this topic among students of medicine or public health be made effective?

I guess the first thing I think when I read this question to, when it says to assure that doctors and public health leaders are anti-racist. It's just about how I, for example, have my own horror story, that I won't share, around my experiences when my first son was born, right? And it's almost feels like I'm in this club where every time I'm in a room with how many ever black women, we all or so many of us have these stories and there's this question of, how do we integrate the kind of knowledge about anti-racism in such a way that we're actually making it so that the public healthcare and healthcare force more generally is able to sort of adopt some of these practices of anti-racism?

DR. HARDEMAN: So, I think it's such an important question, and one I've spent a lot of time thinking about in my work. And in 2016, I wrote an article with colleagues where we talked about, and it was just after Philando Castile was shot and killed in my community by a police officer, and there was this distinct feeling around me that the folks that I was working with and interacting with on a day-to-day basis didn't understand what their role was in dismantling the structures and the systems of racism that allowed that murder to happen.

And so, we wrote a piece that really spoke to how we think about re-educating and rethinking about structural racism within medical education and making sure that folks get the history that, this, the idea of racism wasn't, didn't happen overnight, that it's been embedded in the way that we do things for 401 years now, and that we've been socialized from the times when we were children to really think about and view race and racism through a certain lens and medical education has-I mean, we could spend hours talking about all the history and the historical context for the ways that racism is played out in the medical field and practicing medicine, and I think that there is a lot of work to be done to ensure that that reality is embedded in our medical school curriculum. I know that there's some schools that are doing that work now and there's been some fantastic students, I mean, the White Coats for Black Lives student and med student group has been at the forefront of really pushing this and calling for this work to be done.

And I'm not saying that training is the end all be all solution, right, because we know that training isn't all of the answer, but I think making sure that that training and that content is infused across all of our medical education, not just the four hours on a given day on health disparities, but really, when you're getting your lectures on pulmonary function, you're talking about why pulmonary function is discussed by race and how racism is operating in that and things like that. So, I think we're seeing some, some forward movement there, but then it also has to be embedded into the systems and the institutions that are selecting hiring faculty. Right? And if the faculty is diverse and has an understanding of these issues, and also the student body that's being allowed into medical school. And so, it has to be happening sort of at all of these different levels.

DR. COGBURN: I think, just to add to that, I agree 100 percent with Dr. Hardeman, and I'm really trying to go to this. If we're accepting that racism and white supremacy are embedded in everything, then we're talking about a complete orientation and worldview shift. It's not considering the possibility of racism, it's acknowledging, as a default, that racism is there and then acting accordingly, not waiting until the data come out. We already have the data. Again, we've already done this.

So, starting from the point of racism is probably most likely at play here in whatever it is you do and in whatever station you work. Anti-racism is anticipating that at the outset as a default, and then acting accordingly to avoid it, and really kind of working from a base orientation that if it is not anti-racist, it's racist, because white supremacy and racism are embedded in everything that we do. And if you don't believe that part yet, we can take some steps back and recommend some things to read to try and get you up to speed, but that's true and let's just accept that and then what do we do next? And I think that fundamental orientation starts to anchor that we should all be doing this differently. And, as Dr. Hardman was saying, it's not a day, it's not racism day or diversity day or health disparities day or the health disparities class. If you've studying anything about health and you're trying to understand why those patterns in health are emerging, you have to be articulate and sophisticated about understanding and competent in understanding the function of racism in producing those patterns. And if you don't understand that, you are not a competent health provider.

DR. MICHENER: Wow, throwing down the gauntlet, but appropriately so, I would say.

So, some more, I think this is a challenging question, but I think that the challenging questions are the ones that we have to grapple with. The question is how, or can capitalism be reformed to be anti-racist, or is there a totally different economic system we might endorse? And, so I think in part this is in response to Dr. Pirtle's article that we posted a link to, but I also read here a broader question about the relationship between the kind of patterns of systemic health inequity, that so many of the panelists have so eloquently and sort of accurately pointed out, and our broader economic system. And it really is, I read it as a question of intersectionality, and when we think about the junctures where racism and a kind of economic marginalization come together to affect people's lives, particularly people who are on the sort of losing side of these systems. How do we think about that and what does it mean for imagining and sort of thinking through the role of our economic system more broadly?

