EPISODE 1

[INTRODUCTION]

[0:00:02.9] RC: Hello and welcome to Collectively Us, Unpacking Racism, a show about understanding and embracing our racial and ethnic diversity. We are your hosts,

[0:00:13.4] JR: Julie Radlauer-Doerfler

[0:00:14.6] RC: I'm Ryon Coote and today we're going to talk about the impact that COVID-19 pandemic is having on black and brown communities. We'll discuss some of the many historical, medical and societal factors in an attempt to provide our listeners with an understanding of how they can contribute to our collective efforts by being an ally.

[SPONSOR MESSAGE]

[0:00:38.8] JR: Collectively Us, Unpacking Racism is sponsored by the historical fiction novel, *The Accidental Suffragist* by Galia Gichon, available for sale on Amazon and bookshop.org. Historical fiction is a contemporary voice. In a time when the obstacles for women from any background were insurmountable, a fictional character discovers her voice and dreams of equality in a male dominated society. It's an amazing book by an amazing author.

[0:01:05.8] RC: Thank you for that and thank you for our sponsor.

[DISCUSSION]

[0:01:11.3] JR: Hey Ryan, I wanted to tell you about this article that I read in the Washington Post. My mom keeps sending me these articles about COVID statistics.

[0:01:17.6] RC: I love it, I love your mom.

[0:01:19.1] JR: Just to keep me updated. This article talked about that, 19 months into the pandemic, one out of 500 Americans have died from COVID. One out of 500 Americans.

[0:01:29.3] RC: Wow.

[0:01:30.1] JR: I know. When I read that, I was like, “What?” and then I looked at the statistics. What it says is that one out of 35 people who are age 85 or over have died. One out of 35 people. One out of 780 people that are our age have died of COVID, the 40 to 60.

[0:01:46.0] RC: That’s still high.

[0:01:47.6] JR: I know. If we were Native American, it would be one out of 240 people.

[0:01:51.8] RC: What?

[0:01:52.8] JR: I know, if we were Hispanic, it would be one out of 390.

[0:01:55.8] RC: Oh my gosh.

[0:01:57.8] JR: Then black people, one out of 480.

[0:02:00.2] RC: Wow. If you think about that, that’s incredible because the people who’VE been the most marginalized in our society are the ones that are most susceptible to this virus. You know, I shared a personal story with you about a family member of mine that passed away of COVID, very early on when the virus was first hitting our shores back in March of 2019.

That was difficult for us and when I speak amongst my friends in certain circles, they’ve also lost people that have passed away and you and I have shared this, you know? You have relatives that have passed away and they look like me, you know?

When we look at maybe your immediate family or your network, it’s rare. We have to really think about why is this happening, it’s not that black and brown people or Native Americans are more susceptible to COVID. Dr. Fauci said something a while back that it’s the preexisting conditions that are really causing the higher mortality rate, high blood pressure and diabetes.

We have to examine why those things are happening, think about some of the environmental factors as well too, as to why this is happening. We want to take the listeners on a journey here because I know people always say, “This guy Ryon’s always talking about history.”

Certain things that were done, certain historical things that were done have caused a problem for these marginalized communities right now. They are not equipped to fight off something like this. Because I’m going to tell you something right now, we’re all dealing with COVID, every one of us, it does not know race, but there’s certain groups of people that are less equipped to deal with this virus.

[0:03:39.2] JR: Yeah.

[0:03:39.8] RC: It’s sad because they’re dying.

[0:03:41.4] JR: My friend Erica always says, “When a white person gets a cold, a black person gets the flu.”

[0:03:45.7] RC: Man, she is right. Let me tell you something else too, when a white person gets the flu, black people die. We’re not trying to be the downers here, but we have to speak truth to power and shed some light on the situation that’s difficult in our society right now, and we can’t fix every situation but we could educate people and hope that we could start making the right steps to correct things for the future.

[0:04:05.1] JR: Yeah, I realized, the more people I speak with, I mean, I do a lot of training in my role, in my job. Sometimes we just have kind of casual getting to know you conversations and sometimes that conversation’s about COVID because we’re all dealing with COVID.

