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Invisible visits: Black middle-class women and the U.S. healthcare system

Prof. Peter Sobota [00:00:02] And Ralph Ellison wrote. "So after years of trying to adopt the opinions of others, I finally rebelled. I am an invisible man." Hi, everybody, and welcome again to the InSocialWork Podcast. I'm Peter Sobota. Good as always to have you on. It appears that history accompanies black women into the positions. Examining the conventional wisdom holds that as a person's socioeconomic status increases, the quality of health care access and outcomes increased. But not so fast for middle class black women. On today's show, our guest, Dr. Tina Sacks, discusses her work with a largely unstudied population of the black community. Specifically, she'll describe how middle class black women resist, adapt and have their own behavior influenced by racial and gender discrimination, especially when they seek health care. Dr. Sacks will tell us about her research in which black women who are not poor describe their experiences with health care providers and the lengths that they go to overcome the barriers they face trying to avoid race, gender and other forms of discrimination. Dr. Sacks will describe the specific stereotypes levied against black women as they navigate their health care. Then, as if to add insult to injury, she'll outline the strategies black women use to attempt to minimize discrimination, including emphasizing their cultural health capital, which is defined as their capacity with medical terminology and overt signaling of socioeconomic resources. Finally, Dr. Sacks argues, these data suggest that the very strategies that black women are using to resist discrimination are experienced as an additional form of stress that only further negatively affects their health. 18 oh. Welcome to Social Work.

Prof. Tina Sacks [00:02:25] Hi Peter. Thank you for having me.

Prof. Peter Sobota [00:02:27] Oh, no, it's our pleasure. Thank you for agreeing to talk with us. So today we are going to talk with your work studying black middle class women in the American health care system. But before we get rolling, and if it's okay with you, what I've been doing is I've been asking our guests like how they came either to their profession or to their work. Almost always a story. If you would be willing to do that. We do have to hear it before we get into the you know, into the data.

Prof. Tina Sacks [00:03:03] Sure. No, I'd appreciate it so much. So I came to this work from it, like many people from my own personal experience. Growing up in the Midwest. In Chicago, I am from a mixed race interfaith family. So my mother is a black woman from Mississippi who came to Chicago as part of the Great Migration. She was raised in the Jim Crow South, grew up picking cotton and had a very beautiful and very deeply challenging life. And really faced all of the kinds of things that we talk about now is structural discrimination and structural racism or just just in every aspect of her life. She she came to Chicago. She met my father, who is a first generation Russian Jewish man. His family came from what is now Bella Russia, Belarus. They were they came to the United States through Ellis Island to escape anti-Semitism. And we met in Chicago in the legal system. My mother was a court reporter and my father was a public defender at that time. And growing up in that kind of family, the sort of the similarities and differences between people were always on offer, always just right in my own home became very clear to me that some things were really universal. Some things were so similar that my parents backgrounds in some respects were similar in that they were. They both were in many ways forced migrants. My father's family had to come to escape anti-Semitism to the United States. My mother's family had to flee the Deep South to get away from the kind of just day to day violence that she experienced and that her family experienced. And and yet their experiences in the world in the United States diverged quite sharply from those

similar beginnings in that my mother still was walking around in the world as a woman, in a black woman without a lot of education. My father was still walking around in the world as a white man with a law degree. And so their their experiences really departed from one another. And when my mother got breast cancer, when I was at a late teenager, I was in college. It really made me start to wonder about how her experience. Was different from other people, other people in my own family. And that really led me to consider this idea of health. How race and gender and class and immigration status affect health and how our systems are set up to either facilitate people's experience of healing or constrain it. And that's really how I began to, you know, become interested in in psychology and in social work, in social policy and later in health policy.

Prof. Peter Sobota [00:06:20] Say. I'm so glad I asked. Wow. I'm not even sure what how to react to that other than. Wow. And it fits the work. Perfectly it. Thanks for being willing to tell us about that. All right, let's see. To start off. There's there's a fair amount of data and work on the social determinants of health and some pretty well documented disparities already. But I'm curious why I'm a little less curious now that I've asked you your background, but I'm still curious. Why did you decide to put. Middle class black women at the center of your research.