DR. PIRTLE: Yeah, I'll try to take a stab at answering this one, as well. When I wrote about racial capitalism, that is a theory that's been longstanding. It's a black, radical tradition in the United States, and South Africa and elsewhere. My goal is to link it a little bit more to health equity. But those early thinkers, like Sedgwick Robinson, they argued that racism essentially upholds capitalism, that if you're seeking capital accumulation, it rests upon racialized exploitation.

So, the devaluing in language that U.S. Senators have said today, human capital stock, in order to gain things for capitalist pursuits, that means that those who have more are going to get more and those who have less are going to give their bodies in that pursuit. And so I think the way capitalism has been instituted in the United States since slavery, has always been on unequal, dehumanizing, horrific system, and I think that a reform to that system probably wouldn't go as far to undo that sort of devaluation and racialized exploitation. So, I think that these conversations about reform and defunding are important, but more so, just for what you were saying, it's a time where we're supposed to pause and think anew and think afresh and think what could we do differently. So, I don't think, I think we need to be radical in this moment and I think radical thought would be what do we need different, not how do we make an incremental change.

DR. MICHENER: Okay, yeah, I think that's great. I think that it's challenging, right? Incremental changes, it feels much more possible and it feels accessible and like it's within reach, but pushing beyond that is challenging, I think, in a really productive way.

So, many audience members are wanting to know what they can do to move the health equity agenda forward. Some as professionals, some as citizens. How do we process, and solve the issues that are being brought to light, both by the pandemic and more broadly, with respect to systemic racism? So, obviously this is, this is a big one and I think that we're seeing different versions of it in the questions more generally. But this is really head on an inquiry about what can we do as individuals, as professionals, as members of political and social communities, to address the problems that are being raised here?

DR. COGBURN: I'll jump in. I feel like, you know, rewind the panel in a sense that we've been saying, right, in terms of what to do. There's been a combination of things from orientation and framing. How are we framing these issues? How are we effectively communicating to people in positions of power in particular? I think that's an important point of intervention that people who decide and make decisions about curriculum, the people who make decisions about health policy, the people who make decisions about housing policy, all of those, effectively communicating these data and these patterns to those audiences I think is an important point of engaging. And then that orientation piece. How are you approaching any question now about health? And is racism and the function of racism a part of that question? Because even shifting the way that you're framing questions will lead you to different answers, will lead you to different points of analysis and will certainly lead you to different solutions. If you're pleading this frame in your question from the very beginning and you know, we, we've already talked about specific policy recommendations, universal healthcare, and we haven't mentioned reparations yet, but completely changing our economic system.

There's lots of things that we could be doing, but some of these are so specific to your discipline, your space where you work. And in order for you to figure out what would work in that space, you have to change your orientation and you have to change the questions that you're asking. And you have to be explicitly anti-racist in your questioning, your analysis and in your planning for how to move forward. And anti-racism is not a badge you get to wear or post on your social media account, making claims of being anti-racist. This is an action, this is a behavior, this is a way of engaging, it's an orientation and we should be less focused on how we're perceived as being racist or not or anti-racist or not and start doing the work, and work that may or may not be visible on social media, but work that matters within our own organization.

DR. HARDEMAN: Yeah, I think Dr. Cogburn said it well. I would just add, certainly voting is important and also being willing to examine your own power and privilege and where you sit, and what space you occupy and if it's a space you actually need to be occupying or is there someone else that's better suited to do that? I think that's really hard for folks to do, but it's an important and critical step.

