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"Injustice and Health"
UCSF Teach-in with Soledad O'Brien

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>> Good afternoon, everybody. Good afternoon. Hi, everybody. My name is Dan Lowenstein. I serve as your vice chancellor and provost, and I want to start by thanking everyone of you for taking this time to gather together for what is an incredibly important event. And your presence here has already started that off for us just the way we had imagined. In addition to everyone who has gathered here, we have got folks in S214, in Toland Hall, the alumni faculty house. Thanks to those folks, as well as those in Mission Bay -- welcome everyone to the different sites across the UCSF campus. So this is a teach-in. The idea of a teach-in is that it brings us together for what we hope is a key event in the UCSF history. Challenges facing us across the nation and right here at UCSF with respect to equity and tolerance and justice. We are proud that we serve the ethnically diverse and -- we see advancing health care outcomes across boundaries of race, disability, gender, orientation, and all of the other differences that make us who we are.

And crossing those boundaries and caring for one another is a core responsibility. And we hold ourselves accountable to doing this, and we see raising our consciousness about these issues, our awareness, and taking action as a core aspect of our mission.

So, look, most of you who are here in the audience here and across UCSF, you're our students and our trainees, and you have heard this before. It's really true. You are the future of our nation and of the world, and you are the ambassadors of the 21st century, in terms of the way that we see health care and life sciences research impacting the society that we serve. We know that there's so much that needs to change and to have the impact that we want to have on each and every member of our society.

Now, we're proud of what we do, but there's a lot more that we can do better, and we're confident that we can all work together at UCSF to become an even stronger beacon of diversity, inclusion, respect and tolerance. This is just one day. It's one event. But we hope that it will gain insight and inspiration for all of us to help us do this more.

One of my absolutely favorite sayings from Dr. Martin Luther King is that famous quote, the arc of the moral universe is long, but it bends towards justice. The arc of the moral universe is long but it bends towards justice. I hope taking a few hours out of our lives to focus on these deep issues of such profound importance and the actions that we all take as a result of this collective reflection will move that arc a bit closer to the goal that we all desire.

So, let's begin. A quick reminder. You have, I think your program shows ways that you can submit questions to Soledad and the panelists, when that part of the conversation begins. So you can use Twitter as well as e-mail. And now it's really my delight to ask our chancellor, Sam Hallgood to come introduce our speakers. Sam.

>> Welcome, everyone, and thank you Dan for putting this I think really critical event into the context of the larger program and our ongoing commitment to issues of inclusion, justice, and diversity here at UCSF and in the communities that we serve. As Dan said, you are the future, and we look to you to keep the leadership connected and aware of issues, concerns, and particularly opportunities that we can take to move forward.

So turning to the excitement of today's event, let me begin by thanking Rene Navarro, Alejandra Rincon, and all of the staff and volunteers who have worked, I know, very hard under a pretty strict timetable to get this event pulled together today. And it's really remarkable, so thank you Rene and your team. So Rene's team has done the hard work, and yet I get to stand up here and have the honor of introducing our keynote speaker today.

Soledad O'Brien is an investigative reporter who has done series, documentaries, and live events examining our nation's issues on racial diversity. She is an award winning journalist, documentarian, news anchor, producer, and television personality. She was a coauthor, a coanchor, I should say, for Weekend Today, and contributed to segments on the Today Show and the Nightly News.

In 2003, she transitioned to the CNN winning awards for her hard hitting stories, such as the crisis in Haiti report, examining the status of orphanages following that country's massive earthquake in 2011. She has also worked on kids and race in CNN's reporting of the 2012 presidential election, not nearly as exciting as the 2016 presidential election.

She has also reported extensively on hurricane Katrina and the BP gulf coast oil spill. In 2013, Soledad launched a media platform media production and distribution company dedicated to uncovering, producing empowering stories that take a challenging look at divisive issues of race, class, wealth, poverty and opportunity through personal stories. She was the originator of the highly successful documentary series for CNN Black in America and Latino America which she continued to produce under the star fish media group. Following the tragedy of hurricane Katrina, she and her husband started the foundation helping with the request for college education.

We are honored to have Soledad with us today. Please join me in a warm welcome.

>> Thank you so much. It's great to be here and be part of something that is truly ground breaking. I started working in TV news in 1987. I had just finished up my studies at Harvard, and my very first job was removing staples from bulletin boards at WBZ TV in Boston, and my parents who had just spent about a hundred thousand dollars, this is a good group to talk about expensive education, on my education were -- to say that they were disappointed does not come close. My mother is like, that's a job? But I loved it. I loved it. I loved being part

of a team, obviously, the lowest member of the team, whose job it was, overall, to get stories on the air each and every night. And I might be removing staples or fetching coffee or running scripts at any time, but I could figure out pretty quickly where the true power lay. And it wasn't even really with our morning anchor team. I actually can't even remember who was our morning anchor team at the time. The power was in the hands of producers who decided what stories got in, who decided who would be chosen to tell those stories, and the perspective that those stories would be you told from. And suddenly you realize being able to craft that is actually where all of the power lies. And it came to me pretty quickly that the real power was in leveraging voices and certain perspectives, and that maybe if I kind of went a producer route, I could have some influence in how those stories would be told. But basically when I started back in 1987, I was an underpaid, low level production assistant. And as I climbed the ladder, it never really occurred to me that I would have an opportunity to cover some of the biggest stories of our time, you know, whether the southeast Asian tsunami or hurricane Katrina, all of the documentaries we did on Black in America, Latino in America -- when I started, so much energy was spent on trying to figure it out. My time here in San Francisco as an on air reporter in 1993, a brand-new starting reporter, I had only a few more skills and slightly more talent. And I'll tell you a horrible story that to this day still makes me anxious to recall it. My first story on air ever was to go cover the San Francisco Giants who had made it into the play-offs. Dusty Baker was the coach at the time.

That's how long ago it was. My job was to go to this bar, Joe's Pub. They were friendly to media, and I would interview everybody at Joe's Pub about the Giants, watch the game, do the report. I spent the day at Joe's Pub. My very first live shot ever, had never been live on television ever, and I put the piece together and sent it back, and then at 6:00, when the show opened, they tossed to me. Soledad O'Brien is standing by live at Joe's Pub with the latest there. Soledad, how is the crowd at Joe's? I started to talk, and suddenly I realized two things. One, everybody was really drunk. That was bad. And number two, they were all really close to me. Like, wow, there's a whole bunch of people right up on me, kind of. So just as I started talking to answer what the anchor has said, the man standing behind me for the live shot, I had never done one before, leaned over and pinched my butt. I just wanted to reiterate, my first live shot ever in my life. If you have ever been so freaked out that time stops, and you go -- that's literally what I did. And eventually the anchors, because I wouldn't say any words, cut away to my piece that we had put together. By the time they came back to me and I wrapped it up. If you have ever done anything so awful, usually your friends are like, it's fine. I got to the station, and it was like, oh, my god, indicating that it was worse than it felt. It was horrific. It was actually far worse than it felt. My boss brought me into the office. He started discussing, do I need to be in a smaller market. I am so not exaggerating. Luckily, reporting is a learnable skill, and after a few months I was able to not only figure out the gig but get promoted to become

the bureau chief for Oakland for KRON TV, or more accurately, they just kind of moved me to Oakland, and since I was there by myself, I named myself bureau chief. It seemed completely fair. And I proceeded to cover all of the typical news stories out of there.

My husband, now, charitably describes the stage as not my best work phase in my career. I reported on a cat that had been missing in the Oakland Hills fire that came back, and the person who owned the cat believed that the cat was reincarnated from his roommate, and they sent somebody out to do that story. That was my story, literally, holding this cat. It is believed this cat is the reincarnated roommate. I did that story. You may have missed it. I did that story.

Also, I reported on a black mamba snake that had gotten loose. Everyone thought it was a very big hoax, but I reported on the missing black mamba snake. I covered exploding meth labs. I would tell people all the time to stay off the Bay Bridge where I held my notebook in one hand, telling people, the wind was high. To the point little old ladies at the Lucky's super Market would say, I'm praying for you to get an inside job.

Most of our stories, frankly, lacked context. Poor people that you were reporting on were poor. That was kind of the starting point, or maybe the background stories about crime, hospitalization, or death, we didn't really dig into it. We certainly didn't try to understand it in our reporting. I'm ashamed to say we just kind of reported it as this was it. It was sort of not even relevant. And I remember one Christmas

day, as a low level reporter. Of course, I was working on Christmas, and there was a breaking news story. There was a little boy who had gotten a BB gun for Christmas, and he had shot his sister with this gun. And all of the reporters working on Christmas Day were camped out, you have seen this before, but change the story, camped out on the lawn of this family. And it was amazing, right, from a reporter's perspective, there was a breaking news story on Christmas Day, so we had something to go cover. The mother came out and sort of wearily asked us if we could go home, which of course we could not do, because we had 5:00, 6:00, 7:00 live shots. Our story would be called parenting tragedy, the hinting at -- but we never dug into any of the issues that I now know surround these kinds of stories. By the way, this story will be on somewhere else the day after tomorrow, and the same thing will happen. We never talked about the correlation of race and poverty. We never asked the mother at all about her experiences or her life or her challenges or her frustrations. We wouldn't let the people get in the way of a good headline, a Christmas tragedy. And, you know, we didn't try to understand anything about the woman or her life. We were just covering it for the headline, which was very typical, which I don't think in retrospect excuses much. And I think I realized for the first time all of the social factors in stories that were unfolding and maybe health as well was hurricane Katrina. It became very clear to me for the first time the story we were covering wasn't about the story we were covering. It wasn't really about the hurricane at all. When I got to the city a week after, stories that revealed ridiculous things about

the state local and federal officials, the last residents were leaving. One of the first things I remember, a woman I ran into was pushing a shopping cart through mostly empty streets around canal street, and she was asking for directions to busses that were taking people out of the area. The next couple of months would be spent covering coast guards as they broke through roofs, where people were camped out trying to escape the water. You might recall the final advice from the mayor to the people was grab a freaking axe. That advice, as pathetic as it was, saved lives, as people tried to get from the attic to the roof in order to try to flag down choppers. For me, witnessing it as a reporter, it's such a complete failure to help people who literally needed it the most. We would get into homes where children were living with the dead body of a mother whose oxygen ran out. She didn't have electricity any way, she had diabetes, the medicine was underwater, and she died and the kids were just living with that until they were rescued. I interviewed a man whose wife couldn't make it. He had jumped off the ceiling into the roof into a boat. She couldn't swim. She just drowned.

And so probably for the first time I recognized the headline, the levies break or the hurricane rolls in, was not really the story, and the impact was directly related to the people's poverty, race, their opportunity if they bounced back, if at all, would be correlated to their access. There would be social determinants that were deciding if they would live or die, that some people would be resilient enough to live on and in a big open, you know, warehouse with their kids, as they

tried to figure out a new way or any way to move forward, and other people would just die of stress or disease or sadness.

I remember calling home almost every night, not my home, right before Katrina -- I had my twin boys, so I had four kids under four, which made it great to be on a trip, right? I was like, I think my husband can deal with that. I'll just go cover this story. But I was so overwhelmed by what I was saying day-in, day-out, that I would call my home, my mom, covering stories about people who drowned, wrapped in blue tarps. What they would die is tie them down, under the bridge, and GPS it so they could come back and find their bodies later. So you could always tell when you got there, because human bodies smell a certain way, and my mother would -- I would sort of tell her, I had the weirdest/most horrible day. I saw three bodies that were all wrapped up in plastic, just left there. We knew they were tagged by GPS, and eventually someone would come around to grabbing the body.