Prof. Tina Sacks [00:07:16] So that's the question, the million dollar question that that people ask all the time. And so. It began. Also, of course, there's always a story. As I just mentioned, my interest in health sort of emerged naturally from my own family. And once I had gotten my master's degree in social work, I and I specialize there in health policy. During my master's program, I went to the Centers for Disease Control and Prevention as a fellow. So I was working in Atlanta and I was exposed to all, you know, these public health and epidemiological patterns, ways of thinking about health, and certainly was always interested, even even then, in racial and ethnic disparities in health outcome. And I had a few conversations there as well with many of my colleagues who were other women of color with master's degrees, professional women who, you know, would describe to me their experiences of going to the doctor in Atlanta. And one of the things that they would often describe was, you know, in Atlanta, the CDC is a very large employer. And so everyone in Atlanta knows what CDC is. And at the time we worked there, I don't know if it's the case any longer. You had to wear a physical badge with your photo on it. My colleagues would tell me, my friends and colleagues would tell me, you know, every time whenever I go to the doctor, I try to keep that badge on for as long as possible before I have to disrobe. And, you know, it was clear to us why we really didn't even have to say anything about why unspoken. It was unspoken. We all understood why. And yet, you know, we would talk about, yeah, I really do try to just let them know, you know, I have a good job and I have a good, quote unquote government job. I have a good job. And also I know something about health because I work at CDC and I want to signal to the provider that I know something, that I have this specialized knowledge, that I have a certain certain level of social standing by working at CDC. And so those kinds of conversations got me really interested in what the experience, sort of the experience of the health care encounter was like and what that meant for women, black women and other women of color who were not poor because none of us were poor. All of us had master's degrees because you can't even you can barely get in the door at CDC if you have anything less than even less than a Ph.D.. A master's degree is really sort of the bare minimum. So we were all what we know. We would be considered highly educated, and yet we all knew that when we went to the doctor that we were fighting against a certain type that we were kind of from from the very beginning, jockeying to sort of secure a certain kind of standing credibility or relevance with the health care provider that we were going to see. And those kinds of stories made me wonder about what the empirical data had to say about that. And

so, you know, this was before I got my Ph.D. but it made me very curious going into. It's one of the motivating factors of why I wanted to get a Ph.D.. And so it turns out it's still the case that.

Prof. Peter Sobota [00:10:45] There was none.

Prof. Tina Sacks [00:10:47] No, there wasn't much, but there was some.

Prof. Peter Sobota [00:10:49] A middle class black women.

Prof. Tina Sacks [00:10:51] Well, there's there was definitely data on how. Protective or non protective class status was for black people in terms of. Health outcomes are much less so on. Health care disparities are sort of the, you know, differences in treatment once you reach the point of the health care encounter. But certainly the the seminal study in health care disparities, the Institute of Medicine report from unequal treatment from 2000 to controlled for class differences and still found that providers were much less likely to recommend the standard of care for black people. Much less likely to evaluate their their patients as able to follow medical advice, able to adhere to a particular kind of treatment program, and also evaluated their patients as much less pleasant than other other patients of similar class status. And so that made me really that really brought to light the the, you know, what many people call anecdotal evidence that I had experienced or that I had encountered among my friend group. And so then that's when I decided to go to continue and go on to study this more formally. And that's how I arrived at my dissertation topic. And then eventually my the kind of the research questions and research agenda that animate my study and my interest in this area of scholarship.

Prof. Peter Sobota [00:12:27] Well, and and the book that you that you published about black middle class women in the American health care system is is prefaced by invisible visits.

Prof. Tina Sacks [00:12:39] Yes.

Prof. Peter Sobota [00:12:41] I'm just going to ask. What are you thinking there? Y y Invisible visits.

