"…if I looked at the research through an anti-racist lens, a lot of things came into focus that had not been clear to me before."

Richard David, MD
Stroger Hospital of Cook County

Voices of Health Equity in Chicago
Interview No. 4
March 7, 2017

CENTER FOR COMMUNITY HEALTH EQUITY

DEPAUL UNIVERSITY RUSH UNIVERSITY

Center for Community Health Equity
The Center for Community Health Equity was founded by DePaul University and Rush University in 2015 with the goal of improving community health outcomes and contributing to the elimination of health inequities in Chicago.

To learn more about the center, please visit us at www.healthequitychicago.org

Voices of Health Equity in Chicago
Our *Voices of Health Equity* project collects the stories of people who have made health equity a central concern in their work. We are interviewing academics, clinicians, public health advocates, community organizers, and others to better understand how different disciplines and professions could work together to eliminate avoidable, unnecessary and unfair health disparities.

Tuesday March 7th, 2017
Interview by Fernando De Maio

Background: Dr. David's clinical work involves care for newborns from low-income minority and immigrant populations. His research focuses on perinatal epidemiology and, more specifically, on the relationship between social inequality – especially racism in its various forms – and birth outcomes. His 1997 New England Journal of Medicine article titled "Differing birth weight among infants of U.S.-born blacks, African-born blacks, and U.S.-born whites" is featured in the Chicago Health Equity Reader, an edited book being developed by faculty in the Center for Community Health Equity.

Fernando: To begin, can you tell us a little about who you are and what you do?

Richard: I was born and raised in Jacksonville, Florida, and I think probably that gave rise to some of the psychology that underlies my feeling that something has to be done to make right the inequality between Black and White. My mother was from New York, my dad was from a Syrian immigrant family. My mother, as a doctor's wife, was in charge of making sure that we all complied with the norms of the Deep South in the 1950s. Which meant not drinking from the wrong water fountain, and that sort of thing. She also felt obliged to constantly point out to us that that was wrong and when we went to visit our uncles in New York, sure enough, Black and White people were sitting next to each other on the subway and everything just like mom said. I might have even had some illusions about antiracism in the North because of the way it was pitched to me growing up in the South. I was disabused after moving to Chicago. But anyway, that was an important part of my molding. I was always eager to get out of the south so when I graduated high school, I went to the north east. I went to a college in New Hampshire.

I majored in psychology, biology- a mixed major- and was a pre-med. My dad was a doctor and my older brother is a doctor so it was kind of pre-destined I would be a pediatrician. You know it's interesting. I liked it. I did flirt with the idea of being a lawyer when I was heavy into Perry Mason when I was in the 8th grade and my dad asked me what I was going to be when I grew up. I said I was thinking about becoming a lawyer. He wasn't the kind of person that give a lot of advice but he quietly said, "You don't want to do that. Lawyers don't seek truth. They just try to win cases." So you know, I kind of liked his perspective on it.

Fernando: And at that early age did you see medicine as a biomedical field? Did you have a sense of public health, or epidemiology?

Richard: I had no concept of public health. But I did witness a particular kind of practice. Not only did my dad have African American patients in his practice – which not all white doctors in Florida did – but he also opened the first sickle cell clinic in North Florida. He had received training in pediatric hematology after his general pediatrics residency. For about 20 years he ran the pediatric training program at the Duval County medical center in his spare time from his practice. The small number of trainees were all international medical graduates and he was basically their only instructor. He used to conduct what he called "Sunday school" – several hour-long teaching rounds for the pediatric interns and residents, every Sunday morning. So there was that obvious component of dedication to the community including the more disadvantaged parts of it.

I think a big part of what I eventually ended up doing in research and so forth was related to political awakenings that happened around age 20, you know, college and the years thereafter. So I was a college

student during the Vietnam War. Very apolitical, just a pre-med grind. But I still remember an epiphany moment when I was handed a leaflet and there was a big crowd on the green for some protest, and somebody gave me a flyer and it had a map of Southeast Asia showing the off-shore oil deposits in the South China Sea and crucial shipping lanes as well as tin and other mineral deposits in Indo-China and it was like, “Oh! That's what that war's about!”

You know, I went off to college as some kind of liberal republican, undifferentiated, whatever. But by the time I left, I was probably some kind of socialist looking for some kind of group to work with. Because it was clear that if war is created by the need for profits of the capitalist system, then we're going to keep having these wars as long as we have capitalism.

