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0:00:06.3 Jennifer Rogers: From the California Prevention Training Center in San Francisco, this is Speaking Frankly: The State of Sexual Health. We know good sexual health doesn't just happen, it's created. In this series, we're starting the conversations we should already be having. We'll speak with experts in the field about sex, stigma, and all of the other factors that shape our sexual health and our everyday lives. I'm Jennifer Rogers.

0:00:31.5 JR: Ana Delgado is a nurse-midwife and clinical professor at UC San Francisco's Department of Obstetrics, Gynecology and Reproductive Sciences. She's also Assistant Director of Inpatient Obstetrics, and Co-Director for Anti-Racism, Equity, Inclusion and Structural Change. Today Ana tells us why acknowledging racism in healthcare can be hard for some clinicians, because it's an inherently healing profession. She also says healthcare extends beyond the hospital setting, and clinicians must work to address structural issues, like environmental racism, police brutality, and inequitable socio-economic conditions, as they all contribute to individual and community well-being. Ana identifies as a cisgender, heterosexual woman, and white and Latinx immigrant, who carries significant skin color, educational, and class privilege. Thanks so much for joining us for this episode, I hope you enjoy it.

0:01:34.6 JR: Earlier in the spring, you published an op-ed related to white supremacy in healthcare. And what I found very interesting and important is your writing really highlighted the intersecting factors that we see in healthcare that contribute to poor health outcomes or less desirable health outcomes, like poverty and COVID and race, and I really appreciated that you included all of these different social determinants of health, if you will, to paint a holistic story. And I wanted to ask you, what was your ultimate aim of this piece when you were writing it?

0:02:27.1 Ana Delgado: Well, it's been germinating for some time, and I think the COVID pandemic just gave me the opportunity to clarify or crystallize some of my thoughts. For the most part, my main goal was to kind of refute the scarcity model of social justice organizing that sometimes pits one community, one marginalized community against another, while ignoring the root cause of inequity, which in this case is white supremacy and, in this particular context, in healthcare. And so I really wanted to paint the picture that although Black and Indigenous and other people of color have different reasons why they're oppressed in the US and the impacts are different, depending on the inequity in question, the root cause is the same for all and that it is really white supremacy that's the problem. And as long as the conversation continues to be about who's more oppressed, or as Angela Davis famously said, the Oppression Olympics, we will not get anywhere, because white supremacy will continue unabated.

0:03:52.0 AD: And in healthcare, in particular, it's really important to identify white supremacy as a structural problem, because many people assume that because healthcare is kind of a social good or a healing environment, that it's immune to the effects of white supremacy, but that is... Unfortunately, couldn't be further from the truth. The way that the healthcare system evolved in the United States was very much linked to the development of all the other political and social structures in the US, which are unfortunately very well rooted in our legacy of chattel slavery and displacement of Native American people, and frankly genocide in that respect, and also capitalism and the for-profit model that grew from all of that early foundational influences in the development of the United States.

0:05:08.3 JR: This has been on my mind a lot, so I'm sorry if this is catching you off guard, but it's related to what you just mentioned in terms of the role that capitalism plays within the way that we see racism today in healthcare. And I wanted to see if you can talk a little bit about that, because I feel like that link is something that's not highlighted enough.

0:05:32.9 AD: Well, I think this really came together for me after reading a piece by Ta-Nehisi Coates about the origins of racism and the reality that racism is the child of capitalism, not the other way around. And so, when I started to explore the history of race as a social construct and where racism came from, it really came out of the need to justify the subjugation of enslaved people to... For the purposes of profit. And so that kind of foundational step that was taken and, frankly, was aided and abetted by people who describe themselves as physicians and other healthcare professionals, where folks began to try to codify a biologic difference between the races in order to justify their deplorable actions.