Prof. Tina Sacks [00:12:48] Well, certainly, although I am not. Fiction writer I am influenced by by writers of all kinds. I love the written word. I love writing and books and so forth. And so. I mean, Invisible Visits is certainly an allusion to Invisible Man. Right? But the book by Ralph Ellison, so that it was something that was very important to me. It was sort of tying some of these themes that are really enduring themes about the black experience in the United States. So that's where the invisible comes in. And one way, the other way that these that I would characterize the health care experiences of black middle class women as invisible is because much of the literature, as you alluded to, is really about ethno racial minorities who are poor, who are uninsured, who are burdened by poverty and the structural violence that that causes them. So that that leads to, I should say. And so. And yet the women that I spoke to for my book, the women I interviewed, as well as with the other, the empirical evidence bears out, is that this is a real issue. This is not just something that occasionally happens, but there is an empirical pattern in which black women who are not poor, who have master's degrees, who have health and health insurance, who. Have much more than making their household income is much more than, you know, median income are still subject to the kinds of stereotypes and biases that other ethno racial minorities are subject to. And so that class status is not as protective for black

people as one might expect. And what does that mean? That puts our focus squarely on racism and sexism and misogyny, war and all of the other these other structural factors that cannot be explained away by saying, oh, these these poor outcomes that we see are really about class because they're about race, class, gender, many, many things. And so that's the in many ways that is sort of one of the central conceits of my work, is to say, if we take away this idea of class we are left with. What we're left.

Prof. Peter Sobota [00:15:16] With. Again. Again. So the whole myth of leveling the playing field around, you know, higher incomes and and, you know, higher educational achievement. Is exactly that. It's a myth. And and the show, the badges. Do the badges Help.

Prof. Tina Sacks [00:15:45] So I would say a couple of things about this. One is that. I am not. I want I always want to be very clear about this. People who are middle class, who are upper middle class, black, white, Asian, indigenous, across the board. Absolutely have more resources on hand than people who are dealing with the incredible burden of poverty. Okay. So this is this is not that I'm trying to liken it to poverty. I think that's really important because so many people in the United States are just literally don't know where their next meal is coming from. Right. So that has to be said that I am not trying to suggest that these are equivalent situations. That said, you know, does the badge work? I think it works on the margin. I think it can definitely. Help to mitigate some of the stereotypes and some of the biases, but it doesn't do away with them altogether. And so in that respect, I would say that it's it it doesn't really work. And the other the other thing is. As all human beings know, when you oftentimes when you go to the doctor, you're in a fairly vulnerable position. It's physically vulnerable. You might be sitting there without your clothes. You might be worried about something that's going on in your own body and therefore you're nervous or. And so even if it works, there is a cost to having to do that, too. Thinking about that too, trying to present yourself in a certain way.

Prof. Peter Sobota [00:17:37] That is really the crazy making part of this whole discussion. The fact that women need to kind of prepare for their health care for all the reasons you just said, for their health care visit. There's this additional burden. Will I be taken seriously? And I think I read something of yours that that some of the women that you interviewed actually spent time. Like studying their own symptomology or even their own diagnosis. To appear and to be ready to be conversant and not just avail themselves to expertise.

Prof. Tina Sacks [00:18:23] Oh, absolutely.

Prof. Peter Sobota [00:18:25] E Yeah.

Prof. Tina Sacks [00:18:26] There's a fair amount of preparation that goes into the visits that is also invisible, right? That. There is extra work. There's an emotional toll. There is a. There's just also the time it takes to do some research to try to look up certain kinds of conditions, to be able to advocate for themselves. And this is something that definitely disproportionately affects women in the health care encounter and then women of color and black women in particular, even more so.

Prof. Peter Sobota [00:19:07] Well and. I'm probably not the person to be saying this, but just the the cumulative impact of generational trauma and. Almost fundamental mistrust and legitimate fear of health care professionals. I mean, health care professionals have not always been friendly to black people. In fact, they have been callous and violent. I don't

know if you looked at this or if you studied this, but I'm going to ask anyway. Do. Do black patients. I guess I don't know how to say it other than do they do better? Do they have better outcomes? Do they? Do they experience a better quality of care when they work with black providers?

