Okay. Good evening, everyone. We're going to get started now. Sorry we're a little bit late. We're trying to give people time to get in and get seated. So we're going to get started now, a few minutes behind. My name is James Mendez, the associate dean of student affairs here at Stritch school of medicine, also an assistant professor in the department of medical education and I'm the resident historian at a medical school. That happens when you have a Ph.D. in history, you're a historian. My Ph.D. is in American history, the early parts of colonial period through civil war reconstruction, and then my focus is civil war reconstruction. Mark told me I had to tell you I have a book coming out February 5th. You can find it on Amazon. I'll give discounts. That's a joke, all right? (Laughter). So I want to get through -- I have a few slides because I just want to provide a little history before we move into the film and before we move into Dr. Ansell's presentation. So I'll get through this real quick. I even have a timer so that I don't go too long. Okay? And so I wanted to give a little bit of history, all right? A little bit of history, specifically because I do African American history about the history of African American physicians, this is the first one and their role in providing health care in spite of challenges, especially racism and discrimination. So we have here Dr. James McCune Smith, first American to earn -- first African American to earn a medical degree. He couldn't get it here because no medical school would take him so he went to Scotland and earned his degree there. After finishing his education, he came back home, returned to a hero's welcome in New York City. And immediately because he's a first MD, African American MD, he's a leader within his community. So he's a leader regarding -- as an abolitionist and suffragist getting people to vote. First African American to publish articles and he used science and knowledge to debunk theories on slavery at that time.

Next we have -- at that time -- so we're still talking mid to late 1900s, 19th century. Some medical schools were
taking African American students, still not a lot. Some of them still exist today. Harvard is here. But usually they would take one, maybe two students. So again, not a lot of opportunity, not a lot of people graduating, African American graduating in those positions. First female physician was Dr. Rebecca Lee Crumpler, graduated from the new England female medical college in 1864 and went south to advocate for cared for newly freed slaves, returned to Boston and established a practice serving women and children, regardless of race.

Post civil war, few opportunities again for medical school for African Americans. No hospital privileges, which was a major problem. Then major supreme court ruling that separate but equal was legal, which enabled the legalization of segregation in public institutions, especially hospitals. That said, undaunted, African Americans responded by creating their own institutions. One of those institutions, the first black owned hospital here in Chicago, and founded in 18 the 1 by Dr. -- 1891 by Dr. Daniel hail Williams. These hospitals were throughout the north, mainly the north, similar hospitals serving the African American minority communities.

The association, AMA was already in existence. Preeminent association for U.S. physicians. Unfortunately they discriminated against African Americans and would not allow them. So what did African Americans do? They created the National Medical Association, their own association, created in Georgia in 1895, responding to Jim Crow era racism and discrimination.

There were black medical schools by the end of the 19th century into the early 20th century. It was eight, and the two at the top, Howard and Meharry still exist today. With that, with these new medical schools, all of a sudden in 1895, there were 385 African American doctors, only 7 percent from white medical schools, but 10 years later, 1905, there were 1465 African American doctors and 14.5 from white medical schools. So huge increase, okay? And if that increase would have continued, some of the problems that we have today, some of the issues that Dr. Ansell will talk about might not exist or might not be as big a problem as they are today.

By 1923, unfortunately there was only two left, Howard and Meharry. What happened in 1910, the Flexner report came out. It was issued to identify problems within medical schools nationwide. There was a major problem that created the blueprint to pixel problem, a lot of commercialization of medical schools, pretty much anyone could open one. Two doctors could say hey, we're opening a medical school down the block. And so 700-page report, it led to half of the 150 medical schools closing because they weren't adequate. Unfortunately that included five of the seven black medical schools. And these are the schools that closed. Most of them actually in the south, surprisingly. And
so another African American school did not open, it was not until 1975 when Moore house school of medicine opened.

So what was the effect of that. Limited prospects for talented African Americans interested in pursuing medicine, which led to a paucity of physicians to serve African American community. And an increase in health disparities in that same community. And Dr. Ansell will talk about child mortality in his book he does and that became a bigger problem as that increased.

Still in spite of these obstacles, African Americans continue to challenge the system in advanced health care. As that was happening, most of you have heard of the great migration of African Americans from the south to the north. It started in 1915 as World War I was happening, the factories needed jobs, the men were brought fighting, and so African Americans started coming from the south. So one of the reasons greater employment opportunities, less violence, and intimidation, less discrimination, educational opportunities and voting rights because they couldn't vote in the south.