0:06:44.2 AD: And so the foundational pieces of American healthcare really came out of the need to protect certain economic interests, so keeping enslaved people and the working class healthy enough to work basically, and then the growth of discovery and science within healthcare was really predicated on the backs of Black and Indigenous folks through experimentation openly. There's obviously a lot about this in OB-GYN in particular, and this can be seen all the way up through in the New Deal and expansion of Medicare and Medicaid, thinking about the integration of hospitals and how that took place. And that was really forced, because of Medicare and Medicaid, which was about profit, it was about hospitals needing to get the reimbursement dollars that were being put forth by the government. And so it was, again, sort of another example of how profit really drives our healthcare system and not necessarily morals or the imperative to create a healing institution.

0:08:25.1 JR: You are in a healing profession as a clinician, and when we were prepping for this interview, you mentioned the notion that, for folks who are healers and identify as helpers of our communities, it can be challenging to look at these racist biases, and an undercurrent of racism, and the foundation of what the healthcare system has been based on. And I wanted to know, given that, how do you see clinicians around the country kind of grappling with this truth of racism, and what are the barriers that you see folks have, generally speaking, in addressing it actively, as you certainly have committed your time to do?

0:09:36.7 AD: Yeah. That's a great question, and I think it's one of the more challenging...

0:09:40.6 JR: It's a big question, I'm sorry.

0:09:42.6 AD: Yeah, it's one of the more challenging aspects of what... Of the work that's before us as healthcare providers is that there is this, again, this assumption of good intentions are good enough in healthcare, and the fact that you're trying to help people gives you free pass or permission to not really delve deeper, interrogate a lot of these issues that are both on the individual and on the systems level. And even just starting with education of healthcare providers, and the fact that in many parts of the country and including in some classrooms, even here at UCSF, race is still being taught as a biological construct. So, folks, despite the Human Genome Project and the realization that there's more differences between people who are categorized as Black than there are between Blacks and whites, that scientific proof has still not eradicated these teachings from our institutions. So that's problematic.

0:10:52.1 AD: When you start putting forth this idea that there's these biological differences, it really permits you to then discount and ignore the social construct of race and how that has been developed, again, over time for the purposes of creating power and profit for those on top, which in the United States has been traditionally white folks and more specifically white men. And so the ability for healthcare providers to really take that long look in the mirror and really start to interrogate what we've been taught and what we haven't been taught. So many of us came into the work from a very narrow standpoint of either being very scientifically oriented, very much about the more stereotypical science or caring, healing, diagnostics, therapeutics, the very narrow definition of what healthcare is, which is gonna already put you at a disadvantage in addressing racism, because racism expands beyond the exam room or the hospital operating room, or wherever you might be working, or the research bench or wherever it is, because it's a social construct that permeates every institution in our society.

0:12:15.7 AD: So, if you're unable to see how all of those other factors influence the setting that you're operating in, if you're not thinking about how race is a social construct and racism has impacted the patient in front of you in that operating room, for example, then you're not gonna be able to actually address the health inequity that that person might be dealing with. And that is something that, I think, healthcare providers really have to grapple with. There's so many examples in the popular press. Most recently there was the Journal of the American Medical Association podcast scandal, where physicians were on record saying that there is no racism in healthcare, and there's no racist physicians. And that is just absurd. And it really, I think, revealed a very common misconception amongst physicians and other healthcare providers that, as long as you're... Again, have good intentions and say that you're "not racist," then that's enough. And I think there's a lot of us now who are realizing that, as Ibram Kendi says, it's not enough to be not racist, you have to be anti-racist in order to combat these issues.

0:13:34.5 JR: I love that you said it's a social construct that permeates every aspect of society, and going back to my first comment when we started the interview, that's just something that I really appreciate about the writing that I've seen you do. I wanna read a quote, if that's okay, from the op-ed that was in Business Insider. And just so folks know, the op-ed is named, 'To effectively defeat the pandemic, we have to tackle white supremacy in healthcare'. The quote is, "Evaluating a Black woman in labor, alone due to restrictions on visiting in our triage unit, I imagine what it must have been like to enter into a space where statistics show you have a two to three times higher chance of death, and to make things worse, you're alone. A white woman in that same situation would likely not be carrying the weight of that fear and would be more likely to be cared for by a care that more closely reflects their values and their community." What comes up for you when I read that?