Prof. Tina Sacks [00:20:08] So this is a great question. It's typically what in the American health care space, what we tend to think about as an intervention, right. That we need to increase the pipeline of black providers. And that is absolutely the case. That said, the evidence about outcomes is fairly mixed. Some people do say that some of the empirical studies have found that there is a level of understanding of communication that it that it facilitates a kind of patient centered communication that might facilitate more listening or being able to hear the patient's concerns more thoroughly. And then therefore, you know, when you're taking a patient, a history that maybe you're listening, you're a little bit more in tune. So there's some evidence to suggest that, and there's also evidence to suggest that the the challenges are so deeply structural that simply putting a black patient with a black provider is not is it's it's unnecessary but insufficient condition. You know, it's just not quite enough to do away with these kinds of deeply embedded inequities. And part of that, I think, has to do with. First of all, there are so few. Black physicians and other health care providers. So there just aren't enough to put people in these kind of what we know in the literature are called race concordant pairs. Right. And secondly, the training that providers, health care providers receive is. Deeply troubling in many respects and deeply anti-black in many respects. And that. Goes across race like you can if you're trained in a system that thinks of black people as fundamentally different than white people, fundamentally subpar. Then you're likely to to take that on yourself, even if you are black, you may. And those kinds of messages can be internalized as what I'm saying.

Prof. Peter Sobota [00:22:19] Yeah. Yeah, I knew that was going to be complex. I mean, I've seen some of the data myself that, you know, many people of color. Are not primarily moved by having a provider. Who is that? But they're assessing competence. They want somebody who knows what they're doing. Yeah. Don't we all. Don't we all deserve that? That should be the standard. Unfortunately. Yeah. Go ahead, please.

Prof. Tina Sacks [00:22:51] Can I just add one more thing to that? Of course. One of the things that people told me that I thought was very insightful was that, you know, part of the issue here with with health care disparities and the challenges that we face in the healthcare American health care system, they really cannot be separated from the financial incentives that are built into the health care system. That the fact that providers have, you know, 10 minutes or whatever they have to spend with you, that they are they're under so much time pressure to, you know, get people in and out. And that the the fact that we don't have universal access to care put so much pressure on both providers and on patients. And so, again, an intervention that's based simply on putting, you know, a black person with in the room with a black person is not going to undo those kinds of challenges that we face uniquely in the United States.

Prof. Peter Sobota [00:23:53] Yeah. When we had our. Our kind of informal discussion with me trying to talk to you in about this. We talked a little bit about and you made reference to black women needing to make. Getting to build, I think was the right word. Cultural health capital. Could you give us a kind of a deep dive into not only what that is? And really what are the implications of that as well? That's what I remember being really struck. Even just chatting with you for a few minutes.

Prof. Tina Sacks [00:24:33] Of course. So the idea of cultural health capital is. It extends the idea of cultural capital, which is a sociologist by the name of Here Bourdieu, who developed this idea, medical sociologist out here at the at the University of California, San Francisco, named Janet Shem, really conceptualized the idea of cultural health capital. And this is the idea that in order to be taken seriously during a health care visit, a person really has to have certain forms of capital. And these are things like. And demonstrating to the provider that you are the kind of person that has dominion over there, over your own body, demonstrating that you are the kind of person who would do research about a health care condition before you came in demonstrating that you are a person who feels. Who who believes in the professional expertise of the provider, and that you're willing to take that expertise and use it in an instrumental way to manage your own body. In other words, that you would take what they tell you and listen to it that you would hear. You would adhere to a medical regime or a treatment regime. You would take your medicine on time and with your with your full stomach or on an empty stomach, or don't take it with grapefruit or whatever they tell you to do. Yeah. And that these are things that the physician is sort of intuitively assessing in the patient. Is this the kind of patient who is going to do what I tell them to do? Do they have the capacity, the capital, to do that? So if I tell them, I really think that what you need to do is get your cholesterol down. Will they eat their oatmeal every day? And if they don't seem to have that sort of capital, does that diminish the patient in the eyes of the provider? And then what happens in the course of that relationship? So.