In medical school, I had another epiphany because I had come back to the South. I was at Duke in North Carolina and there were still pretty clear vestiges of Jim Crow. Those of us who grew up in the South recognize what it means when on one corridor there are two men’s rooms next to each other. But anyway, at some point in my years there, I remember getting a strong sense from an African American woman, maybe my mother's age, serving the food from the steam table in the cafeteria and there was a certain vibe. It was like we were in different worlds and it wasn't like she was unkind to me or rude or anything like that. It was just like there's something going on that keeps us from ever having a real interpersonal relationship. I came to understand later by talking to people, I had a lot of friends who were into political groups of one kind or the other, and the idea that there was a lot of profit being made off of exploiting dark-skinned people and separating black and white people from each other, so that everybody could be better controlled. That explanation then drew a link between capitalism and racism – the other big evil of the world as far as I was concerned. If you have to get rid of it to get rid of war and racism, then it sounds like something has to be figured out on how to do that.

Fernando: It's a really fascinating story… as you're tying together capitalism and racism, were these things separate from your more formal schooling? Did you see that it was integrated at all in your medical training?

Richard: Not at all.

Fernando: So different people, different conversations?

Richard: Things were, if anything, obscured, I would say. I did take one poli sci source when I was an undergraduate so I read a little bit of Marx and some of those early socialist writers. But in terms of formal education in medical school, you know, we were supposed to be nice people and treating the poor people kindly, but it wasn't like there's *something wrong*. Actually one of the most interesting things, it was an extracurricular activity, but some of my political friends were trying to do organizing with textile workers in North Carolina and there was an endemic disease called byssinosis which I had never learned about in medical school. It is also called "brown lung". And so these guys say, "You're a medical student, come help us do screening at Cone Mills" That was one of North Carolina’s biggest textile factories. And so I went along and helped people use the spirometer and took a history and that sort of thing. It turns out, there are all these young people, 30 something, 40 something people with severe lung disease caused by this illness called byssinosis which was completely understood and had been largely controlled in England where they had laws against dust particle levels of a certain amount. So why did I not learn about this in pathology or in internal medicine? Duke had some monetary

interests in Cone Mills and some of the other industries [laughs]. So somehow that got left out of the curriculum.

Fernando: Fascinating. And what brought you to Chicago?

Richard: Well, my wife was doing her medical training a few years behind so she graduated medical school and I finished my training in neonatology at the same time, so then we sort of looked around the country and she ended up matching in Chicago and this is where I was offered a job with Northwestern so here we are!

Fernando: Can you say a little bit about the work that you have done in Chicago?

Richard: Let me say that before leaving Duke, I think when it was time to choose a research area, I did start investigating public health. As a medical student, I actually had a year to do basic science research. I worked in a lab doing electrophysiology experiments on sea slug neurons and published my first paper. When it was time to choose a research area as a fellow, by that time some of my friends, the ones that got me to do that Brown Lung screening and other things had me passing out flyers at the hospital to organize the environmental service workers and stuff like that. It was becoming more and more clear to me that these society-wide issues had to be part of what I did and an obvious blending point was with public health.

So, my mentor in the neonatology program happened to be friends with a professor at the school of public health in Chapel Hill a few miles away. So my mentor's friend just kind of took me on as a trainee. I never did get a degree in public health. But I got coaching and my first major projects during my neonatology fellowship were in that field.

So, we moved to Chicago and then there was another thing that jolted me politically and that was when I came back from making rounds in the NICU one morning and my wife and one of our friends who had also been in North Carolina with us were sitting there reading the NY Times which had a front page article on people being killed in Greensboro, North Carolina buy the Ku Klux Klan. I read the first paragraph and my comment was, "They missed Nelson". Every name that was on that list of casualties was the name of someone that I knew, people who were political organizers at Duke in North Carolina. They were leaders of a movement there. Nelson Johnson, another prominent leader, was at the demonstration but had dodged under a car and not been killed. We went down the next week for the funeral which was pretty scary. There were armed personnel carriers and National Guard troops carrying rifles with fixed bayonets and so forth. It was pretty intimidating. But it did make me feel like maybe I need to be more involved politically and so shortly after that I met a guy. He had been conducting an epidemiology journal club in Northwestern and I got a leaflet from this person inviting me to a forum on the political assassinations in Greensboro. I said, "Why is he sending me this? Is this some kind of joke or is he baiting me or what? I don't understand". I ended up going to this thing because I said I don't know who these people are but they know it was a political assassination, that this was not some random shootout between extremists. And it turns out it was being led by an epidemiologist, a cardiologist named Richard Cooper. He was the first communist epidemiologist that I met. He's now head of the preventive medicine department at Loyola. I don't know what his politics are now but he was pretty left at the time I met him. It was really under his influence that I got involved in my first writing. It was exclusively anti-racist in focus.