And my mom always said the same thing, Lovie, she called me Lovie, America is better than that. And I'll confess, at times I didn't think so at all. It felt like America was letting people down, that we were facing another civil rights battle, and New Orleans was at the center of a bigger equality challenge. This happened before. When I went to New Orleans to cover the first week of Katrina, but I was still anchoring in the morning before I left. One morning, CNN had these big giant screens of things unfolding, and you might remember the pictures of thousands of people at the convention center, begging for food, water, can you help us, et cetera et cetera, and I

remember standing there, Lou Dobbs walked up, kind of stood next to me, looked at the picture and said, I just can't believe anybody would say this is about race, literally saying the exact opposite of what I was thinking in my head, a bizarre experience. And it was the moment I think that my eyes opened to we could help tell stories that would better tell and underscore this sense of in equality and inequity in America. I think I was as aware as anybody of the unfairness in America. I certainly grew up with stories about it. My mom would tell me the way she and my dad met -- my mom is black and Cuban and my dad is white and Australian, and they met because they would both go to daily mass. My mom would walk, my father would basically hit on my mother on the way to church, no way to clean that up. That's basically what happened. So every day my father would wind down the window of his car, and I used to tell college students, there were no power windows. So when you were winding down, leaning in, imagine, he would say, would you like a ride, they are both going to daily mass. She's telling her daughters, even if you're going to sit next to him in church later, there is no need to get in a car with a young man. One day, she said yes, they made a date to go to a restaurant in Baltimore, 1958. The restaurant turned them down because my mom is black, my dad is white. My mother told the story of bringing my dad back to her apartment and whipping up a meal for him. Her entire point was not about segregation, not about discrimination, but girls, if you learn to cook, you can get a man. I like to say -- I can't cook at all. I like to say, I

can't make it, but I can make it happen, delivered many 20 minutes or less.

My parents decided to get married at the end of 1958. Interracial marriage was illegal in Maryland and 16 other states. So they drove to DC and got hitched, and drove back to Baltimore and lived illegally as a married couple. Their friends told them, whatever you do, don't have kids because biracial children will not fit in this world. I'm number 5 of six. My parents have this interesting habit of nodding at people, like, uh-huh, uh-huh, and then doing whatever they want. They were terrible listeners.

I used to ask my mom, what is it like in those early years, in the early 1960s, living in Baltimore. She said, oh, people used to spit on us as we walked down the street. I said, oh my gosh, what did you do? And she said this thing that I kept coming back to later in my reporting. She said, Lovie, we knew America was better than that, and I think I always thought of that as this optimism, that even if it's really bad at this moment, that it could be better. And that maybe part of the onus of making it better actually lies on us.

And I think there is a special bravery on sitting on the right side of history. My parents were certainly my first example of forging on, despite huge obstacles, despite disapproval. I think they had a very clear sense that if they lived their lives doing what they thought was right, with dignity and with respect, that eventually people would catch up with them. We were eventually the first black/Latino family to move into our neighborhood in long island, north shore, and that

was fun. And my mother's goal was to blend in as much as possible. She was adamant that we didn't learn to speak Spanish. She did not speak to us in Spanish. There was a great photo of my family in about 1976, my dad, white, bald, my mom black with a giant Angela Davis Afro. 1976, we all had Afros of course. Shirts, thick polyester, shirts stripes this way, pants stripes this way, trust me, young people, it was very, very sheik at the time. We were all leaned, jauntily, against our bus. My picture again -- we could have gone with the Spanish, because there's no blending. This is not a picture of an American family surreptitiously sliding into the neighborhood and no one really knows they're there. But I love that picture, too, because it reminds that there is no face of America, really. We look like everything, and that being different can have its value as long as you value it yourself.

To me, it made me want to dig into differences in reporting, and to tell stories about communities that have incredibly interesting and complex back stories that just honestly never get told.

By 2007, I had come full circle in my own personal journey as a reporter. I wanted to tell stories about communities, about individuals, and kind of how they got where they were. And so, you know, we started doing a documentary on Dr. Martin Luther King junior that was called words that changed the nation. Now, what we wanted to do in this doc was look specifically, kind of do a deep text reading of his work, whether it was sermons or whether it was speeches that he was giving or even his written work. We wanted -- you know, I got

to hold his papers in my own hands at Robert Woodruff's library, which is at Atlanta center. You could see draft one had this, what changed by draft three, what words did he cross out. And you could literally see where anger would give way to hope, optimism would prevail. It was almost like having the sheet music to a song you like and seeing how it was constructed. Ultimately, his writings reveal a regular man, young, steady, but present when the moment was called. He was poetic, obviously, and valued words, but his writing came from a man who was inspired by the moment. He wanted to see, he wanted to analyze how people rose up once they had been kicked down.

"After one has discovered what he is called for, he should do it with all of the power in his system. Do it as god almighty ordained you to do it." He is talking about us. You have been ordained to do something important, and you just have to go and do it. He was 25 when he wrote his first sermon, four pages, back and front, in pencil. They let me hold it. I spill, I drop things, so I was shaking; I'm going to be the person who rips his first speech from 1954. But I did not.

He's talking in that particular sermon to folks, as a young preacher, to folks in Montgomery Alabama. But within a year, Rosa Parks would take the front seat of a bus and refuse to bus, and Dr. King was plucked from obscurity to become the voice of the busboy cot movement. He's chosen because he's not controversial. He's really not pissed anybody off yet in a context when people are arguing all the time, but he would go on to become the voice of a movement that to this day has a huge impact. It's amazing to me when you look at the stress that he

writes about in his work, his notes really betray how unprepared he was for living in fear. They started writing in code, and he has lists of code names. He would be jack Kennedy, and Birmingham would be Johannesberg, he talks and writes about how much he misses family. His lawyer, Clarence Jones, would sneak in stacks of paper so he could write letters from Birmingham jail where he says this. "You have to concoct an answer for a five-year-old son asking in agony, daddy, why do white people treat colored people so mean," and then you'll understand -- by draft three, he's changed the text, and you understand kind of the message that he is trying to tell, and so it makes a world of difference. He's not just telling the story of a black community. He is relating to anything that any parent can understand. Reporting that documentary was probably the first time that I truly understood what these mostly little old black ladies meant when they would say, I'm so tired. I'm so tired. Or, you know, that's another iteration of agonizing pathos.

When I began to realize that it wasn't just this literary device, that there was a physical burden, a stress that came with being Black in America, not just in the civil rights era, but to this day, the stress of living as a person of color has not just dissipated because black people are not being attacked by fire hoses or dogs. And it became clear to me that social injustice really was a health issue when we launched our Black in America docuseries the following year. And if I had known how challenging it would be to do that series, I don't know if I would have gone forward with it. I guess I went into it very naively. We were interested in telling stories about race and

racism. We launched in 2008, the same year that a guy a weird name, Barrack Obama, would launch his presidency. Which made all of the conversations that we were having in our documentary ultra relevant to everyone, because the country was having those exact same conversations. The fallout was interesting in a bad way. One blogger wrote this. "There is no black female Rachel Maddow on CNN, no chocolate Campbell Brown, and not even Gretta. No, Soledad does not count." For others, I was praised for not trying to pass as white. One website ran a photo of my kids and husband and asked, could I embrace blackness without looking black and sounding black. So I guess even announcing the series freaked a bunch of people out.

To me, black America was about reporting on black people, a group, frankly, pretty much rarely reported on in nuanced and dynamic ways. In our first documentary, we looked at health care. And we focused on one particular woman, a Ms. Abdullah, who we met as she was being admitted to the ER, and I want to run a five-minute clip of this documentary that looks at all of the social challenges that present when Ms. Abdullah presents in the E.R.

>> An ambulance, a stretcher, an emergency room. For far too many blacks, this is health care in America.

Ms. Sabra Abdullah is 60 years old.

>> Watch them doors, grandma. I see you.

>> For her, Harlem hospital is too far. Like so many other blacks who are sick, poor, the ER is often their only access to

health care. Injections, IVs, EKGs, dizziness, chest pain and tears.

>> It's a real struggle for you, isn't it?

>> Yes. Yes.

>> It's okay. It's all right.

>> I have been struggling to breathe.

>> We thought you had a heart attack and heart failure during the procedure.

>> Dr. Icilma Fergus is the head of cardiology at Harlem Hospital Center. She sees it, the devastating impact of stress, poverty, and sometimes access. Dr. Fergus believes all are key factors in explaining why blacks face a number of health disparities when compared to whites. Blacks are more likely than whites to die from cancer, stroke, asthma, and heart disease.

This is why Dr. Fergus also believes it's important to reach out to the community on a street level, with health fairs, like this one.

>> There are trust issues, where we have some of the patients really do not feel like they can trust an institution to carry out the right testing. There are issues with discrimination in terms of language, socioeconomic barriers, so I think we have to look at it from another aspect, coming out into the community where they live, work, and play.

>> Harvard economist Roland Fryer agrees, but he argues that those disparities don't fully explain why blacks don't live as long as whites: On average, blacks die about five years earlier.

Fryer believes the answer may actually lie in the twisted legacy of slavery and the gruelling trans-Atlantic voyage, or Middle Passage, of black slaves brought to America.

>> I was in Switzerland, and is I'm reading this book, this history book, and there's this beautiful illustration of a slave trader licking the cheek of a potential slave to get on the boat. And I thought for a minute, what the heck is he doing? And then it occurred to me that he might actually be trying to check the saltiness of the potential slave's skin, to see if he could actually make the voyage across for Middle Passage.

>> What does salt have to do with being able to make the voyage?

>> If you are very salt sensitive, it means that you can hold on to your salt, and you can live in conditions that are very hot, very humid, little water. So being salt sensitive is great for long boat rides and horrible conditions, but absolutely terrible for hypertension. That's the irony of this.

>> The people that could best survive a slave voyage to America are going to generations later be the people most likely to get hypertension.

>> Absolutely, and that's a theory out there.

>> Many doctors and researchers say the problem with the salt sensitivity theory is that there isn't any medical proof to support it, arguing that chronic diseases like hypertension and heart disease are just too complicated to write off to genetic predisposition. But Fryer sees the possibility of a powerful genetic link. What he is saying is that blacks in America may

actually be biologically different than whites. It's a controversial idea to say the least.

>> I don't care what the answers look like. If it's salt sensitivity, and I can show that if we eliminated salt sensitivity, if I can show that and I can decrease the life expectancy gap by half, I don't care if the answer makes people uncomfortable.

>> Do you worry about rubbing people the wrong way, angering people, maybe saying things that aren't particularly politically correct?

>> Absolutely not.

>> Not a little?

>> Not a little.

>> Are you doing well? You look good.

>> I feel much better.

>> A few weeks after we met her in the hospital, Ms. Abdullah invites me to our Harlem neighborhood. She's doing better but still struggling. One of the things that you said to me when we were in the hospital and I was there visiting, one of the things that you said was the stress of all of the sort of pressure on you really affects your health. What did you mean by that?

>> Just look. I mean, there is nowhere to do anything. The supermarkets are just lousy.

>> Poor neighborhoods, poor choices. Simply finding, let alone affording healthy food, is a constant challenge in many black communities.

>> I have a question for you. How does it feel to be Black in America?

>> It's a concern radio talk show host Michael Baisden says he hears often from his listeners.

>> This woman said on the program recently she can find a gun in her neighborhood faster than she can find a tomato. Isn't that something? And it's true. If you can't eat healthy, food is your medicine, and we are not taking our medicine every day.

>> For me to go buy a tomato or vegetables in general, I have to go to 110th street and Broadway.

>> 20 some odd blocks?

>> Or better, because I have to go up and then down. And it's expensive, but it's worth me going there. But then I have to take a cab or take the bus and then the cab back.

>> How long does that take?