Prof. Peter Sobota [00:26:47] Yeah, I think so. Bear with me here. So. Is part of possessing cultural health capital. Also communicating one way or the other that you are also. Ready, willing and able to complain. If you get mistreated or if you get more care that you're actually going to be assertive and you might even. Be kind of cranky in terms of. Maybe even. Speaking. Truth to power in that context.

Prof. Tina Sacks [00:27:28] So I think in the context of cultural capital, there's not so much of this idea that you would you would complain. It really has to do with can you marshal the kinds of resources that might be necessary to control your own body to exercise dominion over your own body? Right. Do you believe that you have that kind of power control or capital to do so? So it's not necessarily about complaining or simply being assertive or advocating on your own behalf? Mm hmm. But there is some there there are some empirical studies that suggest that providers, while they may like that, they may find that to be a. A positive attribute.

Prof. Peter Sobota [00:28:19] Of.

Prof. Tina Sacks [00:28:21] Some patients, but not of others.

Prof. Peter Sobota [00:28:24] I would. I'm thinking that it would scare me. Yeah. Interesting. Thanks. So. So you've built the idea that. And the fact that black women and even more notably especially. Middle class black women. And do this. They build this kind of capital and they prepare deliberately for the encounter. Yeah. It's even it's I think I said this before. It is very weird to actually hear. The fact that women even have to speak casually, that people have to do this right. It just tells you it's a basic human right. I don't know. There's just something very awkward about saying this. Here again, I'm just going to ask, I think what sounds like a very weird question is possessing cultural health capital. Does that help? Does it influence outcomes? As far as we know.

Prof. Tina Sacks [00:29:35] So it's very similar to the other areas that we it's it's really sort of using the using the term kind of a theoretical term to explain something that is. Really about advocating for yourself, advocating on your own behalf. So it definitely helps if you can kind of reduce the social distance between yourself and the provider, right? So if you can kind of connect with them, if you can let them know I research my condition, I know what I'm talking about. But that seems to give the provider the sense that you are a more credible witness to your own condition, and therefore that you might be able to follow through with these kinds of treatment recommendations. Does it work in the sort of grand in the kind of at the population level in terms of minimizing or mitigating health inequities? I would say no.

Prof. Peter Sobota [00:30:31] It's just you would say no, no.

Prof. Tina Sacks [00:30:34] No, because if it did were true, true, you wouldn't see these differences because the differences, I think, are you know, these inequities emerge from deeply embedded social problems and the way that we have set up our society. So they're not really I don't think they're really going to respond to these kinds of, you know, individual level interpersonal strategies. But again, as human beings, I think all of us have the need to feel as though we can influence the outcome of our own lives. Right? So we want to try to do whatever we can when we get to the doctor, to try to be treated the way we think we should to get the best treatment possible.

Prof. Peter Sobota [00:31:21] Is it fair to say and think about. You know, building this kind of cultural health capital as a kind of a subjective experience that maybe even empowers folks when they go to to meet with health care providers.

Prof. Tina Sacks [00:31:41] I think so. I think that's mostly what it is, right? It's just a way of saying you want to kind of be at the top of your game. You want to you want to come prepared for your visit. You want to be as certainly open. You know, when you go to a physician, there isn't there's information asymmetry there. I mean, that's why you go to a doctor, because you don't know what doctors know. I mean, that's the whole point.

Prof. Peter Sobota [00:32:06] Exactly. Exactly right. Yeah. And and what you said earlier about your unless you're going for your annual physical, you're probably not feeling that great or you're worried.

Prof. Tina Sacks [00:32:18] Exactly. So the cognitive burden of all of this is is quite high. Right. And so. If there are things that you can do to try to lower that or to try to just make yourself feel better or more empowered, quote unquote, I think that's great, but I don't think that it reduces or does away with these problems.