Fernando: And at that point, political activism and awakening against racism was beginning to merge with medical practice or was this still seen as a separate thing?

Richard: Well, I was starting to see that there was a way that if I look at the research topics I was interested in – infant mortality – and looked at it through an anti-racist lens, a lot of things came into focus that had not been clear to me before. And it also seemed like it was worth bringing this into the public discourse because it was not being talked about very much.

Fernando: That's the big issue, right? How we look at data, so for example interpret data on infant mortality and instead of blaming poor people, poor outcomes, we see it as a social process. I'm really curious about how that happened for you, and I'm starting to get a sense of that based on your story, but I wonder if there's anything else that you could say on how the anti-racist activism started to change how you saw the data that surrounded you in the hospital.

Richard: Well at that time I was still at Northwestern when I first started writing and also first started going to marches and other protests. Later, Richard Cooper left Northwestern and took a position at Cook County. So in '87 I came over here as well. There was a certain amount of direct, political, anti-racist organizing at the County Hospital because of the deficiencies of the facility here and there were moves afoot even then to shrink it, take away services and so forth. So, I became part of some of those protests but at the same time I was trying to pursue the research work. An important other piece of this which I haven't mentioned – a huge omission – was that while I was as Northwestern, a pediatric resident was looking around for another research project. They all had to do a senior project and this guy was an extremely high-productivity-type fellow. So it turns out I was his second research project. He was already doing bench research on rat carbohydrate metabolism or something, but he heard that I was doing this population health stuff and I had just finished putting together a dataset where I linked income data from the mothers' neighborhoods based on census, to the Chicago-area birth certificates. So this young doctor shows up and I said, "Well look Jimmy [James Collins], here's a new dataset I just created. Why don't you take a look at it and see what you can find." So he came back in about three days with these computer printouts and he said, "Dick, look at how poor these Black women are!" And you know, he's an African American, the son of a pediatrician like me, and so he kind of has one foot in each world. Somehow seeing this population-wide data just really rang with him. So I sort of thought to myself, "Well I don't think he's going to be pursuing rat research" [laughs].

Fernando: That's amazing. I mean that dataset changed the literature and how we think about racism as a public health issue.

Richard: And what a great thing for me to have an African American colleague to work with. I still considered research and publication kind of an avocation. What I really was into was taking care of sick babies and protesting. And at one point, a couple years later, he was presenting one of our early projects at the Pediatric Academic Society meetings and as usual he'd done a great job on this thing and he's an excellent presenter, and he was pretty pumped about it. I said, "Well Jimmy, it's only research. We have to change the system!" [Laughs]. And he said, "Well yeah, but this will help change things by changing how people think." or something to that effect. And I had to acknowledge that he had a point. We had a job. We had to do something, so let's do something that pushes this discussion into places where otherwise people wouldn't be talking about it.

Fernando: You know one of the great hidden gems that we found while putting together our book [*The Chicago Health Equity Reader*] is a pamphlet from, I think 1954, called *What Color Are Your Germs?*" which was put together by a committee with Quentin Young - *The Committee to End Discrimination in Chicago Medical Institutions*. Were you guys aware of those kind of things that had happened in previous decades in Chicago? Or were those things kind of separate?

Richard: I didn't know about that. I have met Quentin on a few occasions but I didn't know about that earlier work. I knew about political activists in medicine at Duke who had been at the social medicine program in New York- is it Einstein, maybe? Montefiore Hospital. Anyway, that was a hotbed of leftist organizing among doctor types and then the Medical Committee for Human Rights came out of that and I think Quentin might have been involved in that too. So that was kind of my first initiation. It was through those people, one of whom actually was an infectious disease fellow a year older than me who was originally from Chicago- Jim Waller. He was one of the people killed in Greensboro. But I didn't really connect with the earlier history of leftwing medicine in Chicago.

Fernando: Let's come back to that dataset because it seems to be such a pivotal moment in your career and, it turns out, for the research literature as well. So the dataset linked area-level income and birth outcomes?

Richard: Yeah. Census track based. Yes.