0:14:46.6 AD: I think it really drives home the fact that race is always at play for people who are racialized in our society. So, for white folks who have had the privilege of living most of their life without really having to think about their race or even identify their race, many white folks I've interacted with around this have had struggles with actually even saying that they are white, getting the words out of their mouth is a struggle, because they've actually never had to identify themselves that way in a public setting. Whereas Black folks, Latino folks, Asian folks, Indigenous folks have been racialized from birth. And so, the fact that we, in healthcare, feel like we can decide when race is an issue and when race is not an issue is a fallacy, because race is always an issue for people who are racialized. And particularly in the setting of the maternal care, Black and Indigenous women are the ones who are most likely to have these inequitable outcomes primarily. In this case, we're talking about maternal mortality and death. That fear and that knowledge is not something that you can turn on and off. It is with you and, unfortunately, does impact you regardless of the actions of your care team. Obviously, it's gonna be worse if you are also picking up on biased or racist actions or behaviors.

0:16:27.2 AD: For around the question of workforce diversity, it's not enough to have a diverse workforce. Obviously, that workforce also needs to be interrogating and assessing and dealing with these structural barriers, and yet, the literature supports time and time again that racial concordance does improve outcomes for folks, and that certainly, in my anecdotal and personal experience, patients have shared many times with me the importance and the positive impact it has on them when they see people who look like them and reflect their community and their values.

0:17:10.0 AD: Let's say you have a patient population that is 70% white, 20% Black and 10% Latinx. If you were to diversify your workforce in proportion to the patient population you're serving, you would still have 70% of your staff be white. And when we look at the impact of that lack of representation on Latinx and Black folks, the impact is much more than it would be on a white person who does not see themselves represented in their care team, because white people see themselves represented everywhere else. So, the lack of representation is more acute. And that is one of the struggles that people have with the concept of equity, is that equity doesn't actually mean give everybody the same, it actually requires us to uplift and give more to the people who have been historically oppressed.

0:18:12.6 AD: And so that requires sometimes an approach that may feel "unfair" if you're in the position of the white majority, where you have always had what you need in abundance, without really thinking about it. And so that issue representation is really important, and it's not so simple as lining up percentages across the board.

0:18:36.0 JR: Seeing yourself represented, is not just about equity of numbers. Seeing oneself represented has such a psychic impact on the folks who experienced that, because I think that... For instance, with the election of Kamala Harris, it's clearly extremely important for a variety of reasons, but what that means emotionally, mentally, and psychically for folks who see themselves in her, does so much more, I think, than any one of us can realize, for what we each think is possible in the world for ourselves. So I guess my point is, if you don't see it, you don't think it's possible, and then you're inherently limited, and that limitation is something that affects the mental and emotional and psychological development of oneself. And so, when we talk about racial inequities, it's not simply folks can't realize a job opportunity or are less likely to feel comfortable in certain spaces, it's an every day all the time emotional burden on one's shoulders, as someone suffering with PTSD, not to equate the two, apples to apples. But do you know what I'm saying?

0:20:18.4 AD: Yeah. Well, and I think when you're talking about the environment of healthcare, which inherently comes with a lot of power differential between care team and the patient and their family, and a lot of vulnerability, there's hardly anything more vulnerable probably, than child birth for people who are having children. So thinking about how much more acute or pointed that impact is, in those situations, I think is really, really critical. We have plenty of examples of people who have a significant amount of knowledge and privilege because of their education or their class, their economic class, going into healthcare settings as Black folks and suffering the exact same outcomes as folks who are less educated or have less class privilege. And so, just time and time again, we have examples of how these impacts are very differential, depending on how you are racialized.

0:21:38.9 JR: What do you want folks to understand, about the ways that these intersecting identities and these intersecting social determinants of health contribute to poor health outcomes?

0:21:54.0 AD: Well, first, I think I have to credit the Black women who came up with the Framework of Reproductive Justice, for my growing understanding of this whole sort of domain, because the concept of reproductive justice, although I didn't come upon it officially by name until probably within the last decade, I came to my work as a social justice advocate, I came into midwifery with a background in political science and that organizing and was not a healthcare provider from the beginning. I came to the work from a different angle, and I used to see that as a liability, because it's not really very talked about or something that is thought to be good on your resume or good on your CV as a healthcare provider...