>> If I took the bus, it would take me maybe 35 to 40 minutes to get there, and I would have to take a cab back.

>> So you're telling me it would take you an hour total time.

>> Approximately.

>> To buy a fresh tomato in the middle of New York City?

>> Yes, in Harlem.

>> And in many other urban centers in this country, whether it's access to fresh vegetables or basic health care, many in black America are struggling, hurting, and dying too soon.

>> That measurement of the 5%, five point difference in black deaths, has now grown significantly. The salt theory that

Professor Fryer was bringing up, many people have said it's unprovable and have debunked it. And of course the irony is that by the time Ms. Abdullah will be able to find a tomato in her neighborhood in easy walking distance of her apartment, gentrification will be underway, an actual sign that she can't afford to live in her neighborhood anymore because somebody has finally decided to invest in the neighborhood and others will be coming in, and is she'll be at risk of losing her home. All of the things that have Ms. Abdullah tired and stress have is links to her race. People that struggle with disease and high medical bills, the root cause is linked to social determinants.

TV news is often reported in a vacuum. The real story is correlated to her stress, which is correlated to her illness, which is correlated -- et cetera, et cetera. Today more people have access to health care than before, but access doesn't necessarily mean health equity. It means more equity in the system, but -- social justice within health, many measures, and I know I'm the preacher and you're the choir on this, show that we are obviously not there yet. When minority women are asked to talk about their experiences in health care, they will use words like feeling dismissed, unheard, ignored, lack of relationship and no trust. And there are correlates to this particular study that I'm thinking of, lower birth weight babies, where educated black women do not match their educated white counterparts. Susceptibility of a lower birth weight frequency is more common in black educated women than educated whites. Research in psychology today show that those ten biomarkers associated with aging and stress in a room full of

doctors and to be doctors, I don't have to lay them out to you but those ten of them measure wear and tear on the body, which makes sense. And that occurs when individuals are exposed to chronic and repeated stress. And in every category, blacks score higher, including 18-24-year-olds whose wear and tear measure is 50% higher than their white counterparts. The point is it's not poverty or socioeconomics. The life expectancy, black college grads have a life expectancy nearly two years less than someone who is white and only has a high school diploma. So think about those correlates. And that means that issues like segregation, which obviously correlates to employment opportunities and bad housing, which exposes residents to trauma and stress, links to bad health habits, no supermarkets, just grab some chips from the bodega, all of that finds itself at your door in health care. Blacks make up 6% of the population, Hispanic 16% of the population, 5.5% of doctors and under 4% of nurses. It's why I think this conversation matters.

The impact of violence on a community was another issue that we wanted to examine in the Black in America doc, the first in 2008, and so we focused on efforts to beat back the efforts of violence in his community, and I would like to roll a little bit of that piece for you.

>> We have folk who are dying from strokes and heart attacks or who are losing limbs because of diabetes, and it's all fitness and nutrition, and we feel like we have got to get our kids really focused on this issue, because they are heavy, and we need these kids to lose weight.

>> So eight months ago, Geoff Canada kicked off a huge experiment, The Wellness Challenge. 200 kids divided into teams, and the team that loses the most weight wins, and wins big, a trip to Disney World. For every child and three friends.

For Tanequa Williams, The Wellness Challenge is exactly the motivation she needs.

>> Are you competitive?

>> Yes.

>> Yes. Do you think you're going to win this?

>> Extremely, yes. Extremely. No, we are going to win this!

>> Tanequa has spent hours sweating through karate class, burning calories, and building confidence.

>> 1250 calories, that's one meal.

>> Nutrition classes have helped her see what she eats makes a difference.

>> What do you guys eat in the fast food restaurants? Let me and that first.

>> Get the grilled chicken, not the fried

>> The fried chicken is still a temptation, but she has the sense to say no.

>> You have a strong will power. Have you always had strong will power?

>> I don't think -- it was there, but I needed to find it. It didn't really develop until I came here.

>> That's good.

>> Tanequa's efforts pay off. She emerges the biggest loser on her team, dropping 25 pounds. It gives her the confidence to take on other challenges.

>> Is there a connection between being successful in weight loss, in karate, and having good reading skills?

>> I feel like I could do all of those things. I could bring up my reading. I just feel like -- it's not that I couldn't bring up my reading. I'm going to get there. And it's going to happen.

>> So, already, overweight has come into this world of why a large number of challenges -- and it's interesting. There was a study done in 2012 that found that two thirds of primary care doctors harbored biases against their African-American patients. You guys probably know this study, and in some cases without realizing it, they were spending less time with their black patients, involving them in fewer medical decisions. And studies like that don't surprise me at all, because doctors are people, and people live in a society where we have many messages about diverse populations, many of them not good, on TV certainly, that enforce stereotypes. For example, if you watch television news, you probably wouldn't know that the majority of poor people in the United States are white. Right? You wouldn't know. The face of the stereotypical welfare mom is not a black woman, actually, but you wouldn't actually know that if you watch television news. TV news has done that too audiences, and there are many reasons for that, that we could go into and it would be another very long speech, but I think part of the answer is that it's an inability to see outside of a consistent

narrative that people buy into. For example, in TV news, we have this thing called man on the street. And if you have ever been stopped by a news crew and they want to ask you a question, you were probably involved in M.O.S. "So, what did you think about Beyonce's formation?" M.O.S. also sometimes called AAA, any available -- I will not fill in the third A for you, I'm just saying how he internally called it. I never scientifically covered this, but certainly anecdotally, the youngest producer would go out to grab people on the street for MOS interviews, and what we would find, they would actually often grab ten white people. Their world was framed around those who looked exactly like them. Grabbing ten white people for MOS, it wasn't strange at all. If I had gone out and found 12 Asian people and said here's my MOS, people would be stunned. They would say, you can't run that; that doesn't show the diversity of New York City. But it happens all the time. The mindset, the perspective of the producer sort of constantly is reinforced, that their own perspective is the most important.

Our second documentary had a similar dilemma. We were telling the story of a principal named Steve Perry, and he's the founder of a school, Capital Prep Magnet School, and we were focusing on one of his seniors who was applying to college. She had a real struggle to get there, but she was a great student and they were excited about her chances. When it came time to write the script, usually a producer takes a first pass.

"Her mother is a crack addict and her father is an alcoholic." Stop reading write there, and those things are true, but they're not the description of an individual. It got

pretty unpleasant. The producer said to me, well, you are trying to cover up the girl's challenges. Obviously not. In the second paragraph we were going to get to it. I just don't think that individuals are a list of their parents' dysfunction. Now that you hear it, watch for it. Literally, we have this shorthand that we use, in growing up in the ghetto, Bob -- da, da, da, da -- I think that when he create a shorthand like that, her mom is a crack addict, we strip people of their humanity. The message that we send to people who are watching is that she is less than human, look, she is this big bowl of dysfunction of her life, the big implication being she is never going to get out of it. Trust me, if she were in fact a 12-year-old boy from Suburban New Jersey, our story would say something like this.

Little Johnny Smith is 12 years old. He loves baseball and wants to be Derek Jeter when he grows up. Every night, he tucks his mitt he bought with his paper route money under his pillow --

We are reinforcing what we know, and every shot is going to reinforce that same story. He would never be the sum of his parents' dysfunction or even their success, at least until the second paragraph when we give a little bit more context to him. We dehumanize poor people and people of color all the time in TV news, and once you start to notice it, you will see it all the time. You just can't help it.

It bleeds into society, and society has these exact feelings that we have created. Studies show that black teens who have experienced racism are more likely to develop stress and chronic issues later in life. The young lady in that piece

is teed up for a chronic issue already. She's likely to live in constant biological stress. If you are black and poor, you are more likely to skip exercise; to buy cheap unhealthy foods, all of those things, and end up as a person more likely to present in the emergency room. You have to analyze the total picture of what she is bringing to you.

Today as candidates discuss income equality in town halls, we know there is a fear among a middle class that is in decline and falling rapidly about falling into the ranks of the poor, while the top tiers, high income are doing better than ever. And poor people aren't just losing in income inequality, they are losing it in actual years of life. In 1980, a 60-year-old man in the top 10 percent of owners would live about six years longer than the bottom 10 percent. That was the figure that you saw in the doc, in 1980 it would have been six years. Today, that extra time has now grown into 14 years extra time. Because we're not solving the income inequality problem in any way, math will tell you that there is going to be a wider gap as that gulf between rich and poor grows.

You know, at the same time, TV news is telling the story less often. News shows are literally dominated by politics and kind of the racehorse, who won the debate, who won the caucuses, but not digging into any of the data around these kind of really compelling and interesting statistics that, frankly, I think are relevant to all of our lives, wherever we live on that big spreadsheet. Exactly at this moment, we should be talking about this more and not less.

And so I think it's a challenging time as a reporter, getting a focus on inequality is a tough sell. I remember when I pitched doing a doc called Poverty in America, I was told nobody wants to see that. It's a challenging time, I think. In the wake of Hurricane Katrina, I covered a family, white, in poverty in Mississippi, who lost everything in that storm. Pearlington was not exactly an economic center to begin with, so it rarely got any coverage at all, and I met woman named Denise Martin, and like me she had four kids, and her four kids were roughly the same age as my four kids. When we met, she was parked in a FEMA trailer left next to her home, which was basically destroyed by water. Christian missionaries would come in and erect tent cities and help them rebuild an abandoned schoolhouse, and Pearlington was turned into a big center, a clearinghouse for supplies. Things were making their way there, but mostly because if you happened to get my modicum at all of news coverage, people would hear about them and say how do we send them stuff. If you didn't get coverage, you would probably just be ignored.

So Denise had a youngest daughter, and her daughter was years old. And at one point she took me by the hand to show me where she was sleeping in this really tiny FEMA trailer that was sleeping a family of five. And I said, so, you know, tell me, where do you sleep? And she sort of points above the kitchen sink, and I'm thinking that's not possible because -- I think you misunderstood me, where do you sleep? And she points again. She's pointing to the cupboard. She sleeps in the cupboard above the kitchen sink, and the only real resource on the ground

for this family is a nurse who happens to volunteer her time, and because Pearlington was placed on the map because we did a story on it, comes in with a truckload of supplies and goods to the degree that she can help. The story in Pearlington was one of an anecdotal account of formaldehyde poisoning from the trailers. We tested Denise's trailer, and Lisa is literally sleeping on a particle board shelf which contains the formaldehyde. It's exactly where she lays her head every night; this cupboard is 80% higher in formaldehyde than federal regulations would call for. Here she says, laying on a shelf, eight years old, her poverty is sucking her under at an age where she doesn't understand it yet. This is the health impact that comes from every level, from being poor. These stories are, ultimately, I think stories of justice, what's fair, but often there's little appetite to care about a bunch of poor white people in Mississippi. There's little interest in telling stories about race and stress, even as I'm hearing stories from young girlfriends of mine, black women in their 20s and 30s who I am finding almost everyone I know in that age group who is black is on anxiety medication, anecdotally, so that is telling you something about the impact of society. We don't want to tell you those stories, well, the gap grows wider, and we are only creating a class of people whose social challenges are reflected and reflected in how they present in emergency rooms and stats on early death and data about low birth weight babies. I'm a reporter, so my job is to find and help highlight these stories and what's coming down the pike. If we don't think about social fixes to help people live longer and better. Being

a journalist is a dream job, even if you are slogging through a hurricane or a natural disaster, up at a ridiculous early hour for a morning show -- talking to doctors, people are like, yeah, yeah, yeah, you know nothing about tough hours -- with all of that, I think truly being a journalist may be a little bit like being in health care. There are not a lot of gigs that you can go do, but you are in one that feels like it has a mission, something you need to accomplish. Maybe that sounds a little bit arrogant as a journalist, but it's true. We need to tell these stories, and you need to push for these stories, because that's true diversity, true representation, connecting the dots around why we are where we are today and our opportunity and inability to change some of these data points.