DR. MICHENER: I mean, taken together, those responses I think are so, so good. And I think I'll keep saying this because I think it's an accurate description. Really challenging to each of us from, from an individual perspective, one thing I appreciate about what Dr. Cogburn said is one thing I heard in your response was a resistance to giving easy answers, right? So, I'm just going to lay out a policy package for you and these are the policies we should all pursue, or I'm going to lay out three steps or five steps and if you follow these five steps it makes you an anti-racist and now you can wear your anti-racist badge proudly. Instead, it's about evaluating, and this really speaks to what Dr. Hardman said, your own positioning, what is within your sphere of influence? Where do you have voice or power and should you? And is there a space for sort of decentering yourself or really reorienting in the ways that Dr. Cogburn is pushing us to do? And it means that if you're in a different professional space or in a different space as a member of political and social communities, perhaps none of us on this panel can tell you precisely ow you can address the problem. Instead, part of the work is reevaluating the space that you're in, your place in it, your options for change through the lens of racism, such that now you're always thinking about it and you can sort of produce or co-produce with others your own sense of the appropriate next steps, right? None of that is sort of easily packaged and readily available for us to just sort of hand out in soundbites. I think that's, it's so good.

Okay. So, moving on to some other questions. One question from an audience member is kind of a follow-up question, and I will say, there are some things that will be added to the chat along the way. We're just continuing, we're continuing it to give you all resources, pay attention to those links, save them, and use them. They're pointing everyone to just resources, research, et cetera. Okay. So, there is a specific question about you know, in terms of the kind of what can we do questions, there's some breakdown here between questions about what allies can do and questions about what people of color can do. I think that we really sort of, you know, touched on some important pieces of that, in the response to the previous questions, but I wonder if we think that there's-or if panelists think that there are important distinctions there? So are there particular things that white folks who understand themselves to be allies should be doing over and above or distinct from the sorts of things that folks of color, for example, can be, might be, or should be doing? How do we think about the kind of call to action in relation to our racial positionality, I guess is really the broad question?

DR. PIRTLE: I think what Dr. Hardeman just mentioned about privilege, I think is so important, and I think that that's something that intersectionality theory teaches really well, in my opinion, the fact that there are multiple sort of intersecting forms of oppression or axes, the matrix of domination and that we all fall on a particular place in this map. And so that means although I am or, and I am a black woman and that means I might enter structural racism and structural sexism, that I do have other axes where I am in a more privileged position. I think it's important to talk about those nuances and to see where we have those privileges and where we need to leverage those privileges. So, for instance, oftentimes conversations about healthcare as a human right are related to legal status, and I have legal status in the United States, and so it makes sense for me to be on the front lines of those conversations because I'm in a protected position. It's oftentimes those people who are most vulnerable, who are ringing the alarm, but they're doing the work at other risks, you know, really important risks to their lives.

And so, that's a movement where we need to think about building coalitions and how we work together to sort of make sure that if I have this particular right that others might have that right too and using my privilege there. But I also think that it's really important to understand that if there is a conversation centering someone with undocumented status, and I do have legal status, that's the moment where I also need to pause and listen and make sure that I'm not taking up space. I think it's a balance to find, but it's very important. It's important to leverage your privilege, but it's also important, like we already discussed, to know when to be silent, to know when to pass the mic, to know when you need to do more reading and talking with yourselves before you ask someone else to do that work for you. So, I think it's really, I think it's a conversation that needs to start with the individual and sort of move up and figure out, where you're at right now in your journey into understanding anti-racism, where you can contribute and where you need to do more in order to get there, to get to that point where you're really trying to leverage your privilege.

DR. HARDEMAN: I would just add from a scholarship or a research standpoint, I think I've seen this sort of phenomenon in the past couple months, where white scholars in particular have decided, because they've realized that racism is a public health issue, racism is an epidemic and worthy now of sort of academic scholarship, that they're delving into this space where black scholars and other scholars have been building the evidence base for, for quite a long time now and I think we touched on this earlier, and so one, I think one of the things I think about with that question too, is ensuring that folks actually step back and don't assume that they have like a sort of brilliant new idea. You may have one and that's great, but step back and read what's been written. I mean even, I mean this is, there is a deep, deep bench here and there is a lot of evidence out there already and I think that speaks to Dr. Cogburn's points around where research should be heading and sort of what the next steps and what interventions and things should look like, as well.