Here's the time line of that migration, and even today historians argue that the numbers might have been even higher. And so with that sudden migration up north, mainly to these cities, again, looking for jobs, steel jobs, factory jobs, and so on, the new immigrants greatly transformed these cities, including Chicago.

Leading us into the '50s and civil rights movement. Black physicians played a prominent role in that. They continued to be leaders in their communities, and they were there. They were at the picket lines. They were -- experienced some of the violence themselves.

Some of the victories of the civil rights movement, brown versus board of education in 1954, reversed Plessy versus Ferguson and made it unconstitutional the separate but equal laws. Civil rights act was signed, which stated that discrimination on the part of race, ethnicity, national, religious minorities or in terms of sex was illegal. And Medicare, Medicaid were signed, banning the existence of segregated hospitals, finally.

So with that, the numbers. Victories of the civil rights movement. In 1968 '69, 780 black students enrolled, by 2012, 5080. However these numbers peeked but according to the AMC, they died and they are slowly rising again. There are more medical schools in existence as well. Still there's a long way to go. The problem is we were always playing catch up. When there was only two medical schools, the black community was playing catch up because we did not have enough doctors in the first place so the civil rights movement opens door, the predominant white institutions all of a sudden start taking more black students, but again always playing catch up. We were
behind. So again a lot of those black students and physicians in the '60s, '70s, are retiring. So already behind playing catch up and now you have this huge group starting to retire. And so how are you going to fix some of the problems regarding health care? That's one of the challenges. And Dr. Ansell has a cure, as he called it, a cure in his book. So at Loyola, we have more, which is a good thing, much more African Americans, I just put a few of them here. Chris Cal cash, wanted to see her when she was younger. And our numbers continue to grow because our students become our residents. Our residents become our attendings, and they serve the population that we have, very diverse populations in Maywood.

So these are our numbers. Class of '20-'22. When I got here going on 12 years ago, there were like five African Americans in the class. We had one class there was only one. And then those numbers have increased. Both Latino, Asian, and African American.

Today our physicians continue to be leaders in these communities, whether it be African American, Asian, Hispanic, LGQBT, native Americans, and others. Helping to lead against the health disparities and death gap, as Dr. Ansell calls it, throughout their communities. Also something I really liked in his book, he called physicians natural attorneys for the poor, uniquely positioned to advocate on their behalf. And so that's a key part of why we do what we do here at Loyola. So with that said, thank you, all right. (Applause.) There will be time later for Q and A. So if we can get the film started, whoever gets the film started. There we go. Thank you, sir. (Film shown).

>> In Mississippi, people who lacked food and clothing and shelter, having to haul clean water from five or ten miles away.

>> Disease, malnutrition, suffering, and their combinations were rampant.

>> This was a population that had no medical care practically and many who had never seen a physician before in their lives, of women who had eight children but had never seen a physician.

>> The system was a futile system. You would get permission from the person that owned the plantation, and they would give you a note that you could go to the doctor. A lot of -- and people assumed it was a birth right my ma'am had so they just started waiting for their attack and waited to have strokes and everything.

>> These were reasons that life expectancy was so short for blacks in Mississippi. The infant mortality was so high.

>> In both the north and south, black babies died at twice the rate of white babies.
>> 30 to 40 percent of white births was at home sometimes, not only at homes but in the cotton field.
>> We didn't have a nursery. We just took draws out of cab -- drawers out of cabinets and put babies in them, and we put those right by the mother's bed so that we didn't lose any babies or anything.
>> There was just a little broom closet where they would stick a bass net, and you had to go and check on your own baby.
>> They would tell fathers of newborns that they couldn't have their wife and baby back until they paid a certain amount of money.
>> It was $125 bill, and I said I don't have $125. And the lady said, well, we'll just have to keep the baby. And I thought that's excellent. I'll come and visit him every day. As long as he's fed and taken care of.
>> In our town we could not use the hospital. It was called park view hospital. For her final pregnancy, my mom was going to need a c-section. The baby was big. Dad went to the administrator at the hospital to say could she please be delivered there. And they refused. She went into labor. They couldn't get her to the colored ward so they delivered her at home. And my brother -- I have a hard time with this. My brother sustained a stroke because of it. That moment is why I'm a physician. It also was the defining moment for me about what disparities really were.
>> Disparities between black and white Americans were legally bounded by a 1896 supreme court ruling that segregation was constitutional as long as the races were kept separate but equal, and they were separate but never equal.
>> It was black and white. There was a black section and a white section, cafeterias, the hospital waiting area, the rooms, the beds and everything were in separate parts of the hospital.
>> Everything was inferior on the black side. From equipment to the blankets to the room to the painting. It was just clear.
>> Everyone was on one floor no matter what you had, a baby, TV, or whatever.
>> Every time you went into a hospital, that was segregated, there were things to you that showed life as a black person is not worth as much as a white life.
>> You didn't give them titles like Mr. Or Mrs. Or Miss or anything.
>> The white patients were Mrs., and the black patients were Pearline or Sally or Sue or whatever.
>> They used boy for black men, no matter how old you were. You were boy.
>> They never got grown, they were always a child until
someone was white.

