RMD 560

Foundations of Medicine

Advocate: Health Inequities & Implications for Future Practice (Summer Book)
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Anti-Racism Summer Reading Program

Overview:

Rush University’s mission is to provide outstanding health sciences education and conduct impactful research in a culture of inclusion, focused on the promotion and preservation of the health and well-being of our diverse communities. At Rush Medical College, we believe it is critical to teach students to have authentic dialogues and think critically about the historical injustices that underpin and currently impact modern-day clinical medicine in the United States.

Race is a social and political construct, not a biological attribute. It cannot be biologically defined due to genetic variation among human individuals and populations. Race is a hierarchical system of classifying people based on visible characteristics like skin color and hair texture, etc., in order to confer certain privileges to one group and to disempower and discriminate against another. It is important that the role of race in medicine is discussed before the first basic science lecture at the start of your medical education. As racism and the use/misuse of race for clinical predictions has negative implications on diagnosis, treatment, and one’s ability to receive equitable healthcare.

Racism is a SYSTEM. It is not an individual character flaw, a personal moral failing, nor a psychiatric illness. It is a system (consisting of structures, policies, practices, and norms) that structures opportunity and assigns value based on phenotype or the way people look. It unfairly disadvantages some individuals and communities. Yet even more profoundly, the system of racism undermines the realization of the full potential of our whole society because of the waste of human resources.

This Anti-racism Summer Reading Program began over 8 years ago and this is the fifth-year we have been assigned the Death Gap by Dr. David Ansell. During the RMD 560 Foundations of Medical Practice Course, you will participate in small group discussions facilitated by a clinical faculty member and possibly upperclass students. This discussion will focus on the understanding of race as a social phenomenon and how various forms of racism: scientific, structural, institutional, etc contribute to health inequities, specifically, the communities of Chicago’s West Side.

Objective of the Anti-Racism Summer Reading Program:

- Recognize that race is a social construct and not a biological or genetic risk factor for disease
- Define the key terms related to race, racism and bias.
- Demonstrate a foundational understanding of the role of racism in contribution to health inequalities.
- Identify how race is used and misused in medical education, scientific research, policy and clinical care.
- Recognize the interrelation between neighborhoods; society; history; and health care.

The Purpose of this Guide:

This guide has three learning goals:

1. to provide foundational knowledge of anti-racism.
2. to provide a reflective guide as you read the Death Gap book [After each part, there are reflection questions related to the previous chapter that you are encouraged to do before your small group session]
3. to assist in your preparation for small group in-class discussion related to the central concepts highlighted in the Death Gap book during the Foundations of Medicine course.
Activity 1: Complete the Pre-Survey - Summer Book by August 15th

Please complete this short survey https://forms.gle/VE7GeHzQoDf6ADgA9 by August 15th. This survey is anonymous. It will be used to guide our conversations during the orientation and beyond. There are no wrong answers!! It will help the faculty to know the various perspectives of new M1 students and assist us in future dialogues!

Activity 2: Review of Key Terms:

Throughout your medical education at Rush, several key terms will be used (Table 1 & 2). An understanding of these terms and concepts is critical as they form the foundation for the clinical skills presented. The central concepts that support the clinical skills presented in this student guide center on bias, racism, and anti-racism skills. More recently there has been a growing body of evidence demonstrating how implicit biases of clinicians negatively impact patient care. You can refer back to these terms as you read the book and within your small group discussions.

Table 1:

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>Bias</td>
<td>Judgment without question</td>
</tr>
<tr>
<td>Implicit Bias</td>
<td>An automatic response or mental association that occurs without awareness, intentional, or control</td>
</tr>
<tr>
<td>Explicit Bias</td>
<td>The attitudes and beliefs we have about a person or group on a conscious level</td>
</tr>
<tr>
<td>Race</td>
<td>A social, cultural, and historical construct that artificially divides people into groups based on characteristics such as phenotype, ancestry, national origin, etc., to facilitate and justify exploitation</td>
</tr>
<tr>
<td>Ancestry</td>
<td>A process-based concept, a statement about an individual's relationship to other individuals in their genealogic history; thus it is a very personal understanding of one’s genomic heritage</td>
</tr>
<tr>
<td>Racial Bias</td>
<td>A person’s identification with their racial in-group, which leads to preference for those of the in-group and negative preconceived notions about those of an out-group</td>
</tr>
<tr>
<td>Racism</td>
<td>Economic, political, social and cultural structures, actions, and beliefs that systematize and perpetuate an unequal distribution of privileges, resources, and power between white people and people of color.</td>
</tr>
</tbody>
</table>
Anti-black Racism