Every story I have reported on, no matter how difficult, if you stay long enough, right, if you stay with that story long enough, at some point somebody comes in to be helpful, and it's almost never a rich celebrity, and it's almost never some big governmental agency. It almost always is some individual who says, well, I heard about this, and I thought maybe I could help. And I believe we can leverage that to create change, to be part of something bigger and more important than ourselves. I don't believe at all in sugar coating problems, but I do think data helps us figure out the best way that we can make change in the world, and we can look at some of these data points and say they are not okay, and they signal what we are going to be facing very soon, and we can start raising the alarm about some of these issues and underscore that they're critical to all of us. Thank you very much. Thank you. Thank you.

(Applause.)

Thank you.

>> Our panel will start. Yes, our panel is going to start in just about 30 minutes, so I think we have a little bit of time for questions. So anybody who wants to go -- you know I can't call you on and run a mic all the way up there. You have to come down to this microphone right here. If you have you a question, come all the way down those stairs right here and ask the questions at this mic.

>> And we'll have questions from Alejandra and -- as well.

>> I think we're going to be reading questions as well from the other side. We want to make sure that everyone who is watching us live right now from the other seven locations is ready to have some questions.

>> It's so weird to feel like someone that I don't see is going to be asking me questions. It makes me anxious.

>> Yeah. Go ahead.

>> This question comes from Twitter, from Kristin Thompson. How can health care providers help tell the bigger picture of social determinants of health.

>> So a couple of things that I think are really helpful. I think the media likes things teed up. It's much more likely if you have access to things like patients and data that you are going to get your story told. So if someone comes it a reporter and pitches them a really interesting story, but has no patient population or a person in the field that you might want to talk about, and I have found that even in the pitches that I do a newsroom, I don't just say here's a great idea; I say it is

about this woman, I think we should shoot this long here, and a second shot over here. It's really about the detail. Saying you have a great story about health care disparity is not going to get any traction. Number two, relationships. People need to have relationships. I would think about hosting conversations with journalists. You just need to know people. The way you get a story on is you know somebody. A lot of what I found was helpful as we were reporting our documentaries is you just kept running into different people who had stories to tell. We would take notes on, we have got to do this in our next round of stories. So I would think very seriously about how you can improve the relationship that you're having with the local press, with the national press. Do they feel like they can call you just on background to pick your brain on something you want to talk about. You have got to be that person or that team for them.

>> Hi, thank you so much for coming. My name is Derek. I'm a first-year medical student. I have a question for you and also for the university leaders that are in the room today.

Scholars have suggested that race is a poor proxy for true determinants of health like genetic makeup, weight, muscle mass, family history or nutrition. But in our lectures and in our medical center every day, we practice versions of race-based medicine. Is that something that we here at UCSF or the medical community at large should be doing, or having a larger discussion around?

>> It's an interesting question, and it's a little bit out of my area, because of course I think that's a question for your

professors. But certainly I don't think in terms of storytelling -- we absolutely look at the correlates with race and absolutely look at correlates with class, and sometimes people use race as a proxy for class, which I actually don't think is a fair thing to do. As it pertains to your professors, you would have to ask them, and I'm more than happy to turn the mic over for anyone who wants to answer that for you. But I actually think it's really interesting, because of this country's history with race, you can sort of trace things back why things are where they are. One of the problems that I have in our story telling as a whole, we sort of act as if slavery never happened, to the point that people literally roll their eyes. Even in this room, I'm sure people are like, oh, jeez, she's going to go to the slavery thing. But especially with stories around finance, everyone acts like this just happened; black people have this kind of wealth and white -- there's a history that led us to this point. Clearly, if you were never able to earn money on something, at some point your great-great-greats don't have an income, and so -- et cetera, et cetera. I think the real challenge from a journalistic standpoint is how do you connect those dots so that these things have some kind of context so that you can understand that Ms. Abdullah doesn't live in this vacuum, that this is the sum total of her life. Some of that is because she's black, living in this particular neighborhood with these particular services, et cetera, et cetera. So I actually would disagree with disconnecting the two. I think you have to look at race, you

have to look at class, and you have to look at some of the other things as well.

Thank you.

>> Thank you.

>> We have a question from the core group that organized the event. How is racism --

>> Say, I didn't hear? You should --

>> How are issues of environmental racism, such as those in Flint, Michigan, connected to the larger move to of Black Lives Matter.

>> Certainly I'm the last person to be able to speak about Black Lives Matter. Somebody from Black Lives Matter should come up and talk about. But I'll tell you my perspective as a journalist how Flint Michigan connected to an overall call for justice. It's sort of a 101 on how people who don't have a voice and don't have political clout are being screwed by a system. It's the clearest case. The sad thing is we have a bunch of other Flint, Michigans that we know about. The thing that's crazy to see, when I first heard the story, and I don't do daily news anymore, when you see people holding up these bottles of brown water, you wonder how did it take a year for the story to come out? It's not like, who knows; literally, the water is brown. There is no sane person who would take a chug of that water and be fine with it. But there's this expectation because they're poor and there's nothing else, they just will. I think the same thing happens with environmental pollutants in the air. It happens all the time. They're poor, they will suck it up, they don't vote, we don't need to represent them. I

think part of is reflected in, Poverty in America, who wants to see that? I think the true of poverty in America is -- this is what the election is based on, this anger that you're feeling is absolutely part of this feel, and I think the New York election of mayor de Blasio when you look at the results and see who supported de Blasio and his call for equality, it wasn't poor people; it was the middle class, afraid of falling into those ranks. That's a lot of the fear and anger that you're seeing. Flint is ground zero of people with no voice who are expected to pay for brown water, and it's unfair. I think the same thing could be said about what's happening in Ferguson, I think in Baltimore. That's another great example of we'll capture pictures of people rioting, but we won't necessarily, again, connect the dots. It just looks like there's a bunch of -- oh, CBS is on fire. But what is happening here? What has been the development in these blocks? What is the joblessness rate in these blocks? Without context, you really just continue to fan the flames of a lack of understanding in people in poverty.

>> Hi. My name is Liz. I'm based in hospital medicine. So I thought it was really great how you emphasized the role of the media in bringing to light certain conversations and that kind of thing. The 2016 election has actually been quite troubling from the perspective of bringing to light some of the bigotry and racism that's been going on in the world. I think it's been sort of there underneath, but certain candidates --

>> You think?

>> Certain candidates have really brought it to the fore which has shaped the conversations on what's appropriate and what's not. How is that changing your perspective on what's been in the conversations and how people are talking about these issues of inequality.

>> I was saying in our meeting earlier, I'm not surprised. I think shifting demographics, when everyone said 2032 is going to -- it's now, right? We have shifting demographics, certainly here in California is a good example of beating that marker, year-wise, where literally the face of the nation is changing, and that it's scaring some people. And I think it's that combined with the middle class that really has disappeared, that has combined with a structure where people are, you know, hourly wage earners with no benefits. Right? You have all of these sorts of things happening simultaneously. I was telling folks at our meeting earlier when I got off the plane in Seattle, there was a man who was yelling into the phone screaming into his phone and explaining to, you know, the person on the other end, I believe that Donald Trump is going to fix these things. It doesn't really matter the content of his conversation, but the fear and anger as he screamed into his cell phone, clearly he is panicking, and so that I think that panic is driving a lot of this conversation. It's interesting. It's the first time, you know, when you start reading stories about like, well, maybe the internment of the Japanese, not so bad -- right? That's the tone of some of these stories. "When you look back, was it all that bad?" That's bizarre. I think we are lacking people to push back hard, because the media itself has changed. You get

very big ratings boost when you have somebody that comes on your air and is really willing to say whatever, true when you are doing the real housewives of whatever or a presidential candidate; if you can go full on crazy, that's good TV. So no one is going to make that stop. I think we have come to this really interesting time where all of these things are happening at once. I just find it fascinating. I guess I always assumed there was a 20% that -- they did a poll the other day where 20% of the people who support Donald Trump didn't necessarily support slavery being ended. It came out yesterday. Google Donald Trump poll, slavery. I'm paraphrasing, but -- I don't know, but I'm not sure I'm completely shocked by that in America today.

>> I have got a question from a nursing student, Andrea Santos, who asked, as a woman of color, would you share how you have overcome stereotype threat.

>> I think I have tried to ignore stereotype threat. First of all, I have found when you are in an environment and you are sort of not the face of a person and you are constantly fighting, two things happen. One, you become incredibly unhappy and crabby and not fun to be with, and two, it's not really helpful to your work. And I have tried really hard to ignore a lot of the data. Because the data points would tell a black female journalist, you should just pack up and go. The numbers have declined. Latino reporters have gained 1 percent, but their numbers were so low it's a tiny increase. It's depressing if you were to look at the stats, and if I were to really examine the stats, I would want to find a window somewhere and

fling myself out. I have tried really hard in my career to try not to do that. I try really hard not to get dragged personally into debates about race or debates about politics. I try to really look at them as an interesting item to study and an interesting thing to try to pull data out of. Because, you know, it's very wearing. It's exhausting. It's exhausting, and not productive. So at the end of the day you are worn out, but it's sort of like cleaning out our e-mail. I cleaned out 7,000 messages -- it was completely unproductive. You actually did nothing today if you spent the last ten hours doing that. You felt like you accomplished something, you are certainly worn out, you need a giant glass of wine, but you didn't accomplish anything. It's important for anybody, women of color, somebody -- don't get dragged into these conversations because it will waste your time.

I remember here in San Francisco, my first job, walking down the street, my first on air job, walking into the hall, and there was a bunch of people chatting and laughing, and I kind of waved, and they were -- and as I walked by, I realized they were talking about the affirmative action hire, and that was me. Like I was the affirmative action hire who they had just -- and again, you have to bite your tongue so that you don't go up and say I went to Harvard University, and I have worked as an NBC producer, and I have -- because then you really lose. So you smile and you say, listen, I don't care about them anyway. But that's your life. And if you get sucked into those conversations, you lose more, so I think you just have to constantly plow through you and not really worry about data

points and really not worry about how those things are going to impact, and fill those things that are going to make you successful. Finding a great mentor, doing your work well, getting good feedback. People are often reluctant to tell minorities the things that they are doing badly. You want to push people to give you good feedback, to make sure that you are being judged just as much as everybody else. That to me is actually useful feedback. Everything else you're just going to have to ignore.

>> Hi. Thank you so much for coming. My name is Kathy. I'm a second year medical student.

>> Doctors are getting younger.

>> One of the things that stuck to me is the things your mother said.

>> I can't tell you some of the other things that she said that are completely relevant but completely full of F bombs. Go ahead.

>> I think I used to feel that way, and I think a lot of the movements that we had on campus and across the nation in the past two years have been borne out of this hopelessness feeling, that maybe America isn't really better than this. And I was wondering, based on your documentaries and all that you have done, all that you have seen, do you agree with your mother?

>> You know, it's interesting, I have to tell you, I completely agree with my mother. Go grab somebody who is 60 and ask them to tell you what their day was like when they were your age, and I guarantee you, you will be stunned, and you will say, oh my gosh, what I am dealing with is nothing to compare with.