I was in a training a couple of months back and there were about 40 people in the training, a lot of young people who are just new into the field of behavioral health and in this training, somebody had had a rather very recent death in the family and so people started talking about the deaths that — there were 10 people that had lost somebody due to COVID, an immediate family member due to COVID and every single one of them was black.

It's shocking to me, these inequities, that you can literally look at the number of people who are dying and recognize that there's more people who are dying based on the color of their skin and their life experiences.

[0:04:52.5] RC: You said it right, inequities. Because if you think about it, in our society right now, so prior to the affordable care act, 20% of the African-American population was uninsured. Now it's about 11%. It's getting better, it's going the right direction. However, think about the environmental factors that are very prevalent within black and brown communities.

They're more condensed, they have multigenerational homes, there's a lot of what we call environmental racism where you're going to put a sewage treatment plant, you're going to put a waste plant, you're going to put an electrical plant, you're going to have bus lines, you're going to have all these depots in these communities, you're going to have major highways, giving off smog from the cars in these communities versus other communities.

There was an interesting article that the Miami Herald published a few years back. I think it was a study done by FIU if I'm not mistaken. They did a study of two cities within the city of Miami, they're only a few miles apart. That was the crazy thing about this, and they were studying life expectancy. Great article.

If you can find it, I recommend you read it. They looked at Overtown and Brickell Key. Overtown is predominantly black, Brickell Key predominantly white. The extent of how long you will live for Overtown was 72 if I'm not mistaken and for Brickell Key, it was 86.

[0:06:14.1] JR: Really?

[0:06:14.9] RC: Yes. A couple of miles separate these two cities. They're in the same county and a couple of miles separate them but almost 15 years of life is given to somebody else because of where they live. You say something to me all the time about zip code. I want you to share it with our guests because it's so true.

[0:06:33.5] JR: Yeah, I know, in public health, it's just like, the common knowledge in public health that your zip code is a better predictor of health than your genetic code. That's a perfect

example of what you're saying. People are living just miles away from each other and there's almost a 15-year difference.

[0:06:47.6] RC: Your zip code also to determine of the opportunities you will have in life, based on your education, the type of food you eat, right? Because just think about it, in our society, urban marginalized communities that are more dense, they typically don't have supermarkets, right?

They tend to have corner stores, where people are eating processed foods versus fresh fruit, fresh meat and things of that nature that your body needs, and there is a direct correlation between health and the food you consume.

Redlining was more problematic for African-Americans now I think, right? It was very problematic back then but the results of it are very problematic now because when you have things like COVID, you've condensed people, because that's the only place they could live, into certain areas.

Once you've condensed them into those areas, all the other resources that are moved into the areas where the people who are given the greenlight to move forward are. All your supermarkets, your banking, your quality schools, all those things that are taken out of these urban communities and pushed out into the suburbs. There's a great book about "white flight" that happened in the 50s and the 60s in this country.

It's where the middle-class, white middle-class left the cities and moved out to the suburbs and when they left the cities and moved into the suburbs, they took everything with them. And then they left the poor and marginalized people to try to figure things out, and what happens in those communities? You don't get the proper nutrition, all the resources have gone because of the way we fund schools in this country.

Then, when a thing like something like COVID happens, you have these condensed communities that don't have adequate healthcare or proper healthcare and then COVID comes in and really creates a more problematic situation for the people.

[0:08:30.1] JR: I mean, when we look at COVID, there's so many different reasons why it would be affecting different communities in different ways. So, you're talking about the way that the people have access of healthy foods, or not. The institutions where people learn, that's also an issue, and healthcare is a huge issue. I mean, there's not a lot of medical facilities in these poor, under-served communities, and people don't even have primary healthcare doctors.

They end up going to the emergency room, which then they're not getting the proper care and they're not getting preventative care. I mean, here in the US, we focus on Western medicine, there's a large focus on Western medicine. Typically, in Western medicine, we focus on preventative care and people go to the doctor on an annual basis just to kind of check in.

A lot of people that I work with and the clients that they work with, they don't go to the doctor when they're not sick, they go to the doctor when they're not feeling well. The idea of going for preventative care is really not even on the table, that's not part of their culture, which is really interesting because, when you look at some of these more under-served communities or lower socioeconomic communities, they don't' have access to doctors so they don't get preventative care.