Anti-Blackness as being a two-part formation that both strips Blackness of value (dehumanizes), and systematically marginalizes Black people. This form of anti-Blackness is overt racism. Society also associates politically incorrect comments with the overt nature of anti-Black racism. Beneath this anti-Black racism is the covert structural and systemic racism which predetermines the socioeconomic status of Blacks in this US and is held in place by anti-Black policies, institutions, and ideologies. (Council for the Democratizing Education)

Scientific Racism

Scientific inquiry that stems from a belief in biological evidence of race and racial inferiority/superiority, and that black people are biologically different and inferior to white people.

Dominant narrative

An explanation or story that is told in service of the dominant social group's interests and ideologies.

Spirituality

The aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant and sacred.

Religion

An organized system of beliefs, rituals, and practices with which an individual identifies and associates and includes a relationship with a divine being.

Sexual Orientation

The presence and/or object of a person's romantic, sexual, physical, or spiritual attractions.

Gender Identity

One's internal sense of gender at a given time.

Gender Expression

The manner by which one choose to express gender, through clothing, mannerisms, and other aspects of presentation, which may or may not align with societal expectations.

Bias can be explicit (conscious) or implicit (unconscious) and exists within individuals and institutions. The table below explores the differences in institutional and individual explicit racism.

### TABLE 2: Individual and Institutional Racism

Data from [https://www.racialequityalliance.org/about/our-approach/](https://www.racialequityalliance.org/about/our-approach/).

<table>
<thead>
<tr>
<th>Institutional Explicit</th>
<th>Individual Explicit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policies that explicitly discriminate against a group</td>
<td>Prejudice in action—discrimination</td>
</tr>
<tr>
<td><strong>Example:</strong> Segregated care via faculty practice vs. clinic-based health care system</td>
<td><strong>Example:</strong> Doctor states “these Mexicans are a waste of resources” while rounding on a patient in alcohol withdrawal</td>
</tr>
</tbody>
</table>

Institutional Implicit

Individual Implicit
Policies that negatively impact one group unintentionally | Unconscious attitudes and beliefs
---|---
**Example:** Use of race embedded in clinical prediction rules and guidelines | **Example:** Doctor spends less time with patients of color compared with white patients

**Activity 3: Watch TedTalk, Race-based medicine is bad medicine, by Social justice advocate and law scholar Dorothy Roberts.**

“Even today, many doctors still use race as a medical shortcut; they make important decisions about things like pain tolerance based on a patient's skin color instead of medical observation and measurement. In this searing talk, Roberts lays out the lingering traces of race-based medicine — and invites us to be a part of ending it. "It is more urgent than ever to finally abandon this backward legacy," she says, "and to affirm our common humanity by ending the social inequalities that truly divide us."

Dr. Roberts encourages viewers to think critically about how medicine perpetuates racism and explores the tenets of scientific racism.

Click on the image below to watch her [TedTalk](#):
Activity 4: A Rush Medical College Reflective Reading Guide for The Death Gap: How Inequality Kills By David A. Ansell, MD, MPH

Below is a companion guide for your Death Gap: How Inequality Kills. This guide was created to be a companion while you are reading the book. You may also use this guide during your small groups. The book is divided into four parts. After each part, there are reflection questions related to the previous chapter that you are encouraged to do before your small group session. The provided discussion questions will be discussed in your Summer Book small groups during the Foundations of Medicine course. Note: the pages on which the question stems is also listed in parentheses within the discussion questions.