You know, when we were talking earlier, I was telling people about this sort of device I use when I'm involved in conversations that I've developed as a reporter that I think are really helpful. So when someone has this conversation with you that is either they come at you with something or it's -- I mean, often conversations about race are so loaded, and if you are black in that conversation or even if you are white in that conversation, it's very challenging to mire through it. And so what I used to say to people is, that is so interesting; tell me why you feel that way. And it kind of created this barrier where you could allow them to explain themselves and not feel like you had to jump into that conversation. So I really found that, yeah, I think America is getting much better. There is no question, clearly, absolutely. And when I would complain about my days of interviewing people, Andrew Young would say to me, I'm sorry, did someone turn a hose on you? I didn't listen to that part of the story. Like, all right, listen little girl, shut it. It doesn't mean that your feeling of stress and hopeless is wrong. That's your perspective. People used to March at the end of our driveway when I was growing up because they didn't want black families to move into town. My mother had a -- she would beep, beep, beep to get people to move out of the driveway so she wouldn't run them over. It's progress, it's growth, it's just not fast; it's not going to be fast. I don't think people in the middle of it ever feel like, ooh, we had a big victory. It's kind of like raising children, right? By the time they are at, what is it, number 27, okay, I think we did an okay job. But while you're in it, it isn't feeling particularly

good, and you don't feel particularly good at it. But looking back, you kind of think, oh, we overcame some things. Some of it worked, some of it didn't. And I think that's what it's going to be like. It's not going to be like, woo, today we won and now we're done.

>> Thank you.

>> Hi. I am so grateful for your optimism. It's really, really refreshing. So my question is you mentioned humanity in your talk. And I'm wondering what you see -- clearly the stories that you tell and relay are a way to help us all connect with the greater humanity, but it seems to me that the inequities that you describe rely upon all of us recognizing the common humanity within all of us. And so I just wonder if you have any other thoughts about what can help accelerate that.

>> You know, I really think ultimately, and I am nauseatingly optimistic, I think it has to be in conversation. I wish this guy who was yelling, I would have loved to sat down and have said, I'm so curious; what are you so mad about? I would love to understand -- not the first three things he said, but the fifth thing. Because I'm sure that fifth thing is something like, I'm about to lose my house, right, and he's panicked. He's clearly panicked, but we don't really allow people to have those conversations, right, because the first three parts of that conversation are so nasty that usually someone then says, well, forget you, and they walk away. So if you can figure out how to really bring people into conversations -- plus, for politicians, it doesn't behoove them to have those conversations. It behooves them for everyone to

be mad and driven by anger. It's not, here's what I'm concerned about, and here are the roots of the problem and how to solve it. You see times where the country comes together, and those are the times that make me feel optimistic. Even the people who say freeing the slaves wasn't the greatest idea, I think if you chatted with them, there would be something really revelatory about why they think that way. It's really interesting. I think having conversations and obviously what you are doing today is opening up a door, and you should do it consistently, and you should invite people in and create conversations where people can feel really safe.

A lot of white people say, we talk about white privilege, why am I being blamed for crap I didn't have anything to do with. It's a version of my family didn't own slaves, or my grandpa came from Italy with a dollar in his pocket. You have to have a discussion, and there are a lot of data points that can inform that discussion, but it can't just be, well, here's what my side of the debate is. You're never going to get anywhere. When I did our first Black in America, the head, the guy who was the head of CNN worldwide brought me to the TCA, which is this big cable conference, and I was asked, so what do you think, Soledad, is the big take away from this big six part series. And I said that I think the thing I found most interesting, regardless of socioeconomic status, anybody who is a parent of a black 13-year-old boy would say almost the exact same thing, verbatim. When my son turned 13, I sat him down and told him, if you are stopped by the police -- I interviewed a woman being evicted from her home, a billionaire in the

Hollywood hills, a famous actor; I interviewed a middle class family -- they all said this almost verbatim. So I said this to the reporter who asked me. And then at the end, my boss said to me, that's not just true. I just spent 18 months reporting this stuff. He said, that's just not true. White people feel the same way; white people want their kids to respect the police. And because I wanted to keep my job, I said, okay, if you say so. But clearly, we are having a conversation like this to the point where he said, I wasn't allowed to point that out again. And I think it's just missed conversations. I don't think he's -- he's not an evil guy. He's the person who said we should do Black in America, and here's a bunch of money to go do it. He's a really supportive person on this. He just has his perspective shaped by what he learned, how he grew up, and the experiences that he has that clearly -- and probably over time, we never talked about white privilege. If I had written the words white privilege in that doc, oh, my god, we would never have gotten that on TV. The fact that we are even discussing it is incredible to me. It's amazing that it's actually said out loud. I think we are making great progress, and you shouldn't be hopeless. Hopeless doesn't serve anything, honestly. If it were with worth it to be hopeless, I would say go be hopeless. It's not a useful emotion.

>> Thank you.

(Applause.)

>> This is wonderful. I'm Dr. Rene Navarro, vice chancellor of Diversity and Outreach. I would ask our panelists to come forward. We have with us Dr. Suzzane Barakat, Dr. Phuoc

Le, Dr. Rena Pasick, Dr. Howard Pinderhughes. We have two students, Sidra Bonner, a medical student in her third area, and Andrea Quinones-Rivera, a second-year medical student. So as they get their mics ready. I want to remind you, in this portion of the event, we would like to have you participate. You can send your questions in on Twitter, #ucsfteachin @ucsfodo.

We'll turn it over to the panel. We understand some people have to leave. Do it as quietly as possible because we want to continue on with the program.

>> So our panelists each have a flier -- I would like to ask them why they care about this issue, and I would love for you to tell us our personal back story. I think as a lot of the questions have indicated, sometimes this is challenging, frustrating, and not necessarily hopeful work. Why don't you begin with me. Tell everybody a little bit about your background and why do you want to be involved in the conversation about the intersection of health and justice.

>> I don't know about that.

>> Good reason.

>> I grew up in Rockford, in Baltimore. And who knows about Rockford?

>> I spent a lot of time there.

>> Yeah. Roxbury really framed my understanding of all of these issues. It was a poor black neighborhood. I was in a middle class family, and I grew up, and I told my students this, I can remember at six years old, looking out across the door, walking across the street -- the mailbox across the street from

us, there's a plastic bag underneath that mailbox. We didn't know what was in it. We come to find out, it was our six-year-old neighbor, and that was the first time I can remember being impacted by violence in our neighborhood, and that's how I came to do the work I do now on violence prevention. And then ending up here at UCSF and starting to look at the issues of health inequality, having seen it up close in Roxbury. I lived in the period where it transitioned from a white neighborhood to a black neighborhood to a burned out neighborhood because of the riots in the '60s to the neighborhood with the highest rate of homicide in the country. So I started to understand the ways in which some of the social determinants got created by the structural dynamics in our society and what I call structural violence, which I think we need to start naming structural violence. There's interpersonal violence, and then there's structural violence, and that's how I think we should take a look at that. I'll say a little bit more about that.

>> We'll dig into structural violence by definition in just a moment.

>> I think I started getting interested in this from two years. One, my own personal experience as a Latina immigrant to the US, and experiencing bias. But also just my interest in health. As soon as I started getting interested in working with public health and underserviced communities, the most striking example came here with me, working in the mission, working with HIV positive low welcome Latinos. And seeing how structural racism, really impacting their lives, and how much a difference

in their health addressing those issues could make, in some of the patients that I saw much more than the physicians could. I think that's how I started getting interested, but also my own experience as well.

>> I'm a second year family resident here. I am a first generation American, born and raised in North Carolina, so in the south. Anytime I would have to fill out those forms, what's your race, what's your identity, my box was always other because I'm not exactly Caucasian, but there is no box for Arab or middle eastern where my parents are from, and I always took an interest in coming to medicine, a connection with the human element, where in medicine we have the privilege and ability to really tap into people's personal lives. And working at the General with our underserved patient population, and also having worked abroad with Syrian refugees, being able to look at an individual and say, you matter, not because of your color, not because of your identity, not because of your religion or socioeconomic status, but because you are a human. And that's what brought me to this intersection and General. But a year ago, my baby brother, who was a second year dental student at U.N.C., his bride of six weeks who had just gotten into U.N.C. dental school and her baby sister were murdered in their home, by their neighbor, execution style, eating dinner having just gotten back from the school because of their faith. And so I didn't ask to be here. I wish I didn't have to be here. But is it my optimism that I'm still here to try and continue these conversations? Maybe. But at the same time, the realist in me, in response to the question earlier, is America becoming better,

while we are progressing in some ways, we are regressing others, and history is repeating itself, and your voice matters. And here I am as a resident, as an intern when this all happened, and I was kind of thrust into it, and I have no choice but to be a voice, and that's why I am here.

(Applause.)

>> Good afternoon. My name is Sidra Bonner. I'm a current third year medical student. In terms of why I care about -- the first way that I could answer the question is about stress as a core tenant of what we do in health care. Every health care provider -- so for me, when I think about stresses in health care, I don't think you can provide ethical health care if you do not care about stresses.

The other component to think about the ethical nature of medicine and its relationship to me is that in health care we have the opportunity to provide the basic foundation for people to take advantage of the resources and opportunities in society. If you are not healthy, you can do nothing. You cannot go to school. You cannot work. You cannot -- you know, you can do nothing. And I think when we think about health and stresses, it's such a core conversation that has to happen if we truly care about equality and fairness in this country. And I think personally why I care about this is I'm a black woman. I was raised by two black parents. When I think about my classmates, I'm the only female in the class with two African-American parents, and it's 2016, and I think this is a very serious conversation that has to happen. I think these questions that

came from some of the other medical students here are questions that I hope we get into more, because I think as a young professional of color in medicine it is a very important topic that we are all faced with.

>> Hi. I'm Phuoc Le, and I just wanted to say thank you for putting on this event. I'm really honored to be here.

Here's my narrative. I think some people in the room don't know this about me. Before I was adopted, I was a refugee. From Vietnam, escaping a dismal future. Before I became a pediatrician, I went to school with the bloods and the crips and the Oriental Boys in south Sacramento. One of them, I don't know who, gunned down my cousin. Before I joined the 1%, I was on food stamps, section eight housing. My mom worked for $3 an hour in a Vietnamese restaurant. And before I became an advocate for health justice, I was taught at home to fear black people, forbidden to befriend black classmates, told to lock the car every time a black person comes near. So there's my narrative. And I'm fortunate because I have the power to express that narrative to you all. And so you hear a lot, and you already have heard a lot about narrative, and you will hear a lot about the consequences of unconscious bias today. If UCSF wants to be at the forefront of that movement, then we need to have faculty and staff and students who represent the narrative of the people, the patients that we serve.

(Applause.)

It's because of my upbringing that I can have empathy for the poor, struggling class, that I can have empathy for the refugee who just came and has conversion disorder, that I can

have empathy for the single mother who works two jobs and has the burden of being called noncompliant because her asthmatic child ends up missing one or two doses of albuterol and ends up in the hospital. Oftentimes those narratives are not told, but we as health care providers are stewards of them and they are sometimes relegated to the sidelines, sometimes boiled down to a word as noncompliant.

So a couple of years ago I cofounded a health equity fellowship called the Heal Initiative, and we have 20 fellows spread out, working in poor communities like Navajo Nation and rural Liberia. And every day, we communicate to them that they need to communicate the narrative of their patients, and it's important to communicating the signs and symptoms of that patients. And I look forward to the conversation today.

(Applause.)

>> I can't believe I'm on this panel. My name is Rena Pasick. I'm a cancer disparity researcher. There are many fabulous health disparity researchers at this university, so I'm just very honored to carry that flag, and I'll try to do it and live up to all that they have done.

I'm here because at the age of ten, my mother was diagnosed with breast cancer, and by the time I was 20, I had lost both my parents to cancer. So I am very familiar with all of the ravages of that disease, and it's propelled me into a career in public health, where I learned that there are some communities where children are orphaned in greater numbers due to cancer. And I found that intolerable, and so I have dedicated my career to trying to reduce cancer disparities.