Then when something like this happens, their bodies are not able to deal with it the same way that somebody who has been upkeep.

[0:09:43.2] RC: How did we get to that point? How did we get to the point where people in society, right, people who are Americans, people who contribute to society don't even have the ability to get the proper care they need to take care of their bodies, or to get the proper food, you know?

[0:09:59.5] JR: I think it's both though. I think it's yes, they don't have the ability to, whether it's financial or access to transportation, all those social determinants of health. I also think though, it's cultural. I think that, in a lot of cultures, the expectation for going for preventative care, it's not part of their cultural practice.

[0:10:17.6] RC: I'll share a personal story with you of my grandfather and my father and those things. I grew up in a home of very strong black men who provided for their families. This is not

like they didn't have the means to go to the doctor, they just didn't like to go to the doctor. It's so funny because I used to always remember my granddad, and my dad and I was different, my mom makes him go to the doctor, you know?

My granddad, he used to always say, "They always find something wrong, and they just want money". You've got to realize, these men, they were great providers, they were working jobs where they had to be at work. Service jobs, you're working with their hands, they're doing things. They had to go to work.

Now, I remember my granddad had an issue with blood pressure and, a little issue with blood pressure, and my grandma had to physically take him to the doctor, right? To get this checked out. Of course, he goes to the doctor and the doctor prescribed this medicine but we think he prescribed a medicine, it was a little too strong and he started getting very lightheaded.

My granddad, after that, he was like, "Forget it, I went to this doctor, he didn't know what he was doing, he made me sicker", right? He stopped going back to the doctor, he didn't go to the doctor until he was in his late 70s, you know? That's a problem, right? A lot of it has to do with the fact that proven instances of misdiagnosed and overdiagnosis and lack of proper care for African, black and brown people in our society. There's already a natural apprehension to go into the doctor because of historical things.

[0:11:45.7] JR: I was doing some research for a project that I'm working on, and the biggest challenge is that it's really – it's structural. It's like the way the system was designed. I was reading something that, in 1910, the federal government commissioned a report called a Flexner Report. It was looking at historically-backed colleges and universities. The result of the report is that they closed five out of seven historically black medical schools.

[0:12:09.7] RC: Wow.

[0:12:11.2] JR: Somebody just recently, this analysis or multi-regression analysis to look at the data to figure out if they hadn't closed those schools, how many more black and brown medical doctors would we have?

What they found is that if they hadn't closed the schools in 1910, there would have been over 27,000 additional black medical school graduates. Right, it just in 2019 alone, there would have been 330 additional black medical graduate doctors, which would have been like a 29% increase to the number of doctors.

You say, "Okay, well what's the big deal about that?" Well, the big deal is that when you speak with black and brown people who would be patients, 100% of them say they would prefer to be treated by a black or brown doctor. That was from a research study that I conducted. In that study, 100% wanted a doctor that looks like them.

When you have somebody, like you said, your grandpa, he was going probably to a white doctor, he didn't have that connection, he couldn't communicate with that person, he didn't like the treatment that he got, and he just walked away from it.

[0:13:16.5] RC: Exactly, never went back.

[0:13:18.5] JR: If he had been going to see somebody who he felt more comfortable with, he could have had a conversation like, "Hey doc, this is not working for me, what can we do?" It just creates this inequity.

[0:13:26.8] RC: It even goes deeper because this also translates to the apprehension in taking their vaccine for a lot of people of color because, if you think about it, in this country, medical experiments on black and brown people are not something new, right?

[0:13:40.1] JR: Right.

[0:13:43.1] RC: You can kind of understand the apprehension. I'm vaccinated and I'm proud to say I'm vaccinated because I did it for myself, my wife, my family, my mother, my father. All these people who can be more susceptible to this deadly virus, I did it for them and for myself too, to prove a point.

If you think about the black and brown community, because of what's happened to us in the past, we're going to naturally be on guard when it comes to certain things because of – you

know, in history again, it's this experiment, Henrietta Lacks, they took her cells without even letting this woman know that they were using her cells to study cancer.

There's been some really interesting things that have happened to black people in this country so when people say, "Oh well, they should take the vaccine." The first thing they're going to say is, "Why are you giving it to me first?"