Welcome Video from author of Death Gap: How Inequality Kills, Dr. David Ansell, MPH:

Note from the author:

I remember beginning medical school over four decades ago in Upstate New York. I arrived filled with questions: would I be smart enough to keep up with the material? Was I cut out to be a doctor? Was this the right profession for me? But I also wondered how society itself was organized to influence health. I grew up in the civil rights era, a time when hospitals across the US were segregated. When I came to Chicago for my internal medicine residency at Cook County Hospital in 1978, I found both segregated and unequal healthcare in Chicago more than a decade after the passage of the civil rights act. While my colleagues and I fought to keep Cook County Hospital from closing, we wondered how a country like the US could allow Rush University Medical Center, a hospital for the
wealthy, and Cook County Hospital, a hospital for the poor, to exist literally across the street from each other.

This book arises from my observations of 40 years as a primary care doctor and epidemiologist on Chicago’s West Side.

The aim of this text is to help you, as new medical professionals, to contemplate a different viewpoint—the viewpoint that many of your patients will have. A very different world exists in your own backyard, depending on your race, gender, sexual preference, income level, and insurance status amongst a multitude of other factors. As you embark on your journey into medicine, particularly in the Chicago community, keep these patient stories in mind. While you may not agree with all my conclusions, I hope this text will stimulate you to think about the interrelation between neighborhoods, society, history, and health care. Remember, we’re here to not only practice medicine, but to promote and deliver good health. And health extends far beyond the walls of a clinic or hospital.

**Key Terms within the Reading:**

Below are a few key terms to have handy and keep in mind as you read the book:

<table>
<thead>
<tr>
<th>TABLE 3:</th>
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<tbody>
<tr>
<td><strong>Term</strong></td>
</tr>
<tr>
<td>Unconscious bias</td>
</tr>
<tr>
<td>Collective bias</td>
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<tr>
<td>Community efficacy</td>
</tr>
<tr>
<td>Concentrated advantage</td>
</tr>
<tr>
<td>Concentrated disadvantage</td>
</tr>
<tr>
<td>Structural violence</td>
</tr>
<tr>
<td>Structural racism</td>
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<tr>
<td>Placism</td>
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</table>
Antiracism | the policy or practice of opposing racism and promoting racial tolerance

Preface: One Street, Two Worlds (vii)

Reflection:
Describe the community you were raised in. What contributed to making it healthy and/or unhealthy? What are some of the divisions in your community that outsiders might not see? If you took a walk from one end of your community to another, how would you describe how the neighborhood changes?

Discussion Questions

- What is the difference between inequality and inequity?
- How might inequity be hardwired into communities?
- Rudolph Virchow described doctors as "the natural attorneys for the poor." What does this mean? Do you agree or disagree?
- In light of this preface, consider your own experiences—what have you been exposed to up until this point? Have you worked with or lived in underserved communities, urban communities, rural communities, minority communities, different nationalities, mixed income levels, etc.? What is your frame of reference?
- Why did the author refer to Ogden Avenue as one street and two worlds?
- The fourth floor of Rush Medical Center is the main floor of the hospital.
  - Imagine why the architects of Rush in the 1980s might have made the entrances to the medical center on the fourth floor.
- Why is it important to consider historical context when understanding why health outcomes vary by neighborhoods today?
PART I: American Roulette

Reflection

Think about your current community or your hometown. Who is thriving in your community and who isn't? Do you think that people of different racial, ethnic, income, gender, or sexual identity have the same outcomes as you? If outcomes are the same, what in your community allows for this? What societal structures—policies, practices, and cultural norms—might lead to poor outcomes?

Chapter 1: American Roulette (3)

“The wealth of one family alone, the Walton’s of Walmart fame, is worth $145 billion, equal to the wealth of 43% of American families”

Chapter Questions:

- “Like so many of my patients, despite working a full-time job and having insurance, she was often forced to decide between feeding and clothing her children and buying her medicine” (6). What is your reaction to Windora Bradley’s story?
- Why was medical care alone inadequate to treat Windora’s illnesses?
- What is structural violence? The author states, “It exists when some groups have more access to goods, resources, and opportunities than other groups, including health and life itself. A hardwired system of unequal advantage and violence built into the very rules that govern our society” (7). Can you describe other forms of structural violence? Especially those that impact health.
  - White men in some Appalachian towns live on average twenty years less than white men half a day’s drive away in the suburbs of Washington, D.C.” (11). Do you believe structural violence occurs to any other groups of people? Consider who might be affected.
- The author mentions poverty and income inequality as a result of exploitative market capitalism as agents of transmission of disease (9). What do you think?