As a young professional in the field, as a young researcher, I would go to my professional meetings and look around, and everyone looked like me. And yet, the communities that bear this disproportionate burden of cancer do not look like me. They are brown, they are black, they are yellow. And I said, what's wrong with this picture? Yes, there is a place in the world of disparities research for people like me, but those who are in the communities and in the clinics trying to address these problems need to be from the communities affected by this, and --

(Applause.)

-- so almost 20 years ago now, I initiated a program to increase diversity in the field of cancer disparities research to encourage underrepresented masters level students in public health to go on for the doctorates and to become leaders in research. And there are some in this room today who are doctoral students. There are some alumni from my program who are faculty in this university. 100 of our alumni have graduated with their doctoral degrees. There is another 100 who are current doctoral students. So I'm here to try to diversify my field because I think that is one of the -- that's something I can do, that I also want to change disparities, and I have spent the last many years, I'm Jewish, I'm white, but I spend more time in the black church than I do in synagogue. And I feel very grateful that I have been welcomed in and embraced in that community. It gives me hope that I can do something there too.

(Applause.)

>> So I think we can tell this is going to be a very emotionally deep conversation.

Are you hopeful? In this conversation we had about are you hopeful or not hopeful? Are you particularly hopeful about where we stand? You. That's what you get when you sit next to me. You get to go first.

>> I'm hopeful, very hopeful. I work with young people. And I look on all y'all. You are here, you are committed, you are internalizing and already understand some of these things, learning these issues, and that you're going to practice medicine and be different than we have had in the past. And I work with young people who have been exposed to violence, and so I have a lot of people who look at me and say, this must be really depressing. And true, I have been through way too many funerals, but it's young people who give me hope. It's the adults that depress me, and, you know, the current elections -- we won't go there.

But, truly, I think as I look at this panel, and I hear you all talk and watch both of your perspectives, in terms of what you're doing and how you're doing it, I feel very, very hopeful in terms of the work that we need to do.

The other thing, and I want to say this while we're here, I'm hopeful because of our current administration in this university.

(Applause.)

Because our administration has a commitment to this issue of Injustice and Health, and I think we have a tremendous opportunity to make a difference in our surrounding communities.

And I'm hopeful that, together, we'll be able to kind of forge that as a set of strategies that we can move forward and we can talk a little bit about that in the future.

>> Yeah. I would love everybody to weigh in. What should be different? You said you're hopeful because you think should be taught different ways and different strategies. So lay out for me, and I think everybody can weigh in on advice, what should be, if it's not already in the curriculum, a strategy, what should be different? What do students have to learn?

I assume the students have some ideas on that too. If this is going to be a quiet panel, I'll have to start calling on people.

>> I can share from personal experience. In the aftermath of February, I became kind of pretty outspoken against Islamophobia and its lethal impacts, and I brought those conversations here home to UCSF. I was on a panel for grand rounds called challenging Islamophobia, and in it I was sharing experiences that I have had on the wards in hospitals here in San Francisco. And in it, I'm telling my colleagues how I found it helpful to stand up to bigotry, and the basic answer is to not be silent when you see it. And I thought it went very well.

And just a few weeks ago, I was senior on the wards. And you all know how rounding is, and I have ten people on my team, and I am senior on the wards, leading the rounds. The last patient we're rounding on me, looks at me, and goes like this, and says "San Bernadino." And the entire group is silent. Not my attending, not my coresidents, not my medical students, not my pharmacy students, not my social worker. Nobody said a word.

I was baffled. I just stood there humiliated, and it was just -- there were no words. I left. We continued with rounds, but I was not happy, especially in life everything that I have gone through, and that I was within my program where I have been a very, very local advocate on how to handle these situations, so it wasn't new to us. A few days later, rounding on the same patient, and to put it in context, she had recently been diagnosed with lung cancer. Recognizing that there is a line to be drawn, in front of ten people, she says, your people are killing ten people in Los Angeles. And I stand there. And in that moment, I'm not really phased anymore. I lost three family members who -- there's not more to say. I have given the ultimate sacrifice in that people within my family are dead because of this. And I just stood there, and I was like, all right, I'm going to turn this into a teaching moment, because clearly no one knows what to do or how to do this. And I look around, and I'm just waiting for someone to respond. Silence.

I sit down next to her bed, on her bed, and I say, Ms. So and so, tell me what you mean by that, so kind of what you were saying, the exact same strategy is what I have come to. In the past, as a medical student, you are at the bottom of the totem pole, and you have to smile and move on. It was no different, a medical student in eastern North Carolina, being yelled at and attacked by patients because of my faith. And I smiled. And I thought, maybe because I'm the only Muslim they have ever met, I can change their opinion, so I carried this massive responsibility on my shoulders to change what they see on the news.

But after February happened, I was like, that's it. I smiled enough. And this is where it got me. Now I need my voice to be heard. So I sat down next to this patient on her bed, and I made eye contact with her, and I said, Ms. So and so, it em what you mean by that. Help me understand, have I done anything but given you compassionate respectful care? Have I done anything to hurt your feelings or disrespect you? And I'm making eye contact with her and bringing it to a very human level. And she looks at me, and then she doesn't want to answer. She sees she knows what she did was wrong. And in front of the entire team, she apologizes profusely and says I'm so sorry for what I said. That was wrong of me to do. There is no excuse. I'm Mexican American. I get the same treatment. I should know better.

And in that in moment, and our program had a conversation about this afterwards, and I share this because this is relevant to us, right? This is not just happening in the news; this isn't happening overseas. This is happening here in our institutions, where we have these conversations where we are advocates of social justice and this is who we are, and we all believe internally that this bigotry is acceptable. But when we actually see it, we are silent because it's uncomfortable. So what we need to do is train ourselves. If and when I'm faced with this situation, I need to be ready to even just say, hey, that's not appropriate, or hey, like, someone needs to stand up for me. My colleagues need to stand up for me because that's not okay.

>> Are you hopeful? Are you optimistic?

>> On any given day that changes dramatically. I think if I'm going to be totally honest here. I'm not one to sugar coat. I'm sorry if you want the PC answer. I don't have one for you. Every decision to make a physical appearance, a public appearance, to do an interview, to be on this panel, you have you no idea how much it takes out of me to repeat the fact that my family members have been murdered. I have PTSD. I am triggered day in and day out, working with patients who deal with a lot of trauma and suffering, but I am hopeful when I feel like these words can have an impact on those around me to make a difference for someone else. I am not hopeful in that I will never hug my brother again. I will never be an aunt to their children. I will never have holidays with them, ever again. Okay? These are nevers that are as real as they get, for me and my family and my community, and it makes me very angry because we continue to have people like Trump say the crap that he does, right? And say this Muslims are deserving of bullets and I need to be banned from this country.

So I could just retract and mourn and be on leave and never show my face to the world again, and I think I would be totally justified to do that. But when I come back and I see people like Trump on the national platform or when I come to the hospital and my patient is basically calling me a terrorist, the exact rhetoric that killed my family, she's attacking me of being a terrorist, no one else is speaking up on my behalf, and I'm tired of being my own advocate, to be honest, and that's why I'm here, too, is to teach us all to be advocates for each other.

(Applause.)

>> First of all, I want to thank you for sharing, both, your pain. But I also want to say that I want to ask you what we can do to support you on an ongoing basis, and that's the question that everybody here needs to ask. Not just how are we down for the struggle, but how are we allies in the moment when people need us? And I'm sorry you went through that.

>> Thank you.

>> All of it.

>> I have two answers to that question. One is, if I may, the burden shouldn't be on me to teach people how to be an ally.

>> That's right. I'm not talking about you, absolutely.

>> And secondly is to realize that we all come from -- and I mean all of us in this room have some privilege that puts us here, right? We all -- you know, I'll share this example of my attending. He's white, Jewish, privileged professor in my program, amazing, wonderful, warm, teddy bear like professor, but he's still coming at this experience from his own lens, where when I spoke with him about this specific experience and I had confronted him after the first encounter and said, I needed you to speak up because you are my leader here, and you need to say that that was inappropriate, and his response was "if I were to do it again, I wouldn't say anything because she's in a sensitive place." And I said, well, you haven't experienced what I have experienced. I have gone through the years of putting on a smile and dealing with the discrimination, the microaggressions, the macroaggressions, and here I have family

members murdered because of this, and you tell me again that you're going to stay silent?

And so we have to ask ourselves, we all come from some kind of lens of privilege, whether we are physicians because of our upbringing, our race, our religion -- these are our realities and we are not immune to them. I sat at a round table with Barrack Obama two weeks ago in Baltimore during his first visit to an American Muslim mosque, and after we went around and shared our stories, he shared his sentiments, part of which I didn't agree with, but one of the things that he said is Muslims need to speak up a little bit more and kind of carry the burden. Like, you know, it's a burden that we all carry, just like I have to carry the burden of presenting my birth certificate and no other president before me had to do that, and Muslims need to do the same. I'm sorry, but I respectfully disagree. So how to be an ally, I would ask you question, how you think you can be an ally, and if you ask yourself that question, if I were to be faced with a situation on the ward, at home, walking across the street, and I see something, it's very easy to just walk past it, very easy because you are not doing anything. But your silence is acceptance of the bigotry.

>> As a medical student, talk to me a little bit about what needs to change and what's being taught.

>> So I want to jump off of some of the things that were just said, because when I think of silence, because I'm at the end of my third year medical school experience, and as third years, you are typically the person on your team who is the most junior. And I think silence in medicine and silence in health

care has a lot to do with hierarchy. I don't think you can talk about them separately, because as a third year medical student I have seen and heard things done to me personally and to patients that I just don't feel as though I can say anything because you are the most junior on your team, and so I think if we are going to talk about changing this culture of silence, we need to talk about the culture of the hierarchy in health care, whether that's between your senior attending and your third year medical student or you're talking about how -- the way that doctors speak with nurses or other members of the health care team. That has got to change if we are going to actually hold each other accountable. We cannot live in a system and work in a system that is based off of power differentials.

I think in terms of something that is an actionable thing, the LCME, which has been an accreditation body for medical schools across the country, they have a section that says if you are a medical school, you have to have some sort of curriculum on social and behavioral sciences and bias in medicine, but the way that that is enforced, no one ever talks to me about how we are approaching these things at Stanford versus in the south. That is something that schools have to be held accountable for the way that they are training the next generations. That is something that can be easily achieved, holding all schools accountable about specific criteria for what medical students have to be taught about bias, inclusion, social determinants of health.

I think in terms of other actionable things at UCSF, I think thinking about research and community projects, I think

there has to be discussion around financing students to do more community work versus just basic science research. I think as medical students here, it is very difficult to find financial resources, not the people -- because we have amazing faculty here who are doing amazing work, but it is difficult to find the financial resources to do that, especially for students coming from underserved and underrepresented backgrounds. So those are two things that I think are achievable and can be done to improve the situation.

>> Can I have you jump off of the items, the first one and then the second thing you talked about, changing hierarchy scares the living crap out of people. I think that's fair to say. I think changing hierarchy is kind of a big deal, number one.

And number two, how do you teach about bias in medicine? I think they are kind of correlated. So walk me through, is that doable, if it's possible? How do you envision that actually happening?

>> I think it's doable. And while we're clearly not there yet, let me give you an example. The wards in pediatrics, we have what we call family and patient centered rounding, which means that we don't just sit in a conference room and talk about the patient without the patient, without the family of the patient. We are inside the room so that the narrative of the patient comes through. We have an interprofessional team, so the nurses are there, the case managers, the social workers, and everybody is pretty much on that first-name basis, and everybody clearly still has a role to play.