[0:14:32.9] JR: That totally happens. My cousin runs a hospital out west and right when the vaccine came out, her hospital system is really committed to equity. They were making a commitment to practice what they preach and they said that they were going to give all the frontline workers access to the vaccine first even before the doctors and the nurses. They want to give vaccine to the aides, they wanted to have people who were in food services, people who were in transportation. The people that were really close to the patients on a regular basis.

They offered to make sure that everybody got it at the same time or that people that were closer got it first and everybody was like, "I don't want that. Why are you giving it to me first? Don't give it to me, you take it. You show me that you're going to do it first." It was just this natural like, "You are trying to test it on us to make sure it is going to be okay" and they were like, "No, we are trying to support you."

They had doctors that looked like them take the vaccines in front of them to show that no, they're not trying to do that. We're just trying to keep everybody safe, and she said a lot of them chose not to have it.

[0:15:34.5] RC: I wish they would take it though, but I can't get mad at them for feeling that way, but I wish they would. It's interesting because the people who really need it are these people in a lot of these service industry jobs because there is an interesting – you know, while I was preparing for this topic, I read a report from the CDC and it was really talking about why these communities are so impacted by COVID.

There was an interesting nugget in there and it said that of all the service industry jobs, high paying and low paying in America, 40% of people who work in those jobs are Black and Hispanic, right? Service industry jobs, nine times out of ten, they don't have the luxury to work

from home because they are dealing directly with people on a regular basis. These are your healthcare workers, your city service workers, your transportation employees, your sanitation employees, your food service employees, you name it.

These are your service industry people, so those people are constantly coming in contact with people, which exponentially increases their chances of getting the virus, couple that with them going back to communities that are densely populated because of how society has pushed people into certain areas, and on top of that, these communities don't have proper healthcare or proper nutrition, you are creating the perfect storm for something like COVID.

Then we forget about the elephant in the room, many of these families have multigenerational people in the home, so there's an aging parent with a child going to school and we all know, 50% of the people with COVID will be asymptomatic, especially children. They're going back to school, you got this aging parent who may have a comorbidity with his diabetes or high blood pressure, they go into the home, they get grandma infected or grandpa infected and what happens next?

I can share a story of a person who I provide services to, because I deal with very under-served people in my professional career. His job was deemed an essential service, so unlike you and I, Julie, where we could shelter in place and work from home because we had access to Zoom and we could take meetings and things of that nature, this person works at a tire shop, essential service.

Vehicles have to go back and forth, food has to move back and forth, things have to be done. Society has to continue to move even though we've sheltered in place. I don't know if any of our listeners have ever been in the tire shop but he wasn't the guy selling the tires, he wasn't the manager, he was the guy changing the tire. That's a hot, dirty, hot, I'm going to say hot again, place. He had to wear a mask.

Come on, let's be very honest. Is he going to wear the mask properly? No way, because it's so hot. It is hard to breath, you have smog from the cars, you have the heat from everything that is going on there, and this is Florida, right? It's always hot and he's changing the tires. Of course, he didn't wear his mask properly, what do you think happened? The man got COVID.

[0:18:41.3] JR: Right, he got COVID.

[0:18:42.2] RC: Okay, went home, infected everybody in the home, himself, his girlfriend, their children and his girlfriend's mom that lives with them in the home. The mom had diabetes, right? The mom ended up in the hospital, luckily, they all made it, and this is what those communities experience, and I am not trying to be a downer for our listeners but it's just the truth, the reality for these people.

[0:19:05.9] JR: What do we about it. The issue is just exponential. People in these low socio economies don't have access to healthy foods, they don't have access to healthy medical care, they don't have transportation, if they wanted to get there, their cultural beliefs don't necessarily buy into the preventative care that we suggest that they should have. I mean, there are so many compounding factors just like where do you start?

[0:19:29.4] RC: Man, Julie, you just asked the million-dollar question. I always say this thing, you can't change history, you can only course correct. But there are so many things to course correct that it would be like trying to take out every sand in the desert with a teaspoon, right? What can we do to get it going? Well, we got to galvanize, we got to encourage them, we got to do as black people, I say this all the time, we got to do something.