>> I learned in a difficult way for them to be applied two. One time two state troopers drove up, stopped the car and came up to me. They said what's your name, boy? And I said Dr. Puson. And they just looked at me. And they said what's your name, boy? And I said Dr. Pusont. And they said what's your first name, boy? And at that point one of the policemen put his hand on his gun. My secretary was trembling and she yanked my arm. She knew the system and she felt that the next step was that they were going to hit me. And she was probably right. And so I told him Alvin. He said good. He said next time you give us a hard time, you're coming down to the station house.

>> Yazoo city at that time was totally segregated and one of my jobs as a young person was to answer the back door, which is where the colored office was. There would be someone who was so wounded, they would have to go to a hospital. So they would have to go to Jackson, which was 50 miles away.

>> People routinely died on the trip to Jackson because there was no hospital in Yazoo city that would take blacks. Segregation made it difficult to get to the hospital. White ambulances would not pick up black patients.

>> They had to use hers hearses. As it fled from town to town looking for a hospital, someone would teach this patient, the patient often died in the back seat of a hearses.

>> Many people assumed segregation was from the south but actually it wasn't. It was very extensive throughout the north as well.

>> Wherever you looked, you could see the reality of segregation, but there were no signs. Most hospitals in Chicago weren't admitting black patients at all. A few did admit some black patients. Usually in some segregated part of the hospital, never put in a double room with a white patient.

>> Emergency rooms would not admit black people. If their (inaudible) were fit and therefore they were sent to county hospital with a note, no beds.

>> Even the wealthiest black patient had to go into the charity ward.

>> You'd have thousand dollars bills coming out of your ears but if the 10 percent quota University of Chicago was filled, you went to county hospital.

>> It was a mob.

>> If you had no money, couldn't pay, you went to the clinic. You sat there all day. Women with children and babies and crying and hot and all of that.

>> People were waiting and waiting and waiting. One night I had 20 admissions and four desks of people I had not seen.

>> For three decades, U.S. presidents had tried to expand access to health care.
We've accepted this would be the second bill of rights, right to adequate medical care regardless of race or creed. Roosevelt didn't put health care in the Social Security bill because he thought it could never pass. Truman tried to do it.

I've repeatedly asked the Congress to pass a health care program. The nation suffers from lack of medical care.

And was just clobbered by the American medical association.

The American medical association or the AMA, attacked Truman's health care proposal as socialized medicine. Black doctors and the NAACP supported it. Truman's proposal failed. Instead, Congress passed the 1946 Hald Burt on act which provided for the construction and reservation of hospitals throughout the country.

It was a really large financial package that was going to transform the facilities of American hospital. Get it through the Congress. The legislative process had to deal with the southerners, and they insisted on a separate but equal clause that would permit segregation in hospital facilities.

What it said was go ahead, keep your segregated hospitals in the south, and the federal government will support you and subsidize the expansion of Jim Crow.

Hill Burt on was the only piece of federal legislation passed in the 20th century that had separate but equal written into it.

As characterized by Brady hospital, the big public hospital in Atlanta was one tower for whites and another tower for people of color.

The hospital was built like an H. The two front wings, the A and the B wings, were the white wings. The two in the back, the C and the D wings, were the colored wings. Everything was duplicated. There were two separate blood banks because it was a criminal offense to cross transfuse blood.

Segregation also made it difficult for blacks to get training to become doctors and nurses. And once trained, to practice.

I came to segregated. I went through Grady segregated. If I saw the class of 1964 white, I wouldn't recognize any of them. We didn't take any classes together.