Prof. Peter Sobota [00:32:38] So I'm not sure that I'm going to get this out eloquently here. So be patient with me if you could. Let's see if I can get this out. The women you spoke to and the data that you have studied and and even, you know, your own lived experience. Is there a cost? For two women, two black women to middle class black women. Simply for having to do this. Here's what I'm thinking. The badge, the clothing, the knowledge that in many ways, I mean this. I know nothing to get the sound. You're almost kind of like working deliberately to separate yourself, to distinguish yourself. Literally from people like you. Mm hmm. So I don't know if that makes any sense, but to me, that seems. Mixed. It's a mixed experience.

Prof. Tina Sacks [00:33:52] Well, certainly it is. And I think it's it's you're working to. Distinguish yourself not from other not really from people like you, but from the perception.

Prof. Peter Sobota [00:34:03] That the perception.

Prof. Tina Sacks [00:34:05] Of perception, other people's perception of people like yourself. Mm hmm. And so. You are. There is something about it where you're you're definitely you're trying to say, you know, like I have this this attribute. I have that attribute. I can, you know, I have a certain level of education, etc.. There is something, I think. I'm a person who just fundamentally believes in the inherent value of each human being. And so when you try to distinguish yourself based on your clothes or your degrees or whatever, there is something I think fundamentally dehumanizing about. Having to do that feeling that you have to do that.

Prof. Peter Sobota [00:34:51] Yeah, just the just the knowledge going in, having the acute awareness that the deck is stacked against you before you walk into the door. My wife is a white female who has been a nurse for 40 years and has an MSW. I don't hear you talking about this when she goes to see her physicians. But what's interesting is that she often comes home and has been doing this for years and and just shakes her head and says. Once again. Hysterical. Mm hmm. I'm emotionally fragile, and they're not. And she's referring to men, of course, who have treated her and. And. Not being taken seriously. And she has all the benefits of middle class. She has health, education. She's white.

Prof. Tina Sacks [00:35:56] Mm hmm.

Prof. Peter Sobota [00:35:57] I can see a lot of good reasons. I can come up with a lot of very good, easy reasons why black women, including middle class women. It would be very easy to see why they would delay seeking care. Or maybe not. Going at all. And I know you've spoken with a lot. You've interviewed a number of women, and I know they've told you their stories. I don't want to put you on the spot, but I mean, is is there a story or two that just really kind of nailed the experience?

Prof. Tina Sacks [00:36:42] Sure. Sure. So one of the ones that always comes to mind is the most salient example of this was a woman I met and I conducted a focus group and she was a participant in a focus group. She was a young woman at the time. She was in her mid-thirties and she had an MBA. She had her own. Accounting company. I believe it was our business consulting and she had had. When she was in college, she started having knee problems and knee pain. She would wake up all the time. It was something that was really. Problem was it was sort of dogging her everyday existence because she was she would wake up in pain, she wasn't getting great sleep and she was in college. Okay. So she's a very young woman and she went to doctor after doctor after doctor, and they just kept saying, it's because you're fat. You need to lose weight. You need to you know, your body is carrying too much weight and that's why you're having these problems. And if you're having a lot of pain, then you should just take Advil and you're just going to have to deal with it until you lose weight. So she was dismissed and dismissed and dismissed and dismissed. And instead, her story illustrates some of the common things that we see with black women. One is the kind of, you know, particular.

Prof. Peter Sobota [00:38:04] Contempt that that's a good word.

Prof. Tina Sacks [00:38:09] It's really contempt the particular kind of contempt we have for women's bodies, women's bodies that are not that don't conform to kind of normative

standards of weight. And beauty and also pain. So her pain was really minimized. The doctor, you know, she said that a doctor told her you just need to take Advil until you can lose this weight and just deal with it. So eventually this went on for 15 years. She never could get any answers. And she was really in agony all this time. She went to physical therapy multiple times and then she did eventually give up. She gave up and she stopped going to doctors and she just thought, I have to live with this until whatever, you know, she was very uncomfortable, very miserable. But she pursued her education and she got her MBA and so forth. Eventually she was in a minor car accident and she had to go to the doctor as a result. And she, through the course of all of this, ended up having an MRI on her knee. And it turned out she had to. Slow growing tumors. Oh. That had been there for 15 years. And the doctor who finally caught it said, you know, I you need to come in immediately and have these removed. We don't need these could be cancer. We don't even know. She almost lost her leg. And but she was able to recover and they didn't have to amputate her leg. And that's one of the stories that I find to be sort of illuminating and sad and tragic and all of those things. But it really illuminates. The struggles on so many levels.