DR. COGBURN: So, I was just about to say something very similar. I think it's so important and I've been having some conversations on Twitter, my digital living room, about this as well, where you have people, who like you said, there's a deep bench and this work has been done for a very long time, so you may not have a new idea or you may be missing important nuances in complexity and you may not be the person who should be pushing a certain piece of work forward. And we also get thinking about culture and systems, academic culture, and systems, we have to think about, especially in moments of crisis, whose research, who's going to have the capacity to apply to a rapid grant? Who's going to have the capacity to write papers to get this work done? And if you're writing about racism, we're often speaking to panels of judges who barely understand how that functions. And so, we're trying to frame it in a way, while still moving the ball forward, but frame this really complicated thing, in a way that a panel that's really not equipped to really understand that complexity and explain it in a way that they ca understand it, while someone else who's new to this space may explain it in a simpler way, and that's aligned with the simpler understanding that your panel of judges have and it's easier. Now you come across as clear and targeted and direct, even though it may not be the work that needs to be done in the space. And so, there's all sorts of complicated things that are wrapped up in this.

So, related to the question, allies or accomplices who are in positions of power, again, if you're starting with the question of in this call for rapid funding related to COVID-19, am I privileging some voices or giving more access to some voices more than others? If I am, how might I go about releasing this call of structured evaluations or proposals that come in that can help avoid that disadvantage? Ask that question at the outset. Who am I publishing, who am I funding, who do I need to be publishing and funding in this particular moment and actively working toward creating equity from the outset, rather than waiting again to see when the numbers come out, who got COVID-19 funding and whose papers got published. Let's not wait to see. Let's just agree that that's probably where we're going to land and try to do something about it now.

DR. MICHENER: Yeah, okay. So, one of the questions, a little bit of a shift in gears here, is about what panelists would suggest about the roles that public schools can play in providing or promoting greater equity, either for access to healthcare or beyond. And I think certainly many of us who are parents are thinking about schools right now, but even beyond that, there are just questions about the role that various kinds of institutions, especially institutions that play such a wide ranging role in many people's lives, and certainly public schools represent such institutions, and so this question is really about what role do they play in this larger conversation about health equity and systemic racism.

DR. PIRTLE: I think our schools is one institution where we might begin to, like we have in the police institution, we might begin to focus a little bit more on the funding. So, if there is funding for school resource officers or stations at schools and sit there, and their job is to enact discipline. Why are we putting money there if a school's goal is to educate? So, what sort of healthcare providers, what sort of social workers, behavioral health, mental health do we have in the schools and why can't we put more funding there? So, I think so, having these conversations about funding, I think would be important for schools.

I think right now during the pandemic, we're also talking a lot about equity and access. We've all of us are professors and we're teaching, and we had to deal with that in our own classroom. If we're assigning a research paper, what's limiting particular students from getting that done compared to other students and how might we change our, even if it's more work, how might we need to change our syllabi to make sure they're more inclusive? What sort of things that we're changing, sort of in the rules, written and unwritten to make sure people have more access and equity?

So, I don't know. I mean, it's a big question. I'm a professor, I'm teaching classes, I also have children who are in school and we're trying to work all of those things out. But I think the issues related to funding schools are highly tied to racial residential segregation too, as well, and so we know that there is really unequal access in terms of schools segregated in areas. And so, it also ties back to the bigger policies, related to neighborhoods. So, I think we can focus. There's again multiple mechanisms and multiple levels. You have to think about how the schools even get their funding, once they have their funding, what they're doing with it, what the teachers and schools are doing, their role in calling on that resource officer and also representation in schools is really important, so we talk about that in higher ED, but how many, for instance, black kindergarten teachers do we see? And these are often our first, our student's first step into an educational system and there's so few and so we need to change that, who even has jobs, who's administrators, whose the superintendent, whose on the school board? All of those things definitely play a role and impact health.

DR. MICHENER: That's great. Okay. So, we're getting quite a few questions about the, well, I was going to say effectiveness, but really relative ineffectiveness is what the questions are focusing on, of anti-biased training. Although this training now appears to sort of be a reflexive response of many institutions to, their kind of newly come understanding of racism. And so, this is what many institutions are doing, but there are also some concerns about its effectiveness. So, I wonder if the panelists could speak to this and/or talk about potential effective alternatives from a kind of institutional vantage point?

DR. HARDEMAN: Go ahead, Dr. Cogburn.