We entered on one side of the hospital and I cannot tell you which door the black students entered, but they didn't enter with us. We were not allowed to go to each other's dormitory. I'm afraid that I really didn't get to know any of the black class.

The white students had a blue dress.

This is the white student, what you see, the uniform, and this is the black student.
Some were determined to maintain segregation. They barred black students from attending state medical schools but paid the out of state tuition in exchange for returning home to practice. Many northern schools also refused to admit black students.

I was required to send a picture to Johns Hopkins. I had very good references from significant academic members of our community. But within two weeks, I got a rejection. And my conclusion was they saw my picture.

About 85 percent of all black physicians were educated at only two schools, Howard and Meharry. Faculty of students at these schools became the hub of act advice civil rights activism. After graduation, it was very difficult for black doctors to get specialized residency training.

Most blacks if they went into a residency had to train in an all black hospital such as howl and prove dent in Chicago, mercy Douglas, Philadelphia.

Black doctors could not get hospital privileges. Once they finished their training because they were barred from their local medical society. As a result, they could not admit their patients to the hospital or treat them there. These county medical societies were affiliates of the AMA which refused to end these discriminatory practices.

American medical association has never been a friend of ours. If you did not belong to the American medical' site, you were denied admission.

Some of these doctors now, you couldn't admit your patients to the hospital? No. That's not good.

Apart from the AMA and refused admitting privileges, black doctors have to find sympathetic white doctors to admit their patients. Many carried a hospital in their black bags, delivering babies at home and performing surgery on kitchen tables. They continued to fight these injustices, forge their own medical society, the national medical association, or the NMA, to advocate for themselves and their patients.

A hospital is the workplace of doctors who determines who's going to be on the medical staff is the doctors themselves. All the doctors in these hospitals were white. They were admitting white patients so that if you wanted to charge them with segregation, the doctors would say, well, we're practicing in this neighborhood. We serve our patients. Our patients are white. This is our hospital. That's the essence of what you mean by institutional racism, right? It isn't something that you can pinpoint in terms of an action. It's built into the structure.

Having fought for their country in World War II, returning black doctors became increasingly active in opposing segregation back home.
>> For many of us who fought for this country, fought for Mississippi, we fought for Alabama, we fought for North Carolina, we fought for Illinois, we fought for every state in this union.

>> In the army, Negroes were in separate barracks. They were in separate place to eat. We began thinking what did we fight for. We came back and saw how we had been mistreated. We couldn't register, we couldn't vote. We couldn't sit in on any of the juries because we were Negro, and that was unfair. That's when we got active.

>> Civil rights activists scored their first major victory against separate but equal in 1954 with Brown versus the Board of Education. The Supreme Court ruled the segregated education was unconstitutional. A crackless opening for the end of separate but equal. Black doctors were on the front lines fighting to desegregate beaches, lunch counters, schools and hospital. The national medical association joined the fight for integrated health care and leading the charge was Dr. Montague Cobb.

>> He was editor of the national medical association journal. He was very involved in trying to identify and change access problems to education, scholarships for education, privileges at hospitals.

>> Working with the national medical association, Dr. Cobb invited the AMA and other white medical practitioners to an annual meeting on hospital integration. The goal was to develop a joint strategy to desegregate the hospitals. But the AMA never sent an official representative. Par.

>> The MMA joined by Bob Smith and John Holderman, leaders of the newly formed medical committee challenged the AMA at the 1963 convention.

>> I accepted the role to go to Atlantic City and do something that no other physician had done on record. That was the first time a group of physicians had taken direct action against AMA, demanding that they come out unequivocally against segregation and discrimination and that the federal government would put some kind of enforcement clause into Hale Burton hospital. That was the beginning of some real pressure on the AMA.

>> Less than a week later, Dr. Smith attended a meeting of the NAACP for Mississippi. When Evers arrived home, he was shot dead in his driveway.

>> We were just all personally devastated and wanted to do something, so I started to provide medical care to civil rights workers who had been involved in some type of activity, such as this.

>> That summoned civil rights civil action intensified, drawing public attention to the brutal segregation. The movement was meant for increasing violence on televised on the
nightly news. On August 28th, several hundred members of the medical committee for civil rights joined more than a quarter million people on the march on Washington to demand justice. It was the biggest demonstration the country had ever seen.