Prof. Peter Sobota [00:40:00] And. And there is. A fair amount. If I've seen it. There must be. There must be some, because I'm nowhere near an expert in this area. But. That black people, let alone women. Get way fewer like diagnostic testing, things like MRI's and even routine. What for most people would be routine blood work. They're not even offered that in most cases. Yeah. Oh, brother. Okay. Huh? So. One of the things I do, Tina, is I when I can, I watch John Oliver, who does a TV show, I think, and on HBO, and he does, you know, for TV, he does a fairly deep dive into some important topics. But what I like about what he does is he spends a time educating and defining, you know, the challenge or the problem. But then he always he also offers like, okay, so now what's the solution? What do we do? So. I guess what I'd like to do with the time we have left and any of you given this, I'm sure you've given us some some thought. We don't have 7 hours, which I think is what we would need to do to at least scratch the surface of what needs to be done on about 20 different levels, including the largest. The broadest levels of institutions in our society. But what do you think can be done in the relatively short term to change the. I know that's a tough one, but I figure I don't take I'll take my shot.

Prof. Tina Sacks [00:41:53] Of course. So I think. One thing that's really important about this. Is to imagine a world and to be able to imagine a different world. I think we get so caught up in you know, of course, it's structural, it's so hard and those things are true. But what would the world look like if we just allowed ourselves to say, what if we did away with all of this stuff? Okay. So that's the first thing, is to imagine a world and within which that is possible. That is really important. And so like Mariame Kaba, the abolitionist organizer, says, hope is a discipline. We have to think that this can change. So that's the first thing.

Prof. Peter Sobota [00:42:45] Yeah.

Prof. Tina Sacks [00:42:46] The second thing is, I think we have to acknowledge the real depth of this. We have to be able to hold in our mind that hope and change are possible and get real. This is not going to go away. By just saying, let's have some more anti-bias training, okay? It just isn't. And I understand anti-bias training is a whole cottage industry and people are sending their kids to college on it. And I am not mad at them. Go for it. But that is not going to do it.

Prof. Peter Sobota [00:43:24] Would you stop sugarcoating everything and say what you really think? Start.

Prof. Tina Sacks [00:43:31] What I think is what I think we have to do is we have to do multiple things at the same time. So some of this is we have to do the cultural work. And the equity in the antibodies training. That's part of the cultural work. The cultural work is to say. Health inequity is baked into the cake. It is not incidental. It is actually on purpose. Okay. So if we acknowledge that that is true, that people are trained, health care providers are trained in a way that reinforces racial biases and gender biases and ableist biases. That is just a fact. If we could just acknowledge that and then we could start to do something differently in terms of our, you know, the way we think about medical practice and medical training in medical school, that's really important. The other thing that's really important is to, I think, do the, you know, the broader cultural work in the society as we are starting to think about now, reparations, structural racism, how all of these things are baked into the cake of every kind of American institution that is really important and must be done. And as we add, you know, what flows from there is the idea of trying to write these wrongs, trying to make housing more equitable, trying to make education more equitable. All of those kinds of things are the inputs that we would need to change these health outcomes, because those are the things that really change our health. Where do we get to live? What kind of housing do we get to have? What kind of education do we get to have? And if we did all of those things, we'd have to do them simultaneously. And we will be doing this work for a long time. But those are the things that can change a true acknowledgment of what's going on. And in stuff, we have to stop pretending that we don't understand why this is happening. We do understand why this is happening.

Prof. Peter Sobota [00:45:36] Yeah.