Chapter 2: Structural Violence and the Death Gap (14)

“Western medicine focuses on the individual and biological manifestations of disease. Patients attribute their diseases to their own failings. Doctors and patients typically do not consider that the disease they experience might be the embodiment of ills created by conditions imposed on communities”

Chapter Questions:

- Often, structural violence is better evidenced overtly by natural disasters: the 2010 Haiti Earthquake. “If you lived in Port-au-Prince in 2010, you were much more likely to die from an earthquake than if you lived in Oakland California in 1989” (17). Why do you believe this is?
- Consider the patient with “broken heart syndrome” – her home was likely less habitable and safe for her condition than the makeshift hospital. How would she continue to receive her medications after the team had left?
- Consider the discussion of the “death certificate” and listing the cause of death (21). In the case of the woman in Haiti, what was her true cause of death? On the west side of Chicago, is it any different? Can inequality itself be considered a root cause?
- Consider the life expectancy gap between the US and Haiti (15.7 years in 2013) (21). Thus far, we have
attributed the gap to preventative measures, prenatal health care, societal safety, as well as other general health care (due to structural violence). Does this type of gap exist in the US between places of concentrated advantage vs. disadvantage? We lend aid to Haiti, but do we lend aid to the communities located in our backyards?

- Think about the causes listed for “excess mortality” in the US (23). Are there others?
- Why does a 16-year-old black boy on the South Side of Chicago have a 50% chance of living to the age of 65? (24).
- What is your interpretation of the “obligation of physicians?” Do you agree with the author’s comments? (25).

Chapter 3: Location, Location, Location (26)

“The American real-estate industry believed segregation to be a moral principle.”
— Ta-Nehisi Coates, Un conto ancora aperto

Chapter 3 Questions::

- What role did the great migration and housing segregation play in creating neighborhoods of concentrated disadvantage? Do you think the past has shaped (or continues to shape) our current state of inequality? What about our healthcare system? When you begin to see patients over the next few years, take a minute to get to know their own histories, stories, where they came from, how long they have lived in their current home, and what role they think this history has played in their lives, concerning their wellbeing and health (27-28).
- What is redlining? Do you think the legislation that followed in the 1960s and later have eradicated these practices and their effects? (28).
- What does the role of the economy in neighborhoods have on health? (32).
- This is not just an urban phenomenon; consider the example of McDowell County, West Virginia in terms of its life expectancy (39). What are the similarities between McDowell County and North Lawndale in Chicago?
- What are the “eight Americas?”

Chapter 4: Perception is Reality (42)

“Systems do not maintain themselves; even our lack of intervention is an act of maintenance. Every structure in every society is upheld by the active and passive assistance of other human beings.”

Chapter 4 Questions::

- What is the “perception gap” and how does it play out between individuals of concentrated advantage and those of concentrated disadvantage. Houston is used as an example in the text; how have you seen it play out in your own neighborhoods, cities, etc? (45).
- What is the “broken window theory?” (47). How does a disordered
  ○ neighborhood become a “bad” neighborhood? What is the role of perception?
- Implicit bias is described with perception and innate prejudice. It can be found in everyone, but do you think it plays a role in medicine?
- “If a neighborhood is perceived as bad, it will become bad.” Do you agree with this statement? (50). Given what you know about implicit bias, why might collectively held perceptions about neighborhoods predict future neighborhood decline?
- Do you agree with the description that “upward mobility” is always possible in the US?
● What does the author mean by “stuck in place?” (51)
● What was Windora's understanding of her neighborhood and its relationship to Darrel's diabetes. How could her neighborhood conditions predispose individuals to diabetes? (52)
● The author talks about the three ways in which the lack of empathy contributes to premature mortality. What are they? (54)

Chapter 5: The Three Bs: Beliefs, Behavior, Biology (55)

“The Western concept of race, although socially constructed, was always rooted in ‘biological’ features; that is, the characteristics used to classify individuals into races were always assumed to have a basis nontrivially rooted in human biology.”