>> The events in Birmingham and elsewhere have so increased, the cries for equality, that no city or state or legislative body can choose to ignore them.

>> Hospital desegregation was gaining more disability, but the breakthrough they had all been fighting for was led by a dentist in North Carolina.

>> One civil rights activist and a dentist named George contacted legal defense. It was not the first time. He had been put in jail for trying to integrate a golf course and he was a local gadfly and a courageous man and said I want to bring a lawsuit to get staff privileges at the white hospitals in greens borrow.

>> Dr. George Simkins was the president at the greens Boro NAACP.

>> He came in my office and he had a temperature of 103 and his jaw was swollen. I said this boy needs to be in the hospital the. So I called the black hospital, the AL Richardson hospital. They didn't have any beds available. I called cone. They had beds but they would not accept him because of his race.

>> In the south almost all of the cases either against hospitals or schools were brought by dentists. They were totally independent. And therefore had a degree of freedom that even the black physicians in these communities did not have.

>> Both hospitals had been built with hail Burt on funds. We proceeded to attack them on that point on the basis that they had been built with hail Burt on funds.

>> This was a chance to challenge the constitutionality. Simkins and a group of black doctors sued the hospitals. They lost in district court. It was a bitter defeat.

>> We lost it in the middle district and then we appealed it to the full circuit court of appeals.

>> When you challenge the constitutionality of a federal statute, you notify the government.

>> Robert Kennedy saw that notice and all kinds of bells and whistles went off for him because here he could enter into this decision as a friend, not the defendants but of the plaintiffs. That was almost unprecedented.

>> Even a surprise from the part of legal defense fund. They hadn't expected to have the weight of the executive branch on their side.

>> By throwing the full support of justice department behind the plaintiffs in the Simkins case, attorney general Robert Kennedy reversed 100 years of federal collaboration with Jim Crow.
Discrimination must stop not only because it is legally unsupportable, economically wasteful and socially destructive, but above all because it is morally wrong.

President Kennedy sent a tell Graham to Dr. Cobb determining that he was finally joining the fight to end hospital segregation. On the first of November, 1963, the appeals court ruled in Simkins's favor. The separate but equal of hail Burt on was determined unconstitutional. It was a huge victory but the only way to enforce it would be to sue every segregated hospital in the country. New legislation was needed. President Kennedy proposed a civil rights act, was using language from the Simkins decision prevent discrimination and any entity receiving federal funds.

Next week I shall ask the Congress of the United States to act, to make a commitment it has not fully made in this century that race has no place in American life or law.

The prospect for moving civil rights forward looked promising. Less than a month after the Simkins case was decided, John F Kennedy was assassinated. Two president Kennedy's goals were left unfinished, the aged and the Medicare. As Americans mourn the loss of president Kennedy, the country did not know if their new southern president would pick up the mantle. Without presidential support, civil rights activists feared that progress towards equality and access to health care would be halted.

Let us carry forward the plans and programs of John Fitzgerald Kennedy, with the earliest possible passage of the civil rights bill for which he fought so long.

One of the great tributes that we can in memory of President Kennedy is to try to enact some of the great progressive policies that he sought to initiate.

Well, I'm going to support and you count on that and I'm going to do my best to get other members to do likewise. I never needed it more than I do now.

Dr. King was able to talk rationally, soundly, sanely and effectively with president Johnson. And president Johnson understood and certainly he was in concert with Dr. King.

No president, including Lincoln, did more on civil rights than LBJ.

There is time now to write the next chapter and to write it in the books of law.

President Johnson and the civil rights movement fought for the passage of the civil rights bill. They faced fierce opposition.

It is a very drastic bill, which enacted into law, it will effect a change in effect change our system of government.

It's unnecessary, it's unwise and unconstitutional.

Every significant committee and subcommittee was
chaired by a senator or congressman from the south. They had achieved those seats of power by virtue of seniority. They were elected again and again and again. Congress is, in fact, a bastion of southern Congress men.

>> I see no room for compromising this bill. We are paying for it right up to the end.

>> The bill came to the floor of the senate on March 30th, 1964, and the southern Democrats proceeded to fill buster it for 57 days. President Johnson needed minority leader Everett Dirksen to get Republican sport to break the fill buster and he asked civil rights leader to help.

>> They said I'm an arm twister but I can't make a southerner change his spots anymore than I can make a leopard change them. If we lose this fight, we're going back 10 years.