(Dr. Cogburn motions for her to continue)

DR. HARDEMAN: Okay. So, I think first I want to make the distinction between, I think we, for the past few years, we've seen a lot of implicit bias trainings, right? And I think that's different than an anti-racism training. We've relied quite a lot, particularly in healthcare, on implicit bias training and really getting folks to understand that they're unconscious or automatic biases can lead to poor quality in the clinical encounter and things like that. And I think that there are a lot of problems with implicit bias training because it suggests that it's a social cognitive process that can't necessarily be changed. And we also know there actually is very little evidence that shows that implicit bias training, is effective, that it actually has an impact or a long-term impact on changing someone's biases. Now, I think we're starting to talk more and hear more about anti-racism training in institutions, and there are states like California, where they've passed legislation, SB 464, which is mandating that all perinatal care providers in the state go through anti-racism training. And I think it's an important signal, right, that there's a problem, A, and B, that, you know, that it's more than sort of, that we all have a responsibility to do something about that problem.

But again, and I think I said this earlier, I don't think, training alone isn't the solution, so I don't think there is anything wrong with anti-racism training, generally, I think that the problem lies if that's the only checkmark, right. If, if folks are like blowing through anti-racism training modules and then feel like now to check the box, I'm anti-racist, that's a problem. As we've heard throughout the past hour it takes more than that and it takes sort of asking questions and reading critically, conscious and critically reflective, all the time and asking the hard questions and examining positionality and power and privilege and all of that. And so, I see the training as one small piece of this bigger picture that really, I want to see a healthcare institution or some other institution saying we're doing training and this, this, and this. We are committing to making sure that our faculty are, 50 percent of our faculty are diverse and represent, or 50 percent of our clinicians represent like the population that we're serving. It has to be one part of this sort of bigger picture of what we're doing to become anti-racist.

DR. COGBURN: I think, I agree 100 percent, and I think to add onto that, when we're thinking about where do we start and what do we do, intervening on unconscious bias is probably one of the last places I would go to deal with this. And I know I step on toes when I talk about this, but it's such ultimately a -- task to fix the bias of every individual in an organization when we haven't done anything about the air that they've been breathing from birth, that produced the bias in the first place and we haven't changed the container that we're putting the training into. I mean, I just don't understand how that's supposed to function. And I'm not saying it's not important, it is, it is important psychological process to understand unconscious bias and how it functions, but there are so many other places to intervene that might be more effective, such as anticipating that humans are going to be biased in any number of ways. How do we account for that possibility and help diminish the significance of that in decisions that we make? That's a whole different point of intervention that I'm going to change human nature to be biased against groups of people. So, I just wouldn't recommend it as a place to start. And I think what Dr. Hardman was pointing out in terms of really thinking about the framework of like structural competence. Do you understand how systems work? Do you understand what racism is and how it functions in society? Those are the sorts of understandings and competences that I think are so important for us to focus on, as opposed to only thinking about trainings and unconscious bias.

DR. MICHENER: Really, really great insight. So, we're getting to the point where I want to sort of be mindful of the fact that eventually we have to wrap up this conversation. And I want to kind of offer what feels like a good final question and hope that each of the panelists can speak to it. The question is what keeps you hopeful when working against these huge structural inequities that can seem insurmountable? I know personally, this is, I find this challenging. I manage to do it, but sometimes really resist what I feel like is the sort of urging to articulate some sort of false hope, everything will be alright in the end, because that’s not necessarily true and so that's not what we want, but I do think it's good to sort of, if and as possible, articulate those sources of hope that are out there, right? Because it's a long struggle. I think this is something that each one of the panelists, in one way or the other, has pushed us to acknowledge and confront, and so hope anchors in the long struggle, right? And so, I'll turn it to the panelists now. What keeps you hopeful?

Hardest question of the day, right?

DR. PIRTLE: This panel keeps me hopeful. So, I think for all of the reasons we identified, the fact that we are at a reckoning, it's a moment to learn, and I think also me, I've been engaged in my community recently seeing youth and their, the knowledge that they have, that they're already speaking about how to be anti-racist and thinking about, you know, the ways that they are calling out and calling in and just the fire that they have and bringing us to the table too. I think that's been empowering for me to see. Related to COVID-19, the mutual aid communities that have been sustained in black and brown communities forever, but we're seeing even more resources going into those. That's been a bit empowering. Reading, continuing to do the work that I'm doing, engaging in black feminist thought. There's been a few recent pieces related to the Combahee River Collective and the focus on freedom and that the reason why I said being here with you, they had told us long ago that if black women were free, that would mean all of us would be free. And so, I think this conversation of black women and talking about systemic racism and health equity is one of those things that's giving me a hope today.