- Joel Z. Garrod, A Brave Old World: An Analysis of Scientific Racism and BiDil

Chapter 5 Questions::

● Why was the woman at the dinner party skeptical about the author's explanation about death gaps? (55-56) How would you make the case?
● Were you familiar with the Tuskegee Experiment prior to this book? How does it make you feel? (58).
● Discuss the idea of environmental racism and give other examples (59).
● Why is race a social and political construct and not a biological one? (62)
● “Biological explanations are not the only flawed explanations that people believe. There are many who say that the black-to-white death gap in the US is not a product of racism, but exclusively a product of education, poverty and income inequality?” What are your thoughts? Do you agree or disagree? (64).
● How does the social gradient affect life expectancy (62-63)? Explain the table on 63?
● How does racism, poverty and income inequality interact to cause poor health? (65)
● How do you believe stress affects health? Consider the terms “allostatic load” and “biological weathering” (67). What do they mean?
PART II: Trapped by Inequity

Reflection:
Imagine a time when you travelled to a neighborhood or a country where the living conditions were palpably much different from the neighborhood you grew up in. What were your first impressions? Why do we respond differently to natural disasters than day-to-day neighborhood conditions that result in inequitable health outcomes?

Chapter 6: Fire and Rain: Life and Death in Natural Disasters (75)

“Those badly hit by a natural disaster are often the ones already struggling to get by.”

-Joshua Lewis, author

Chapter 6 Questions::

- Do you agree that natural disasters are indiscriminate in the death and destruction they cause? (76).
- What do you think makes some neighborhoods more resilient than others in the wake of natural disaster or extreme weather conditions? (82).
- How does the media change the perception of certain communities during disasters and the aftermath? (86).

Chapter 7: Mass Incarceration, Premature Death, and Community Health (89)

“Oh we address those that are leaving prisons, we can’t begin to repair the damage of mass incarceration and make our communities whole and healthy once again.”

-Susan Burton, activist

Chapter 7 Questions:

- Discuss the notion of “missing black men” and its impact on communities (90).
- “Sixty percent of young black men who do not complete high school will be incarcerated by their middle thirties;” “one in three black men can expect to go to prison in his lifetime” (91). What are the systemic consequences of these facts?
- From a population health perspective, what are the consequences of mass imprisonment? (93). Consider individual, family, and community health consequences.
- What are the health and other consequences of mass incarceration on the general public? On children? (94)
Chapter 8: Immigration Status and Health Inequality: The Case of Transplant (96)

“To address health we must address housing, education, childcare and other social determinants. And to address those, we must face the impact of racism, income inequality and immigration policy in communities.”

-Mary A. Pittmna, DrPH, CEO and president of the Public Health Institute

Chapter 8 Questions:

- What are the current laws surrounding immigrants receiving health care in the US? (96)
- Sarai was 25 when she died. How did the health system fail Sarai and her family? (97)
- If you were a medical student at Stroger when the Rush transplant team told Sarai and her family that she was ineligible for transplant, how might you have advocated for her?
- The case of the undocumented community’s fight for transplants is only one example of circumstances that have required advocacy for individuals to receive adequate care. Other examples that are difficult for the undocumented and uninsured to obtain are end-of-life and long-term care. Are there others?
- Do you believe the outcome of the transplant situation in Chicago is just and/or sufficient? (107-109)

PART III: Health Care Inequality

Reflection:
Based on your own or other’s experiences, are you happy with the US healthcare system? What do you think are the positives and/or negatives of the system? What would you like to see changed?

Chapter 9: The US Healthcare System: Separate and Unequal (113)

“The country is in a state of health care denial. The U.S. lags behind other industrialized nations in many important health measures - partly because citizens of certain races, ethnicities and incomes experience poorer versions of U.S. health care than others. The disparities are glaring.”

-Robert Pearl, M.D.