0:22:53.6 JR: But in reality, it's a benefit.

0:22:54.8 AD: When you talk about your background.

0:22:55.4 JR: It's a benefit.

0:22:55.5 AD: Absolutely, absolutely. And that's... I think there's a growing understanding of that. Just thinking back to a few years ago, when at the American Public Health Association Conference, they declared police violence a public health crisis. This idea that we are starting to understand that, understanding these societal factors that contribute to health, to the health of various populations, is really a critical part of our role as healthcare providers, and so I feel now very blessed that I came into the work in that way, and when I kind of stumbled upon Reproductive Justice Framework, it really kind of connected so many dots for me or a deep intuitive feeling that I'd had for many years. And so, I view my work very much through that lens and I try to use that as a sort of an accountability tool for myself, around how I'm approaching my work, both clinically, in my service administration role and health care administration, as an educator of future healthcare providers, as a community advocate, and remembering that it makes no difference if I attend the safe birth of a child, if 10 years later, that child is gonna be gunned down by the police.

0:24:29.5 AD: For that family, the work that I did in that labor room, is irrelevant at that point. And so, there's been calls for healthcare providers, the NRA famously told healthcare providers to sort of stay in our lane when there was a big push back against gun violence, and I think, rightfully so, that really enraged a lot of healthcare providers, because many of us say, "No, that is our lane," our lane is addressing, naming addressing and really working tirelessly in these areas, to address these things that ultimately do impact our community incredibly. And again, it's just worthless to be working on all of these therapeutic treatments for cancer and dealing with prevention of HIV and all of these things, if we're not actually addressing the structural issues that are really determining health for many folks. Environmental racism, why are pollution levels and garbage dumps and factories disproportionately located in communities of color? Why does Flint still have water that is undrinkable? These are the kinds of questions that directly impact health, there's a straight line connection. So we must address these issues. And...

0:25:51.7 JR: And it's really interesting, we can't afford to not pay attention to them, and it brings up for me, just a culture of siloing that we do. I think what a lot of folks are kind of catching on to now and inspired in part, by kind of a more Eastern medical philosophy is, total body wellness and just the idea that we can't silo the physical body from the mental body, from the emotional body, in the same way that we can't silo, like you said, you delivering a newborn from what that newborn's environment then is, 36 hours later when they go home and what their life trajectory looks like. So I feel like Americans and our culture is... It's hard to operate because we're really based on something that's very fragmented, and it's a disservice, and we have a hard time wrapping our heads around the enmeshment and entanglement of every aspect of society, and that's how I see the truth about our culture.

0:27:17.6 AD: When we talk about the impact of stress, for example, chronic stress on the human body, there's actually well-documented scientific evidence that there is a biological impact. So that's an important distinction to make. Some people get twisted around this idea, "Well, if race is not biologic, then how can these biologic differences be noted?" And I think it's a question of the origin of the difference. So when you think about the chronic stress that a Black woman or an Indigenous woman is exposed to, over the course of their lifetime, they're not gonna necessarily have the same cellular resilience, for example, at the cellular level that a white person, who perhaps even had the same education and economic class, because they don't have this impact of the chronic stress of racism, and it's really...

0:28:16.0 AD: When you think about it that way, it's to me, really a story of strength and incredible capacity, that these communities continue to thrive despite this 500-year history of colonialism, chattel slavery, displacement and genocide of Indigenous people, capitalist expectation, that you still have communities of BIPOC folks here in the Bay Area even, we have a tribe of Ohlone people in the East Bay, who are not even federally recognized because they're so displaced, they don't even have a federal designation, and yet they're still thriving and kind of coming back and trying to reclaim that land in the East Bay for their people.