But we welcome all input, including, and especially input from the patient and his or her family. So I think that is one small step. But I think it only happens in pediatrics. We tried it in a randomized trial in internal medicine, we tried it.

>> Why did it fail?

>> And patients loved it.

>> Oh.

>> But residents did not like it.

>> Why?

>> It took too much time because you would have to stand there and listen to patients, and you -- the way that it's -- it's a structural issue. It's not like you become a resident and then you start not wanting to talk to patients. It's because there is just no time. There is just no time. You are allowed a certain amount of time, and you have other obligations, and this is a pervasive problem in medicine and nursing and pharmacy, all of the health professions. We are asked to do much more than is humanly possible if we want to do compassionate care, allowing the patient narrative to come across and representing that and communicating that to the care team. So that's a huge problem, and I think we're making small headway into that.

And I also wanted to echo what you said about social medicine. There's a famous German physician called Rudolph -- you have you probably heard of him, and he said that medicine is a social science and that physicians are natural attorneys for the poor. My wife is an attorney for the poor?

Does that mean I get a cop-out and she's the attorney to the poor on my behalf? No, because I'm the one who sees the impact of what he called structural violence. And we can define that; my definition is legacy and government and politics and the political economy that leads to the robbing of agency from a person, which basically an agency meaning control and will, walking down the streets if they wanted to. It robs them of that in the form of led poisoning in their water, or in the form of being shot and killed. Those are all forms of structural violence that we need to teach not just in the School of Medicine but the School of Nursing and School of Pharmacy, all across the schools. Because we all know it's an interprofessional endeavor to provide high quality care to patients.

(Applause.)

>> I would love if you would tell me about why you wanted to be part of the founding of White Coats for Black Lives, and do you find it -- it's funny, I think you mentioned, I can't remember, the panel said something about this is a teaching moment, and I think everybody on the panel probably said, okay, here's my teaching moment, once again. And the onus is always sort of on us, right, to be the teachers, even though it shouldn't be on us. If you want to make progress, sometimes I think it is on us, it just is. So tell me about White Coats for Black Lives and if you feel, as you go around school as an activist, do you feel like this onus is on you to constantly be doing a 101 on White Coats for Black Lives and trying to talk

your colleagues and your classmates into understanding what it's about?

>> So, yeah, it's difficult. I think it's difficult because of some of the things that the panelists were talking about, which is what is it that we value as a medical institution. Is it the patient histories? Is it the patient backgrounds? Is it the injustices that they face that affect their health and that are very important to their health? Not really. And our systems are not set up in a way to pay attention to that or to treat it. We might counsel about that or say it's a social factor that we can't really address, but we don't consider it important enough to be a part of what we need to address with the patient.

And I think it's been interesting throughout this whole time that -- I think one of the main reasons why White Coats for Black Lives was able to be started is because there were and there are so many minority students that come from low income backgrounds, that come from backgrounds of violence, backgrounds of racism and experiencing racism, and we see that deficit in medicine, and there's a big silence. I think after the Mike Brown and Eric Garner grand jury decisions, we felt that silence. We felt like, how is this not under the realm of medicine and health care? It's affecting our patients to the ultimate extreme, and I think it's difficult, but I think because we have increasing number of minority students that that makes it easier, and that makes it easier to talk about bias. It makes it easier to talk about racism. But I think that we have a long way to go in building those numbers up of minority

students and minority faculty at UCSF to continue these kinds of initiatives.

>> Sidra, do you feel like there's receptivity to those types of conversations on campus?

>> I think so. I think originally when White Coats for Black Lives was started I don't think any of us who were sitting in this room, now probably 18 months ago, thought that this would be here. I think we were all afraid of the potential implications of our actions on our future career, our experience at UCSF. I think we were fearful that if we say things that people maybe aren't ready to hear them, and I think a lot of us who are in this room are very surprised that this reaction has happened.

I think, you know, a lot of us have mentors at UCSF who have been doing this work for a very long time, and we have seen their own struggles in their careers, and I think to see that not only are students getting more support but seeing that our faculty and staff are getting more support is a huge sign. But I also want to go back to talking about, you know, that founding -- I can't speak for everyone who was in that room, but I think I will speak for myself and what I was feeling when I came here. I think in medicine, as a woman of color, I think I have to focus on academics. People will always question your intelligence more than they will other people's, and so so much of the first year or two of my medical education, I just wanted to do well in class. That's my goal because I know people will challenge my intelligence. I know that I'm going to have to do more and be more successful to get the same thing.

And I think when the Mike Brown Eric Garner cases happened, it was that I can no longer deny this aspect of myself that, you know, I have put aside in order to do well in medicine, and I think a lot of us were coming out because we were saying, I have a brother who is black, I have a dad who is black; this matters, and I can no longer say in order to be a successful physician I have to put that stuff aside.

>> What have you found works in closing the gap in underserved communities that are dealing with cancer?

You have done it for a long time now. What works and what does not work?

>> Well, one thing I want to say first is that I wish I could share the optimism that I hear. And I'm happy that it is here and that you're expressing it.

>> But you're not optimistic?

>> But having worked in cancer disparities for almost three decades now, I'm discouraged. The cancer death rates are dropping, but the disparities are still there. And it's for many reasons. It happens across the entire spectrum, from prevention to early detection, treatment. There are disparities in different causes, many complex causes of those disparities. But the thing that I think is particularly pertinent to this institution is the fact that the people who have the greatest need have the least opportunity to get the best care. The people who have the greatest need, and in the case of cancer there are disparities in every of the minority groups, but African-Americans bear the greatest burden of cancer, by far and for every cancer. African-Americans have the highest mortality

rate, for all of the common cancers; prostate, breast, lung, colorectal. And I was happy to hear the discussion about slavery. And it took me a long time -- this is why it's not so great to be a white person working in diverse communities -- it took me a long time to connect the dots, but I see that these disparities are the long shadow of slavery. I see the stress, the oppression, the marginalization, and I particularly see it when I leave my beautiful office at Mission Bay, and I drive across the bridge to Oakland to do my research in safety net public hospitals and public clinics. The contrast is shocking, and I can never get used to it. And so I have started having conversations with very senior people at this institution and asking, what is our responsibility at UCSF for this right at our doorstep, these third world conditions of hospitals? And I'll just share another sound bite with you.

I love ObamaCare. I hope nothing happens to it, but the cancer outcomes for Medicaid and, in California, Medi-Cal patients are no better than for the uninsured. The cancer outcomes are no better.

So access alone is not the answer. It's access to what quality --

(Applause.)

And another discouraging thought in my mind is we have these incredible facilities here that we've raised hundreds of millions of dollars to build this magnificent Mission Bay campus, a monument to biomedical research, but I would argue, and there's data to support this, that as our science advances, disparities will worsen. Because those who have fallen behind

will be further behind. The people who participate in the research and will benefit from the advance of precision medicine are the educated, the insured; those who have easy entry into institutions like this.

So something has to change. There is nothing in our health care or biomedical research institutions that was built from the bottom up to address disparity. Disparity is tagged on, it's worked in; you have got to have grants. It's not an institutional priority. So I would like to see them.

I think if this institution could become a champion for disparities, we would go a long way to diversify our faculty as well, because if we built that --

(Applause.)

-- if we built as a central focus of this university attention to disparities, we would have to keep them out, because this is where they would want to be. And I'll just say one more thing. I'm very proud to be affiliated with the UCSF -- family comprehensive cancer center, because that institution is doing what I would like to see the whole institution do. We have a new director, Dr. Allen Ashworth who came to us a year ago, actually a bench researcher, a distinguished biologist, who said I want to change cancer in San Francisco. This was startling to us in population health to hear this, from a genetics expert, and he has launched an initiative, and he's committed to raising the money to change cancer in San Francisco. This is almost unprecedented. So this is what I think that we could be a win-win-win, all the way around for this university, if we could maybe build one less

building at Mission Bay. And start something like that campus wide, it would bring us the diversity. It would help us with disparities, and that would be a wonderful cycle. I could be optimistic.

>> Let's talk about structural violence, if we can. And did you agree with the definition that you heard, earlier?

>> That will work. I mean, it's -- structural violence is a lot of different things. It's the ways in which our society is arranged to produce ill health and disproportionate death among certain populations.

>> So is a solution tackling structural violence? Is there a solution dealing with something other than something that I think to many would seem incredibly entrenched and out of the reach of medical students?

>> I think from our standpoint here at UCSF, to deal with structural violence is to deal with our role in structural violence, and in that that way, what we do is we do some of the things that Rene just talked about. We are the second largest employer in the city and county of San Francisco. That's huge. If we think of the goods that we utilize and produce and pay for on a daily basis, it's billions of dollars. And if we think about what that socioeconomic engine does in relationship to the poorest and most underserved communities in San Francisco and the Bay Area, unfortunately, our answer is it contributes to their disparities rather than improves their outcomes, so that we have an opportunity with that part of it. And again, I'm not talking about health care now, because I think we need to improve health care and the health care outcomes. But what we

all know is that health disparities, 25, maybe 30% of the disparities are due to health care. The others of them are the social determinants of health, which are housing, which are employment, which are education, and which are the social dynamics that people engage in the built environment that they live in, and that we can have an impact on those aspects of the lives of people in these communities and the communities themselves through the economics of our university. And I think that that's one way that we can have an impact on structural violence, rather than be agents of the structural violence, we could be agents of change within the context of the trauma that gets produced in structural violence, to healing in these communities.

>> I want to open it up to questions. We have about 20 minutes left. And so if you have a question, come to this mic here or come to that mic there, and tell me who you would like to address your questions to. Anybody who has ever done a panel with me before should know that your question should have a question, or I will stop you in the middle of it.

>> My name is Denise, and I'm a MP student, finishing up this year. And it's not so much a question as --

(Laughter.)

>> I am just going to warn you, you are treading on very thin ice.

>> It's a potential answer to a question that came as what will we do to change some of these problems, in speaking up for one another. And when I heard you say that, ask that, I was reminded of a quotation I learned probably some 30 years ago

that I try to remember and keep present at all times. It's from Martin -- and it was when they came, and the quotation is when they came for the socialists, I said nothing because I was not a socialists. When they came for the trade unionists, I said nothing because I was not a trade unionists. When they came for the Jews, I said nothing because I was not Jewish, and when they came for me, there was no one.

You shouldn't have to be the teachable moment. I think I like to believe that most of us want to say something and lack the tools sometimes on how to say it. So I would just say I would have hoped in that same situation I would have said something for you.

>> Thanks for that.

Do you have a question? No, no. Thank you for the statement. Next person, do you have a question for me? You'll know when I'm being sarcastic and catty, trust me. I'm very clear. Go ahead.

>> Hello?

>> There you go.

>> Okay.

I really do have a comment, but I am going to roll it into a question. It's really hard to be here and not -- it's -- I sat here literally crying throughout this, and I'm here to really report on a lot of what's being talked about. But I'm a mom. I have got three kids. We moved from the east coast. We live in the south bay. My husband works in tech, and there's really a lot that is happening with inequality across industries. Before I got here, I was at a P.T.A. meeting

dealing with communication around all of these sorts of issues, and I'm the only one, the only family there that looks like our family, an African-American family. And so it's very troubling, but it's very hard to deal with that. To come here and hear all of your stories, hear all of the hope in the room, as a parent, as a wife, as a person trying to raise my kids, it brings me great hope because we have little kids that are looking at us, that are learning from us, that repeat the behaviors that we do.