I think again that the political lens was helpful here because what I knew was that behind all the data and papers and so forth, there was an important theoretical question. Almost, you might say, an ideological question: What is “race”? And the biological determinists, you would call them, and everybody from E.O. Wilson to William Shockley to Richard Hernstein and Charles Murray were claiming that race is package of genetic stuff that comes from someplace in Africa and results in these inferior people in our midst. And of course the opposing theory is that health is determined by social factors including race. Race is a social, political thing, not a biological thing. And that was being argued in the research literature. People like Stephen J. Gould, for example and others had already formulated strong evidence against the genetic basis of race from protein chemistry data that was available in the '80's or earlier. They debunked that biological theory of race. And Richard Cooper, my communist epidemiologist friend I mentioned earlier, was probably one of the leading people to debunk that idea as it applies to medicine and epidemiology. So that was sort of the thing I had at the back of my mind, these basically Nazi-type biological determinist ideas, should be disproven and so we structure our inquiries in such a way that we could, you know, uncover social relationships and debunk the putative physical ones.

So one of the first things Jimmy and I did with that dataset was, we looked at White and African American women with different combinations of risk factors and what we found was that if you look at the most vulnerable group, the youngest in the poorest neighborhoods, who haven’t finished high school, I don't know maybe we had another variable or two, they all have terrible outcomes – White and Black have low birth weight rates of between 15-20%. But as you come out of those most oppressive situations, so you have more education, higher income neighborhoods, etc., the decline in risk goes down much more steeply for White women than it does for Black women. They both improve, but the gap between Black and White gets wider and wider. But clearly, with one objectively defined set of social criteria, the outcomes are equally bad for both. That suggested to us that this is not some kind of biological difference but rather conflicting social factors.

Fernando: That's interesting. I don't think I've seen that particular paper. I think the first paper that I read from you started looking at place of birth as well. Looking at immigrant and US born women. I could see how they all started building into a complex puzzle for you. I've also seen some stuff you've done with migration in and out of the city

Richard: Yes those things were later. So this was really back in the early '80s or so.

Fernando: Am I right to say that the paper that was featured in *Unnatural Causes*, looking at US-born Whites, US-born Blacks, and African-born Blacks, was that the one that received the most attention for you?

Richard: It's definitely the one that got the most attention, probably because it was in a prominent journal. NPR hasn't called me about any other papers!

Fernando: Tell me a little bit more about the story around that paper.

Richard: That was kind of a fluke. I was looking for something else. I had a dataset that had information about place of birth and ethnic identity, so we were able to find actual country of origin for women. Jimmy and I were certainly not the only ones with this anti-biological determinist outlook, you know. Public health people tend to think that way. That's our instinct. Many of us had been looking for the population of Black women who had babies the same size that White women were having. And it didn't matter if you took African American women who were college graduates, married to college graduates. It seemed that no matter how well you controlled for these social and economic variables, there was still a big difference in birth outcomes by race. And then I was playing with this other dataset, looking for something else, and I did a frequency run on the birth weight of these African moms. Low and behold, there they were. They were the women that were having the same outcome as the European-American women.

So as soon as I saw that, I thought this is going to be important. So, Jimmy and I sort of did the other parts of it, most of the basic stuff to turn it into a paper, and we submitted to New England Journal of Medicine. And I've never seen that much difficulty in getting something published. Normally, your manuscript comes back and this is Reviewer A, and this is Reviewer B, maybe even Reviewer C. Okay, this came back with A, B and C plus two in-house editors. Maybe there was even a D. I mean there were a lot of reviews. And they ranged from, "This is the most important finding in any recent manuscript..." up to, "This cannot possibly be true". This was the spread. So, the editors said they were not going to throw it out, but we had to answer these objections. So we did, and we submitted again. By the third submission, we were talking about should it go to another journal, I mean should we just give up on these guys? Jimmy said, "Let's hang in there." So we did, and I think we got through four or five revisions. We doubled the sample size, introduced all these other statistics. A very telling comment in the last set of comments we got back, one of the reviewers who had been an earlier version – by this point I think we were up to reviewer K or L – said, "I can no longer disagree with the authors' sample size or their statistical methods, but I still don't like their conclusion". Pretty honest.

Fernando: Remarkable. And for my personal interest, was the final version of the paper stronger? Did that process of having to defend it and strengthen it make it better?

Richard: I don't think so. Maybe a little bit. The N was bigger, but the story was the same. The editor said something about how I needed to remove the "sociological rhetoric". [Laughs] We had to tone it down a little bit.

Fernando: I don't know if you know but my PhD is in sociology… I've always been amused when medical doctors get *accused* of being sociologists!

Richard: That's funny. Just walking about the hospital, if I go to a ward where I'm not usually known, people think I'm a social worker. I don't know why that is.