Chapter 9 Questions:

- Do you agree with the author that health care in the US is separate and unequal? (114).
- “…in the United States, black women are 40 percent more likely to die from breast cancer than white women.” Do you believe similar gaps are present in other diseases between minority and nonminority patients? (114).
- What role does institutional or structural racism play in the case of breast cancer in Chicago? (116).
- “What is the amenability factor?” (117).
- Explain how the figure on 119 and the map on 120 could be examples of structural racism.
- The author purports that implicit bias contributes to unequal care (123). Do you agree? Have you ever taken an implicit bias test? What were the results?
- Why did economist Angus Deaton describe American health care as Apartheid? Do you agree or disagree? (125)
● How does hospital type (think academic versus community, reimbursement rates, etc.) and location affect care? (125).
● How does neighborhood and insurance status of patients affect the ability of hospitals to provide top care? (125-128)
● Explain how hospitals that serve predominantly minority patients can have different outcomes (see examples about trauma and cardiac surgery).
  ○ Discuss how structural racism might contribute? Are there other considerations?

Chapter 10: The Poison Pill: Health Insurance in America (133)

“There are more than 9,000 billing codes for individual procedures and units of care. But there is not a single billing code for patient adherence or improvement, or for helping patients stay well.”

-Clayton Christensen, author, academic, business consultant

Chapter 10 Questions:

● The author supports the idea “health care is a human right.” Do you agree or disagree? Why?
● Consider the pros and cons of the Affordable Care Act. (136).
● What are the potential advantages of a single payer health insurance system?
● What are your thoughts about the national debate about health care for all?

PART IV: The Cure

Reflection:
How do you think we need to bring about change? Discuss examples of large- scale social movements that have led to change in the US. Can individuals make a difference, or does change require large groups of people? If you believe an individual can create change, how would (or will) you do it?

Chapter 11: Community Efficacy and the Death Gap (145)

“Without social cohesion, the human race wouldn’t be here: We’re not formidable enough to survive without the tactics, rules and strategies that allow people to work together.”

-Peter Guber, author, entrepreneur, and educator

Chapter 11 Questions:

● Discuss the case of Chatham. Why does social cohesion cause a neighborhood with a similar poverty rate to Roseland, to consistently demonstrate better health outcomes? (147).
● What has been the effect of altering people’s perceptions on the development of the Oak Park neighborhood? (150).
● Can the example of Oak Park be replicated elsewhere?
● Discuss what links collective efficacy and social capital to health outcomes (154).
● What are the positives and negatives resultant from the Moving to Opportunity (MTO) experiment? (159).
Chapter 12: Community Activism against Structural Violence (160)

“Dismantling structural violence thus calls for identifying the cultural violence that nourishes it.”

-Cynthia D. Moe-Lobeda, author

Chapter 12 Questions:

● Community activism by the STOP and FLY groups successfully fought for a Level 1 trauma center at the University of Chicago. Do you believe activism, such as the #BlackLives movement, has a role to play in health care? (161).
● What are your concerns around activism?

Chapter 13: Observe, Judge, Act (174)

“There may be times when we are powerless to prevent justice, but there must never be a time when we fail to protest.”

-Elie Wiesel, author, political activist, Nobel laureate

Chapter 13 Questions:

● In his book Pathologies of Power, Farmer documents three precepts that guide social justice work: observe, judge, act (174). Similarly, the author of this text has stated that for change to occur, you need a compelling narrative, data, and support to back the cause.” Do you agree with these statements?
  o How did these factors play out in the University of Chicago’s decision to create a Level 1 trauma center from the previous chapter?
● “Often I am asked why, in the face of so much evidence of a growing tide of human suffering, I remain hopeful... I am optimistic that when it comes to achieving health equity, after so many missteps, we will ultimately do the right thing” (190-191). Why do you remain hopeful? How will you “act?
Other Recommended Readings:

- **VOX: What it means to be anti-racist**
- Great American City: Chicago and the Enduring Neighborhood Effect (Robert J. Sampson, 2012)
- Community Health Equity: A Chicago Reader (Fernando De Maio, Raj C. Shah, John Mazzeo, David A. Ansell, 2019)
- Mama Might Be Better Off Dead (Laurie Kaye Abraham, 1993)
- The Case for Reparations (Ta-Nehisi Coates, The Atlantic, June 2014)
- There Are No Children Here (Alex Kotlowitz, 1991)
- How Science and Genetics are Reshaping the Race Debate of the 21st Century
- The uncanny return of the race concept
- Nieblas-Bedolla, Edwin; Christophers, Briana; Nkinsi, Naomi T.; Schumann, Paul D.; Stein, Elizabeth “Changing How Race Is Portrayed in Medical Education,” Academic Medicine: May 5, 2020
- “UW Medicine to Exclude Race from Calculation of eGFR (Measure of Kidney Function)” Department of Medicine, University of Washington
- Race Rx: Anti-Racism Efforts at Warren Alpert Medical School, Brown Alumni Magazine
- Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present by Harriet A. Washington
- How to be an Antiracist by Ibram X. Kendi
- “Myths about Physical Racial Differences were Used to Justify Slavery – and Are Still Believed by Doctors Today” by Linda Villarosa, published in The New York Times 8/14/2019
- So You Want to Talk About Race? by Ijeoma Oluo
- Racecraft: The Soul of Inequality in American Life by Barbara J. Fields and Karen Elise Fields
- Breathing Race Into the Machine: The Surprising Career of the Spirometer from Plantation to Genetics by Lundy Braun
- Equal Treatment: Includes brief online modules on the role of race in medicine
- True Justice: Bryan Stevenson’s Fight for Equality. HBO documentary, available on HBO or Prime Vide
- Vice: Self-care tips for Black people who are struggling with this very painful week
- Refinery 29: Your Black colleagues may look like they’re okay — chances are they’re not
- Mashable: How to be anti-racist
- VOX: What it means to be anti-racist
- The Body Is Not An Apology: 7 ways non black people of color perpetuate anti-Blackness
- Psychology Today: Anti-racist action and becoming part of the solution
- Centennial: Twitter explains how To support black lives matter as a non-Black person
- American Public Health Association: Addressing Law Enforcement Violence as a Public Health Issue
- The Atlantic: Ta-Nehisi Coates “The Case for Reparations”

Websites:

- Black Lives Matter
- 1619 by The New York Times
- National Museum of African American History and Culture: Talking about race web portal
- https://www.raceforward.org/
- 21 Day Equity Challenge
- Guide to Allyship
- The Seattle Civil Rights & Labor History Project
- Coalition of Anti-Racist Whites
- About Black Perspectives
- www.WhiteAccomplices.org
- Racial Equity Tools
- Seattle Racial and Social Justice Initiative
- Racial Equity Glossary

Few Videos to watch:
● **Black Feminism & the Movement for Black Lives: Barbara Smith, Reina Gossett, Charlene Carruthers (50:48)**
● **Dr. Robin DiAngelo discusses 'White Fragility' (1:23:30)**
● "How Studying Privilege Systems Can Strengthen Compassion" | Peggy Mcintosh at TEDxTimberlaneSchools (18:26)

**Few Podcasts to subscribe to:**

- [About Race](https://aboutrace.podbean.com)
- [Code Switch (NPR)](https://www.npr.org/section/code-switch)
- [Intersectionality Matters! hosted by Kimberlé Crenshaw](https://IntersectionalityMatters.org)
- [Momentum: A Race Forward Podcast](https://momentumraceforward.podbean.com)
- [Pod For The Cause (from The Leadership Conference on Civil & Human Rights)](https://podcastforcause.org)
- [Pod Save the People (Crooked Media)](https://podcastforcause.org)
- [Seeing White](https://seeingwhitepodcast.com)
- [Teaching While White](https://teachingwhilewhite.com)
- [The Praxis: Connecting theory and practice for health justice](https://praxiswellness.org)
- [UW CLIME Critical Teaching Series](https://uwclime.org)
- [The Curbsiders](https://thecurbsiders.com)
- [First Reckoning](https://firstreckoning.org)
- [Not Built For Us: Audio Essays on Medicine, Structure, & the Marginalized](https://notbuiltfor.us)