I expect to just also add that a couple of years ago a doctor found three holes in my heart that I was born with. Nobody knew that we had had them. We lived in New York at the time. I know that given where my husband worked, what kind of insurance we had, it did allow me to get my heart repair. It will be a year in March that I had an ablation done. I don't know much about the west coast, but what I can tell you is the type of care that I was given, the type of respect that I had, that I felt here in this space, and I didn't see any of you as doctors, but you I think whatever was talked about had some implication to what I experienced as a patient, and I want to just say that, because when somebody looks at me, they might have some type of perspective about whether my life is valuable or not. My cousin died last year, 35 years old, to breast cancer. 35 years old, six children, lives in Chicago, a totally different life. And I know that the health care, the different contexts and conditions of our life, certainly do correlate with the outcomes of who is here. So you I just wanted to share that, and I do have hope. I'm glad to be here.

>> Thank you. I appreciate it.

>> My name is -- I'm a nurse in the School of Nursing. I do have a question, so, for the whole panel.

>> Thank you.

>> I feel pretty good about that. My question is, history has shown us that most of the great advances, the social advances that we have had have resulted from people going into the streets and taking action on this. And my question is to the panel, earlier, Soledad talked about those in power having the leverage to create and shape the stories and narrative. I'm curious what your views and beliefs are and your insight into the role of grassroots movements for creating the narratives in Injustice and Health. If you could share with us some current groups that you guys are passionate about and allow us to get involved in.

>> So let's throw out some organizations that are grassroots movements in Injustice and Health that you think line good for people in the audience, who are interested in volunteering and reaching out and being a part of.

>> There is White Coats for Black Lives, there is the UNCI student group -- medical student groups who oftentimes, this isn't going to be very PC, but I think when you go to undergrad, college, medical school, you always have the black student unions, Filipino student unions, and people are afraid to join groups that they do not identify with as part of their socialite, and it is okay to say I'm going to go over to hypertension Sunday at FMNA and do blood screenings at a black church on Sunday. Do not feel awkward about that. Now I'm going to start ranting, but I really think that is one of the

greatest things about UCSF and this student body; regardless of what school you are in, we are lucky enough to have a diverse student body. You know, our peers at schools, you know, UC Davis, there's way less diversity at a lot of medical schools across the country, so take advantage of that and really branch out to student groups that you perhaps have no idea, you know no one in it. It's a little bit uncomfortable but by being uncomfortable, that will make you a better health care professional.

>> Great advice. Did you want to add anything?

>> I would recommend just being part of your local neighborhood. I live in Berkeley, and I'm part of a group called friends of Adeline corridor. It's an area where the city government wants to take over and turn it into a more gentrified area, and a group of community neighbors have said, no, we are going to stop this and make it so it's walkable for the elderly, the disabled, and all of the poor who were living in this area, and no, we will not stand up and just bend over, roll over while you, you know, try to raise a gentrified neighborhood from under our feet. So that's one thing.

I also wanted to get back a little bit about the UCSF Health. While this room, the people in it and the people simulcasting are an amazing bunch, what is distinctly missing are the people who are actually working at UCSF Health, rather than part of the school of UCSF. UCSF Health is the entity that actually provides care, thousands of nurses and techs and physicians. And I wish that this would be -- would have been

advertised widely to that community as well. I wish the CFO were here to hear this.

>> We can send them the link.

>> Because I know that taking care of patients from certain socioeconomic criteria are not allowed to be taken care of by me, or we cannot support them and come to see a cancer physician because of structural violence. Okay? Because they can't get to clinic, or because they have two jobs and we don't have office hours or we don't have clinic hours. These are all structural things that I believe UCSF Health has the money for, the resources for, and definitely the passion amongst its faculty and staff and all of the health care personnel that are here.

So that is a challenge for UCSF Health. It's not a zero sum game. We are sitting on an area has probably the most wealth in the entire nation, the Silicon Valley, the Bay Area. You can't tell me that we don't have money to take care of poor people.

>> First of all, I wanted to say how great it is to see such a diverse panel up here. It's not something that we are able to see as often as we would like to see in the city and county of San Francisco. I am an operations manager here at one of the clinics in the city and county of San Francisco. So I have been working on creating forums to where we can have a conversation about issues of race in the workplace, so once we kind of start this forum and began to sit down and have these conversations about it, we realized that we weren't the only clinic who was having these issues and problems in terms of

different employees who had issues, problems, as far as, like, race was concerned. So we started to have these different conversations, these different forums.

>> I know you have a question for me in there sir.

>> There is a question. I guess I'll just get to it. I'm sorry.

>> That's okay. I just wanted to make sure you have one coming.

>> One of the things I wanted to get it, I wrote it down to make sure I have my question, how can we encourage care providers, social workers, nurses, in their communities in terms of health care. We do have a lot of folks working in health care who definitely want to improve the lives of their patients, to see the disparities in providing medications in terms of race, like? The question also says black and Latino patients are prescribed pain medications at a lower rate than their white counterparts with the same health issues. How can we begin these conversations with our providers and doctors?

Maybe I should have talked more.

>> No. I'm trying to figure out who is the best person to tackle that on our panel.

>> As not an expert by any means in this, I would just say that the most important thing is just -- medicine can be really removed from the communities that it serves, and I think that that's one of the reasons why there's so many health disparities, is that physicians, especially given the demographic of physicians now, might not identify or might not understand their patients or where they come from. So I would

say if there's any way to really do community outreach, really get to know your patients and the communities that they come from, that's a good step.

>> I would like to tell a short story and reiterate the points that have come up again and again and again, and that's the diversity of a body like this -- I recently took care of an adult at Moffett Hospital right over here. And he came in with kidney failure. The machine, the computer when you click on it, with his name, up pops a warning. FYI, this patient comes to the ER a lot and asks for narcotics a lot. He was in excruciating pain in his hips and knees, but yet that little trigger then triggered into my resident the thought that this guy is a narcotic seeker, he's an opiate seeker, I want to make sure just Tylenol for this guy. When you actually talk to his care providers, he doesn't have a primary care doctor, he's XYZ miles away, and he ends up in the ER a lot. And when you do a report on how many times he's actually gone to get those narcotic medications, he received a total of 60 pills in one year, in one year. And yet here we were as a team, a top-five, top-ten hospital in the country, saying no because of a preconceived notion of what he was. And this is where that narrative equity comes into play. You know, his voice needed to be heard before we could actually make a true determination of what he needed, and what he needed was narcotics. And so just to answer that question. So I think the solutions that many of us have brought up here are going to be the things that change and allow patients to have their narratives told in a more equitable way.

>> Question right over here.

>> First, I just want to thank everyone for sharing their stories with us and for sharing your experiences. Second, I just want to say how incredibly nervous I am being up here.

>> I know you have a question though, right?

>> I do have a question.

>> If you don't, you should be more nervous.

>> I absolutely have a question.

>> There you go.

>> And it's one that's framed from my experiences. I am originally from Harlem, not very far off from the woman that you interviewed, just blocks away. I knew exactly where she was. I grew up in the projects. I come from a family of immigrants.

I went to an elementary school, 99% African-American/Latino students. I had an opportunity to take an exam, just 30 of our class, to go from this school in Harlem to a school on the upper west side of Manhattan. Out of everyone who took that test, only three of us got in.

When, you know, after that I had the opportunity to get into one of the specialized high schools in New York City, super competitive testing, 30,000 students apply, only a thousand get into each school, and I was one of those students to get in. Out of the students who had the opportunity to get out of Harlem, I was the only one who got to go to college from my classmates. And years after, I decided to go to medical school, and I was lucky enough to be accepted into multiple schools. It ultimately came down to here and another institution that, you

know, gave me a really abundant amount of money and said, you know, you can come here; you can be here.

>> And your question is?

>> And my question is, I chose to come to UCSF, right? I chose to come to UCSF because of the spirit and what it stood for and what it represented and what I had heard from it. And so I ask my question framed by the $600 million of, you know, funding that UCSF was able to fundraise over the last year, and I say, what can we do to get students who went through experiences like I did, and because of their commitment back to their community, there are oftentimes many students who can't be here, or weren't accepted here and chose not to come here because the finances was just too much. My question is, what can UCSF do about that? And if any of you have anything to share about that, that would be really helpful.

>> To add to that, I think part of what you described, it seems like such a crap shoot if you come out of a bad school system, right? But that it's this constant game where you are rolling the dice, and you won, and then you have got this slot and this slot, and everything is winnowed down as opposed to some sort of mass way of really being able to really help students reach the level that they need to get to, because they could be good enough to get into those schools or their own school would be high enough quality that they wouldn't need a specialized high school to make sure they are eventually going off to college. I don't know who can speak to this, but --

>> I mean, this is something that students at least in the medical school have been calling attention to, which is the cost

of medical education. And even though we know the levels of debt are much higher for other schools, we know that for UCSF, an institution that's incredible and that wants to increase the number of minority physicians, the number one reason why people don't come here is because of finances; and yes, we are an incredible institution that has just fundraised so many millions of dollars, and I think being part of an anchor institution and sort of securing the health care for our Bay Area community and our communities is increasing minority student representation within medical school, within dentistry, within pharmacy, and I think part of that has to be a real investment in their education, especially for low income students and students of color.

>> I think we are out of time, so I want to ask everybody to give a big round of applause for our panelists. They're amazing. Thank you.

(Applause.)

>> Thank you.

>> I hope that we can address -- you can e-mail your questions. We'll try to address your questions. Again, I want to thank the panelists. You're fantastic. Thank you for sharing your stories and your passion. To our honored speaker, thank you so much, Soledad, we appreciate you greatly for being here and facilitating this conversation on our campus.

I also want to take this moment to pause and really thank our students and for the actions that they have done to inspire our campus to move forward. The White Coats for Black Lives movement really invigorated and initiated a movement on our

campus that has been of great importance to really all of us in moving this work forward. And as you say, it sparked in us a leadership retreat. The first time in my 32 years here that we had a leadership retreat focused on race. We have initiatives that have come from that. We have commitments to change things based on that. The chancellor identified in his state of the university speech his priorities for the campus, and they talk about equity and inclusion as core to our values and core to our institution moving forward. So we have come a long way. These things are important to us as an institution, and I agree that we need to have more opportunities for conversations, and we will have more opportunities for conversations on our campus. We will launch a social justice initiative and allow for ongoing conversations about these very, very important issues and activities, and we will engage interprofessionally as we continue to move the needle forward for the work that we're doing, because social justice is such a fundamentally important aspect of health and health equity, and so important to the communities that we serve.

No doubt, we talked about bias. You know, bias in the differences by which patients receive care, pain medicine. We have launched an unconscious bias initiative, but we have to take that and train ourselves as health care providers. What are our biases? How are we treating our patients differentially, and really challenge ourselves and be accountable to ourselves. So we are going to continue to educate ourselves and be conscious about bias, to be allies, to

speak up and be all that we can be as an institution. So I appreciate that.

I have to thank the staff, the Office of Diversity and Outreach, Alejandra Rincon, thank you so much. This has been an amazing endeavor, and all of the volunteers. We had an army of volunteers who stepped up to the plate to make this happen, to be at all of our sites where we are streaming. We have two people in the room. We have individuals who have been working with us for the last several months to make this happen, and I appreciate them, and I appreciate each and every one of you. To our provost, Dan, thank you for your support, to the chancellor as well, for supporting this work, for facilitating this conversation today. To our crew, obviously we couldn't have done it without the technical crew, so thank you.

And I just want to say that I trust that at some point UCSF will be able to look back and pause and say that this was a really important moment. We have had many on our campus. We, you know, starting with our 1968 -- people and what they did for the diversification of our campus and our student body, for the White Coats for Black Lives, for the race matters retreat, for the prioritization of equity, for taking the time and pausing in our day to talk about race and health and justice. Thank you, thank you so much. And I appreciate you and trust we'll be continuing these conversations in the future. Thank you.

(Applause.)