>> I'm going to be on it Mr. President. We know the work has to be done.

>> Who are you going to pick, all your Republicans, give me one or two of them.

>> You have enough votes.

>> No I haven't. You either have civil rights or you're not.

>> He understands Dirksen well enough to say, this is one of my favorites, Dirksen you come with me on this bill and 200 years from now, school children will only know two names, Abraham Lincoln and Everett Dirksen.

>> Fed failed in that, his whole presidency would have failed. He would never have been elected in November.

>> I think in the long run, the real significance of the civil rights act would be found in title 6, in the use of public funds.

>> Title VI stated if you were a recipient of federal funds as a hospital or any entity, you are not allowed to discriminate on the basis of race.

>> Nobody believed that title VI was going to work.

>> It was extensive, a permanent established accepted patterns of discrimination and segregation.

>> There was no way to enforce it. There was no funding for investigators. There were no fines.

>> It was like the supreme court decision around desegregating schools where they said with all deliberate speed, which means what? Go as slow as you want. Take your good time doing it. You don't have to do it right away.

>> What southern citizens were fill busing the civil rights act, the civil rights movement continued to move across the country. 15,000 volunteers headed down south joining 50,000 Mississippians for freedom Summit. The medical community for human rights as they were now called recruited health care professionals to provide care and document police brutality and
discrimination in health care.

>> When the call came in 1964 for the Mississippi it summer project, I was afraid, but I made the decision to go and really solidify that decision, you know, to die. And that's what we were asked to do, to make a decision to die. And if you couldn't make that decision, go home.

>> The danger was real, and sometimes deadly.

>> James Janey, Andrew Goodman and Michael went to Mississippi to help register negroes. The three had last been seen heading southeast on highway 19.

>> These young men have probably been killed in the state of Mississippi. They were murdered by a system of racial segregation which over the years relegated persons to the status of things.

>> I went to Mississippi basically to do voter registration, but I got immediately involved in health activities because it became very apparent that there were really great health problems within the community and health needs.

>> When the MCA Shaw, they gave that as one of my duties was to help get these hospitals and health facilities desegregated, look at the health issues and what we're going to do about them for this population and this change in social order. So we made that one of our priorities.

>> The department of health education and welfare, HEW, was not enforcing title VI of the civil rights act.

>> Nearly all the hospitals in Mississippi after the civil rights bill of 1964 was passed was still segregated. So I called up Washington and they said we haven't received any complaints. So I said you mean so we have to send in a complaint on every hospital before you will act or do something? And they said that's right. We organized this whole mission to get complaints documenting that these facilities were still segregated and practicing discrimination and sent hundreds of letters to the department of health, education and welfare. You needed to complain and raise a raucous to make the federal government move on these things.

>> These complaints journalists got ahold of them and pointed out a particular hospital had done something egregious was still considered in compliance that HEW had not moved to force them to comply with title VI of the civil rights act.

>> The next phase was to try and make sure that the federal government not only accepted nondiscrimination in theory and in law but required it in fact.

>> To respond to the complaints and desegregate the hospitals, HEW faced the impossible task of suing every hospital that failed to comply with title VI. But a new law would present a different alternative.

>> The great society rests on abundance and liberty for
all. It demands an end to poverty and racial injustice.

>> With the 1964 presidential election looming, president Johnson made the passage of Medicare a priority. His new legislation would provide a way to enforce civil rights in hospitals.

>> I'm proposing every person over 65 years of age be spared the darkness of sickness without hope.

>> These two major pieces of legislation, giving health care access to the elderly and to the poor, they were opposed by the American medical association.

>> The new system of health care financing that is unwanted by many Americans, protested and in my opinion unnecessary.

>> The AMA, who still refused to require local and state societies to admit black physicians, remained unrelenting in their opposition to government funded health insurance. They had previously rallied against president Kennedy's health care for the aged proposal.

>> Medical care for the aged bill was defeated in the United States senate. A program which has been fought by the American medical association and successfully defeated.

>> Now that AMA doubled their efforts to raise a war chest and hired an actor named Ronald Reagan as their spokesman.

>> It's very easy to disguise a medical program as a humanitarian project. If this program passes, it will invade every area of freedom as we have known it in this country.

>> Dr. Montague Cobb testifies in favor of the bill.

>> The national and political association support it, first time a president had ever been to a meeting of the national medical association to speak, is when he came to thank them for their support.