0:29:10.1 AD: And you think about that, and the fact that they still speak their native language, and I think it's just remarkable, I think it's just incredibly a testament to the strength of these folks, that they're able to persevere despite all of this. I think it's a fine line, 'cause again, you wanna make sure that folks are not... It's a fine line between saying that there's an impact of chronic stress and trauma, and then drawing the conclusion that people are damaged. So it's... To me, there's a very specific, nuanced kind of way to pull that conversation that I think most people don't have the capacity. I find myself sometimes falling into traps of sort of either/or thinking and things like that, where... I've recently heard a Black colleague talk about the amount of joy and celebration and happiness and love and contentment that she experiences and not wanting that part of her story to be erased.

0:30:17.6 AD: And so I think there's kind of a dehumanization, whenever we distill anything to one thing. And so we wanna make sure that we're viewing people in the fullness of their whole lives, which is one of the great things about reproductive justice, again, seeing people come together in a very difficult time during this pandemic, for example, the amount of mutual aid organizations that have risen up from the community to take care of the community. And so I think, to the extent that we can think about how do we actually uplift those types of efforts, as opposed to us at an institutional level, always thinking we have the answers, how do we just get out of the way in some respects is really, I think, an important thing for us to think about.

0:31:12.9 JR: I wanna ask, what other strategies, based on the work that you do, would be helpful to be employed within UCSF or any other health care system, to address the issues that you've been discussing today? Where do we go from here?

0:31:36.2 AD: Yeah. I guess in addition to this idea of uplifting community solutions, I think one of the things to think about is, "What are the structural areas that are impacting your particular community?" I think we get in a little bit of a danger of that analysis paralysis, where we're data collecting until the cows come home and we don't actually ever get into the action stage. So I think it's important to not wallow too much in that, because there's so much literature kind of worldwide, about health inequities, that I really get frustrated when people are like, "Well, I looked at my own data and I just couldn't find an inequity," and I'm like, "Really? I think that's a fault of the data, not because of the inequities." And so thinking about action and actually impacting structures, I think you do have to do some data collection to understand what's happening in your community, but then to really be led by the community around what are those next steps.

0:32:38.0 AD: So for example, in our community, we're looking at our work around the kind of policing of families that historically has happened in the child welfare system, because the community has told us that this is a concern they have, that... We've had people come and give birth where they are... The entire time they're in the hospital, worried that someone is gonna call Child Protective Services and take away their infant, and that the relief they have when they get home and are able to close their door behind them and be home with their child, is just immense. And I think about... Referencing back our conversation about the stress and the reality that people carry with them into the birth space, that's real. We wonder why people have a prolonged labor, why would you wanna give birth to this infant that someone can then just take away from you. While that baby is inside of you, that baby is safe with you.

0:33:32.8 AD: And so, thinking about all of the ways in which this impacts even just the normal physiologic process we're trying to shepherd through, the birth. And so, when we think about next steps, it's not just about, "Okay, how do we better treat hemorrhage?" Of course, that's part of the picture. We don't want folks having excessive blood loss and hemorrhaging, and at the same time, if our focus is narrowly on, again, what's happening specifically in the biomedical model, we're gonna miss all of these opportunities to improve health and outcomes for the community. And so, we're looking at this issue very closely, we're looking at our urine toxicology testing policies, we're rewriting them to really try to limit the role of bias, particularly racial bias, and who gets a urine toxicology test, we're looking at our practices with our Child Protective Services system here in San Francisco and thinking about how can we really limit the kind of criminalization and policing of families that is often the result of, again, these "innocent" or well-intentioned acts on the part of healthcare providers, where we don't really think through what is the ultimate downstream impact of these actions on these families.

0:34:54.3 AD: I recently read that women are one of the fastest growing populations in jails and prisons, and a lot of it is related to substance use related "crimes". And so, when you think about the impact that has on families and then on those families health and all of that, downstream from that, you really start to realize, "Okay, I really need to take this all into context when I'm thinking about the person sitting in front of me in a prenatal visit or in the labor room, so that I'm not artificially narrowing or excluding factors that really are of prime importance to that person, for their own health and well-being and their capacity to thrive and the capacity to have a family that is thriving in their community."