Prof. Tina Sacks [00:45:36] And we have to acknowledge that. And then we have to say, Listen, do we really want to change this? We also have to acknowledge that there is in every aspect of American life that there is power. There is power embedded in these systems. It's not individual level malice. Certain people benefit from subjugating other people. And so that must be dealt with as well. And then finally, the the way we've arranged our health care system in which money and financial incentives and. Sorting people based on whether they have insurance or not, what race they are, what color their language status, what kind of body they show up in, all of that stuff. Has to be acknowledged and then addressed. And so, no, there's no sort of short term fix here. But I think to acknowledge what we are really dealing with is critical.

Prof. Peter Sobota [00:46:38] Yeah. Thank you. Thanks for taking a shot at it. And thank you for the hopeful message, actually. You know, I'll just be honest. I'm going to insert myself into the podcast here. It's it's been a rough. Time here in western New York, in the Buffalo area. We. You know, the the white supremacists kid essentially drove halfway across our state because he he knows that in Buffalo we have a segregated city and there was a Topps market for black people. And the sentencing was on Tuesday. We're recording this in February. And, you know, honestly and I think that that's even maybe why I asked my question to you earlier because. Either. The resilience of the families is always trumpeted as the. The focus, right? That's because I think it's true. And it also makes everybody feel better. But we're still reeling here. And the and the community itself. You know, it's easy for me to say, but the community is reeling. And we had this gigantic snowstorm around Christmas time, even by our standards, it was crazy. And many people died and they were disproportionately people of color again, again. So this, you know, it's pervasive. And sometimes you wonder. You got to play the long game or it's not going to be helpful. So actually, thank you for letting me get that carried out. I think that was more about what I've been feeling then and even listening to your. Comments. Finally.

Prof. Tina Sacks [00:48:35] Can can I can I say this, please?

Prof. Peter Sobota [00:48:37] Go right ahead. Yeah, stop.

Prof. Tina Sacks [00:48:38] Just I just you know, I just want to. I just think it's important to acknowledge that grief, you know? And that grief is real, and it must be. It's, you know, not again, not to be too Kumbaya, but grief is really about love. Right. And it's like this is very painful stuff and. That. You know that kid? He was a kid. And just to think about it, he'll spend the rest of his life in prison. And the families will never see their loved ones again. And the incredible grief that I saw in that courtroom. It's just it is it's really it's a heavy burden to carry. But I think the. The collective grief is important here, too, because it's sort of like, you know what, we've all of these systems, we've created all of these systems to separate, you know, people. And yet we are still just humans trying to figure this out, you know?

Prof. Peter Sobota [00:49:37] Yeah, exactly. Is there anything you'd like to add as we think about wrapping up our chat today?

Prof. Tina Sacks [00:49:53] I think, you know, my work is really around. It's really about trying to. Dismantle all of these structures that take people away from each other and from other human beings. And I think. I just want to just want to acknowledge or to put a placeholder here that it's not only about, you know, black middle class women, but about all of the structures that we have we have created. You know, like the evil ism that is rampant in health care. The fact that people with certain kinds of bodies are just totally discarded, devalued, all of that. I find that to be just an affront to my humanity. And I want that to stop and I want to do whatever I can. I mean, I'm just an academic, but I want to do anything I can to try to get that to stop, to put words of anything like we all have some kind of responsibility here to do something and to try to really labor under the words of Mariame Kaba and have, you know, continue to be disciplined in our hopefulness, but also to act. So that's what I want to say.

Prof. Peter Sobota [00:51:11] Yeah. Thinks that. Well-said. It has been an absolute pleasure to talk with you and to get to know you a little bit. We're really grateful. Thank you for taking the time.

Prof. Tina Sacks [00:51:22] Thank you so much. I really appreciate it. It's been a wonderful experience. Thank you.

Prof. Peter Sobota [00:51:30] Thanks again to Tina Sacks for taking the time with us. The ENSO short podcast team is Steve Sturman, our media and production director, our terrific G.A. production assistant and guest coordinator, Nick De Smet. Say hi, Nick.

Nic DeSmet [00:51:45] Hi everyone.

Prof. Peter Sobota [00:51:46] And me. Peterson about. Drop us a comment on our website and tell us what you think about our podcast. Tell us what you want to hear about and comment on specific episodes. Until then. See you next time, everybody.