DR. HARDEMAN: I would just add to what Dr. Pirtle just said that certainly conversations like these, and I've had the opportunity to participate in a handful of them lately, gives me hope. And I think the other thing that really gives me hope right now are the students I get to work with and even those that I'm not working with directly, but who have really, particularly here in Minneapolis, where, you know, we are right in the epicenter of where George Floyd was murdered by a police officer and the civil unrest then ensued and I have seen so many young people and so many students speak up in ways that have been incredibly powerful. I always use the example of our, the University of Minnesota student body president, first black female student body president at our university, Jael Kerandi, who wrote a letter to our president, the president of the university demanding that we divest from and defund the Minneapolis Police, and we severed that relationship and the power of her words and her actions and what she was asking for and the outcome. The fact that she got it done. I think it gives me hope and I mean that's one example of the power and the activism that young people and the students that I get the chance to interact with every day. It, it leaves me really hopeful right now.

DR. COGBURN: I agree with Dr. Hardeman and Dr. Pirtle. One, my brilliant black colleagues who inspires me every day, and I'm not using the term brilliant lightly, in terms of the work that they're doing, the scholarship they're producing, the ways in which they're engaging public discourse, not shying away from helping steer us as a country in the right direction, I think is continued to be really inspiring to me.

And to also echo, to see the youth and I'm using that generously, anybody younger than me is youth, and just really like they are not having this and they are not putting up with this and they are so thrilled with all of us. And so that's climate change, that's racism, that's all of it. They want all of it gone. And I'm so here for it and so inspired by them as well.

And then I think increasingly what gives me hope is the possibility in carving out more space to imagine black futures and create space for black imagination, and not only talking eventually about racism every day, thinking about new possibilities gives me hope and so I am going to continue to claim that space as much as I can. I hope we all do.

DR. MICHENER: Yeah, you know, I will say that that sharing space with you all today, certainly, despite the kind of intensity and the kind of serious difficulty presented by so much of what we've been talking about, that I could share space with all of you today and talk about it, gives me hope. And to hear and really be able to soak in your insights, it gives me tremendous hope. And even hearing about your sources of hope, looking in the panelists list and seeing students of mine and knowing that they are getting to listen to you all, right, that this is the kind of conversation that gets to shape the discourse and that gets to shape how it is that they think. And then all of the audience questions, there were so many audience questions that were essentially what can we do, what can we do, what can we do? And there were plenty of questions that we didn't get to answer just because of time constraints, that were just really in depth. Some super specific; what about telemedicine and what about trading medical professionals. Some pretty broad, more versions of, I want to intervene. What can we do? I think that the urgency and the kind of specificity and the honesty and, honestly, just the volume of those questions suggests that there is real possibility, is real potential out there.

And I guess I'll wrap up by saying something that gave me hope in this conversation from the onset was how Dr. Hardeman opened us with an invocation of love. Right? I think that remembering not just the science and the research but what this is about, right? Giving people access to life honestly and to lives that are full and that are fair, because they are people who have an inherent dignity. I think that when I take myself back to that broader perspective, it gives me a lot of hope and you all have really helped to take me there today and I, and along with me hundreds of people who have signed in to this webinar. So, thank you for doing that. Thanks to all of the audience for watching. I'm going to shift now and give my colleague, Monika Safford, a chance to close us out.

DR. MONIKA SAFFORD: Yes, in the last minute, I certainly am not going to be able to add anything to that spectacular conversation, except to give my personal thanks to Drs. Pirtle, Hardeman, Cogburn and Michener. And I want to remind the audience that everything has been recorded and a recording will be available on our website, and that is cornellcenterforhealthequity.cornell.edu

Thank you so much to our panelists, to Dr. Michener and to all of you for joining this conversation. Take care.

[END RECORDING]