0:35:48.1 JR: I'm really happy that you brought those issues into this conversation and all really underscoring the fact that all of these factors need to be weighed and considered, when helping healing, when helping patients and caring for patients and when interacting with one another as human beings, whether you're in a room for care, or if you're on BART or on the street. So I appreciate that.

0:36:22.3 AD: And thinking through that piece, remembering that there is a racialized component to that, that... The example of the "opioid crisis", as compared to, let's say, the crack epidemic of the '80s. So thinking about the sort of compassionate response and then frankly, snow blower amount of cash being thrown on the opioid crisis, which is primarily... Which is really a crisis that it goes across many demographic groups, that has impacted a lot of white folks, and then compare that to how the crack epidemic was handled back in the '80s and the criminalization and stigmatization, and frankly, disregard and discarding of an entire generation. Really, when you talked about that intergenerational impact, we think about between the mass incarceration and the policing of families and the removal of children from their homes, that is literally like... We have a lost generation of folks, in that regard, and it's just incredibly stark to me, that that was what we did back then, and now we're having this "compassionate response" to the opioid crisis, and it feels like such an obvious example of how racism is at play all the time, unfortunately.

0:37:44.3 JR: And it's hard to... Hard but certainly not impossible, depending on when you're born, and to get the whole picture, because history takes just naturally a long period of time, so you have to have been aware of what was happening in the '80s, and it would have helped if you were an adult, to then weigh what happened then to what's going on now. And so, I think that's one of many reasons that research and doing one's homework and investing in the investigation of these topics, is so critical and really the responsibility of each individual person, to do that. So I wanna be cognizant of time, and I just wanna ask you if there's anything else that you'd like to add, or what have we not talked about, that you want folks to know about your anti-racist work?

0:38:40.2 AD: I guess, for me, one of the key messages that I carry with me on a daily basis and is a constant in my steps forward, is just the great humility with which I come to this work. I have made many mistakes in my career, in this area, in this domain, I don't pretend to have all the answers and I don't believe my understanding or my... The place that I have arrived at this point, is due to my own kind of hard work, it's definitely, like I said, on the shoulders of primarily, women of color, a lot of reading from the social sciences, my background as a community organizer, all of that really coming and coalescing now, with the... I do have the privilege of being in community with some amazing people, here at UCSF, people like Dr. Karen Scott, people like Dr. Monica McLemore, who have really taken the time to be in community with me and my incredible learners, the midwifery students that have come up in the last few years and have really been incredibly instructive to me, as I grow in my understanding of what my role needs to be here.

0:40:05.1 AD: I just have immense gratitude for them. And then finally, my patients in the community, I would be nothing without the families that I have been privileged to serve over the last almost 20 years now, as a midwife here in San Francisco, and the trust that the community has placed in me, and coming back to me for multiple pregnancies and seeing me both as a member of the community and as their midwife. I think it's been incredibly rewarding and one of the... Will always be one of the hallmarks of my professional career. So I think just remembering that I'm not alone in this work, there's a whole community behind me and in front of me, for that matter, [chuckle] and I'm just really privileged to be able to be in this space.

0:41:07.6 JR: Well, on that note, I wanna thank you so much for your time, and I'm really just blown away at your work and your perspective, and hope that folks listening will take it to heart and that we've planted some seeds, based on the amazing work that you're doing. So thank you, and all of your colleagues, as you said, because it is not a singular effort by any means.

0:41:36.7 AD: Yeah. Thank you so much.

0:41:37.2 JR: A special thank you again, to our guest, Ana Delgado, nurse, midwife and clinical professor in the University of California, San Francisco's Department of Obstetrics, Gynecology and Reproductive Sciences. Speaking Frankly is a production of The California Prevention Training Center in San Francisco, California. It's produced by me, Jennifer Rogers and Laura Marie Lazar, and is edited by Podcast Prowess. Stay tuned for our next episode, when we'll speak with JaDawn Wright, of the Pacific AIDS Education Training Center or PAETC, about sex positivity and why language is so important if we want to create a more inclusive society. Thanks, everyone.