Fernando: And what was the impact of the paper when it first came out? Was your institution interested and receptive? Were your colleagues?

Richard: Well I was working at County and it was probably not a secret to them that I'm sometimes one of the people standing out in front of the hospital passing out flyers, calling them racists [laughs]. The PR department here was not really interested, but the University of Illinois, where my faculty appointment is, didn't know about my misbehavior at the County. And so they took up the mission and sent out press releases and stuff like that, so I got interviewed and it had legs.

Fernando: Thinking more broadly now, do you think that researchers are doing the right things? Are we producing the right kind of research? Or do you envision the need for a shift in paradigm?

Richard: I think there are a lot of paradigms working at this simultaneously. In terms of the direction that people are encouraged to go by the biggest mainstream funders like the NIH and so forth, they I think still have some kind of a biological, genetic outlook on a lot of things. I was invited to be part of a seminar discussion at the National Institute of Child Health and Human Development some years ago. Turns out me and this African American anthropologist were the two token representatives of the social determinants outlook and then everybody else was a geneticist. You know the fact that NIH has never given us a penny of funding for any of our work, in all honesty, Jimmy is the one who writes the grants, he does the heavy lifting there, but basically the March of Dimes and CDC have been the most helpful on the funding front. And we basically do low budget research. Up until recently, we were doing all of our own statistics. But the mainstream model is still, at least at the biggest national level, too much oriented towards things which would be more consistent with the overall political economy of the country we live in. I mean if the mandate coming out of your research is that we need to make this society more equal and egalitarian, that's not easy to mesh with what's going on in American politics – or what has ever been going on with American politics, as far as I'm concerned. Whereas if your research shows that the problem is some deficient gene and all you have to do is fix the biology with some medication, then that sort of result meshes with the overall political economy and is the model that is favored. Of course, some company has already patented that part of the genome, so only they can fix the genetic problem and you have to buy their product to be healthy.

Fernando: Do you have any thoughts on how we can measure racism, or measure perceptions of discrimination?

Richard: …The only interview-based study that Jimmy and I ever did showed that if you answer "yes, I've been discriminated against because of my race", that doubled or tripled your risk of having a premature, very low birth weight baby. I don't know if you saw that article, but it was in the American Journal of Public Health like 12 years ago. Anyway, to do that, we had to have African American women of child

bearing age doing the interviewing and they had 30 minutes to establish some rapport before those questions came out.

I think it has to be done in some kind of a non-threatening, anonymous way. And even then, when we did our little study, we found that the highest prevalence of people answering that question positively, wasn't the African American woman that lives deep in the west side and hasn't finished high school. It was someone who was already more educated, who's out in the workforce in a more mixed environment. And so, the structural determinants that are going to cause women in the ghetto to have terrible health are not going to be picked up by those kind of questions. You have to look bigger than the individual level.

Fernando: I agree. So all kinds of really important research challenges facing health equity researchers as we move forward. That people are talking about structural determinants of health, racism as a public health issue, in a way that they haven't before, even if we don't have the best measures of these things just yet, is a good thing. Last questions then. Zoom forward, 10, 20 years in Chicago, is the city roughly the same? Or will it be a more equitable, just, city?

Richard: Well I don't think it will be the same, because I think the nature of reality is that it always changes and what it will look like is very hard to predict because I think it depends on a lot of other things. Like, is there going to be a world war? Is there going to be a revolution? Will there be global warming to the extent that vast areas of the world no longer produce food? I mean who knows? I'll give you a big "I don't know" on that one. But even though the things that I just rattled off are pretty scary sounding scenarios of doom, on the other hand, one of the things that keeps me from being discouraged is I do like to read about history and not just the history of the last two weeks, but history of the last century or two. And you know, a lot of terrible things happened in the 20th century but also some very good things happened in the 20th century. These historical facts were probably not unrelated. It was the horror and destabilization of WWI that probably permitted the working class to take power in Russia. And that was the first universal healthcare system, and the first universal education, etc. For all of its weaknesses and what it turned into half a century later, there's no denying that something huge happened at that time. Who could've said in 1905 or 1910 that there was going to be complete change like that. So, in 2017, you ask me what's going to be happening in 2037, I don't know. But I think it's fair to say that things could change on a more profound level than I have seen in my lifetime.

Fernando: One more question. Since I'm hoping that students will read this interview, do you have any general advice for anyone either going into medicine or public health, or sociology or just beginning their studies and are concerned about justice and fairness in society. Do you have any advice for them?

Richard: Just be daring in what you read and dream about. Don't be limited to what seems immediately plausible.