We got to change certain things within us. Number one, we got to start taking our health serious. I get it, we got to work, we got to keep a roof over our heads, we got to pay the bills, I get it, but if you can't go out there and physically do that, everything goes away anyway. So, your health has to come first. When they say your health is your wealth, we got to invest more stock into our health and number three, we got to start really looking within ourselves and educating ourselves on how we can be better for us.

By being better for us, we can prepare ourselves for the success that is going to come our way once everybody else says, "Hey, we get it. We got to move forward now" and I think it starts there, but I'm not leaving other people off the hook. They've got a big role in this. You know, I am just saying the little things that we can do, but the big thing has got to come from other

people. Some of those societal, I am going say, structural racism that's embedded into society, we got to start fixing some of these things.

Why is it that there aren't proper supermarkets in these communities? Why is it that they don't have banks? Why is it that they don't have proper healthcare? One thing COVID taught us in this country, we can afford to give everybody in this country healthcare if we wanted to. I'm sorry, but we can, right?

[0:21:06.2] JR: Right. Well, that's interesting. I mean, that's interesting so I mean, just for a second to talk about kind of a silver lining of COVID is we did, we learned a lot of lessons and one of them is that public health has been talking about this for a really long time is that we have to look at these inequities and try to level the playing field a little bit. We can't just continue down this path because it's not fair.

First of all, it's not fair. Second of all, people are dying. Thousands and thousands of people are dying because we're not figuring out how to take care of them. And I mean, worldwide 80% of the vaccines have gone to upper or upper middle-class people worldwide.

[0:21:41.0] RC: That's sad, isn't it?

[0:21:41.7] JR: I was reading something about from the Gates Foundation, it said less than 1% of the doses have gone to low socioeconomic communities. Less than 1% of vaccination doses have gone to those, and that's worldwide though, that's not just US, right? But that's not okay. That right there is such this incredible inequity.

[0:22:00.2] RC: Every one of us who are able to or are better equipped, I should say, to fight this virus off and protect ourselves and our family from it, we need to take a step back and think about those who couldn't and why is that? Why couldn't they do that? Especially the children and the elderly, why couldn't they protect themselves in these communities? What happened there? Think about some of those things, just think about some of the privileges that we had, right?

Try to figure out how we can extend some of those privileges to those who don't, because COVID affects us all but it effects some much, much, much harder, the impact on others is much greater than it is on us –

[0:22:39.2] JR: Right, it's the flu, right? It's not the cold.

[0:22:42.5] RC: It's not a cold, it's the flu. Like you said, you know, when white folks get a cold, black folks get the flu, and then of course, when white folks get the flu, black folks die, right? That's what's happening, right? What can we do, those who are better equipped to make sure others are better equipped. I think we just got to exercise more empathy, man, and when you see something that's not right, you have to call it out and be an advocate for it. You just can't sit back and be complacent because all you're doing is adding to the problem. I'm going to tell you this right now.

So, how do we course-correct? I said it, I'll say it again, you cannot change the past, but you can course-correct for the future. We have to think about giving everybody in this country equitable healthcare. We have to think about giving people a living wage, housing.

Do you think if a lot of these multigenerational houses were there, would the seniors be interacting with the young children and they're passing these germs onto those who are more — because you said, the data was there. The older you are, the higher your mortality can be if you get this virus.

[0:23:43.8] JR: Yeah, one in 35.

[0:23:45.1] RC: One in 35, so we have to really look at some of those things and figure out those policies that made these things happen and create policies, as the person where this is your real house, you know, behavior health, healthcare, this is your real house. If you and I know this is a huge question but how – if you could do something to correct the system, what would you do?

[0:24:09.1] JR: Yeah, I mean that's a tough one. I think what you mentioned, you know, the activities that we can do at the individual level, both as somebody who's black or brown, as well

as somebody who wants to be an ally to somebody who is black or brown, at that individual level, those were really great suggestions of a place that we can start. I think it also has to though, I mean we have to attack it on multiple levels.

You've got this individual level that you really spoke to, and then there's what we can do with the organizational or the institutional level and then there's policy level. When you're talking about healthcare for all, that's more of a policy level thing so in my head, I try to separate things so that I can wrap my head around it, but the individual level, people need to start looking out for each other and taking better care of their own personal health and helping other people take care of their personal health and within the community, support each other.

At the organizational level, I think that organizations need to begin to look internally at their processes, at their organizational policies, you know. Medical doctors need to learn how to work with people of other ethnicities and recognize the value in that and understand their own bias. Organizations need to do things like change their policies around when somebody shows up 15 minutes late for an appointment and they no longer can see the doctor.

[0:25:25.2] RC: Wow, yeah that's ridiculous.

[0:25:26.7] JR: They took like two buses to get there, and they get turned away at the door, you know? That's not okay, but that's the way that a lot of services are provided in low socioeconomic communities. It's this lack of respect and empathy for understanding what it took for that person to get there and then at the policy level where we really need to look at the way policies are crafted to be more equitable and we're able to do that now.

I mean, the Whitehouse has said that we're going to be looking at everything with an equity lens in every action, so that is really encouraging. We are in a different space than we've been at for a really long – since, you know, reconstructions, but we're really in a different space. I think that one of the things when I talk to people about this, and you talked about structural racism, people, when you speak about all redlining and lack of access to healthcare and lack of access to –

[0:26:13.2] RC: Food deserts, yeah.

[0:26:13.9] JR: Food deserts, when you look at all these different arenas, it gets overwhelming because you think like, no matter what I do, we're not going to move forward. You know, in my head I was doing a presentation to system leaders and funders in the behavioral health field, and I said, "You know, look, there are all these issues going on in every arena, but if we just focus on our space."

I was speaking to behavioral health professionals, "Let's just work at the inequities within the behavioral health system and let's make that system run in a way that everybody is receiving equitable care, and if we can just do that in our system and somebody else can do that in their system when they are focusing on physical health, and somebody else can do that in their system when they're focusing on child welfare."

"If we all, at the same time, simultaneously, in a parallel process, we're able to work on our own systems, we might actually be able to make a collective step in the right direction."

[0:27:04.6] RC: Wow, I like that.

[0:27:06.3] JR: I don't know if it's possible but –

[0:27:07.7] RC: You know what? It takes time, it's going to take time and like we say, collectively we can do this together and it's going to take us collectively working together to make it happen.

[0:27:20.1] JR: Absolutely.

[0:27:21.8] RC: It's a heavy topic Julie, thank you for this.

[0:27:23.8] JR: I love bantering with you. What do we want to talk about next time so we can just let our listeners know what we're going to talk about next time?

[0:27:29.6] RC: I think we need to stick on this topic, this behavioral health topic.

[0:27:33.6] JR: Okay.

[0:27:34.2] RC: Because I think it's something that we neglect. We talk about physical health but the stressors that we deal with every day, mental breakdowns that are happening so frequently now, we need to talk about some of the structural inequities, I should say, or racism if you want to call it that in the behavioral health system.

[0:27:50.2] JR: I think that's a great idea because, more so now than ever, everybody is experiencing some level of stress, which is impacting people and their mental health. I mean, people are talking about the stigma around mental health has really decreased a lot, because everybody's experiencing them on some level, or can relate to it and so I think that would be a good thing to talk about. Let's talk about mental health.

[0:28:12.7] RC: I think so too. Well Julie, this has been a great show. I think we should thank our sponsor again because without them, we couldn't do this.

[0:28:19.9] JR: Okay. Absolutely, I love to thank our sponsor *The Accidental Suffragist* by Galia Gichon. Again, it's available at Amazon and bookshop.com, highly recommended book. Very impactful for what we're talking about, you know, dealing with inequities.

[0:28:34.9] RC: Absolutely and we thank her for her support and most of all, I want to thank the listeners and remember, be good to each other.

[0:28:42.0] JR: Bye.

[0:28:43.0] RC: Bye.

[END OF DISCUSSION]

[0:28:45.1] JR: That's our show for today. We hope we inspired some of our listeners to engage in meaningful conversation about race. We want to thank our sponsors again in the historical fiction novel, *The Accidental Suffragist* by Galia Gichon, available for sale at Amazon and bookshop.org.

[0:29:00.6] RC: Most importantly, we want to thank our listeners. Tune in next time as we discussed structural racism in behavioral health. Thanks again.

[0:29:09.5] JR: And remember, be good to each other.

[END]