>> As voters went to the polls, sides were clearly drawn.

>> There's a lot of our older people are perfectly capable of handling their own financing, and they're doing so.

>> Because it does nothing, nothing at all, for the older person or any person who becomes ill and can't handle their own bills.

>> President Johnson wants a program of hospital insurance for older Americans. He is determined to see this program pass in the next Congress. Vote for president Johnson on November 3rd. The stakes are too high for you to stay home.

>> President Johnson uses his overwhelming victory in the 1964 election to make sure that the house, ways and means committee supports Medicare. No other health insurance bill had ever made it out of this powerful committee.

>> I think the committee has done this in a way that will make a contribution to improve possibilities of medical care in all areas and without any socialization of any profession.
involved.

>> And I'm so hopeful that we will finally be successful in this Congress in providing comprehensive hospital and medical insurance for our senior citizen.

>> The American medical association still indicated that they did not think doctors should take on Medicare.

>> How much money would you estimate the AMA has spent over the past few years fighting Medicare.

>> I would have to only guess that it's several million dollars.

>> So president the president invites the AMA to the White House in the cabinet room, puts the president of the AMA to his right. He says I have this terrible war in Vietnam. I have the doctors in the military, but I need doctors to help take care of civilian population. I want you to start a program. Your president of your country really needs you. Will you do it. And the AMA says, of course, Mr. President. We'll do it. Call in the press, Johnson says, right away. The press comes in. LBJ announces the program. The first question from the reporters is will the AMA support Medicare? Will the doctors support Medicare? And the president looks surprised at the question, puts his hand over the arm of the AMA and he says, these men are willing to put their lives on the line for this country. Of course they'll support it. The doctors said, yes, Mr. President.

>> President and Mrs. Johnson and Vice President Humphrey arrive for ceremonies that will make the Medicare bill a part of the. The independence Missouri is a scene of a historic event. Mr. Johnson chose to sign the bill here as a tribute to former president Truman.

>> But we wanted you to know and we wanted the entire world to know that we haven't forgotten who is the real daddy of Medicare.

>> The only representative of the medical profession invited to the signing of Medicare was Dr. Montague Cobb. He flew on air force one with the president. No representative from the AMA was invited. The president brought in John garden to head the department of health, education and welfare.

>> You had a huge program that was involved millions of elderly people and thousands of facilities and tens of thousands of physicians that had to be implemented within a year.

>> 19 million Americans have enrolled so far in the great society's Medicare program.

>> 25 percent of the revenues of hospitals were becoming as a result of the Medicare program. How could the federal government begin the Medicare program and give federal funds to already discriminatory hospitals.

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The federal government was moving very slowly. They talked their -- we're doing the best we can. We're going to get things together. We're going to find more investigators.

I would say, well, that's good. And when are you going to show us something?

Black doctors were angered by the lack of progress and demanded a meeting.

The NAACP blasts AGW for the inadequate enforcement of the health law under title VI.

It is guilty of a double cross. They have been traitors and deceived us. They have been exposed to a (inaudible).

It was a grand piece of political showmanship. The press came. They told them they were going to miss a golden opportunity if they failed to desegregate the hospitals.

In response, Garland created the office of civil rights and hired Pieter Labassi, turning all of HEW into a civil rights enforcement agency.

This is Pete Lebassi, my special assistant for civil rights.

The (inaudible) went out and it went out all over the country, not the most important federal job in the world, but civil rights was the most important issue in the world. This office for civil rights at HEW, which didn't exist until January of '66, had the talented people that were there, the people who had lived through the civil rights issues, working for the NAACP, working for local communities.

Sharon Ornstein who had been a young staff assistant had been desegregating in Virginia said for Medicare don't do what you did for education. Which was incremental. She said you have to do it all or none. You have to desegregate it or they don't get any money.

At that point they could grasp you have to get civil rights into the administrative process. You can't dough it court by court, district by district. Then if you didn't like the decision denying federal funds, you had to go to court and you had to pay for the lawyers and you had to bring the action against the government instead of the government always being the one who was suing to desegregate. So it reversed the roles as to who goes to court.

That changed the game. This was a national program of great importance. Suddenly the health care facilities realized that they better get their act together if they wanted to receive funds under Medicare.

What civil rights activists had begun to discover is what we call the golden rule. Those that have the gold rule.

With only three months left, Gardner and Labassi, less than half of the bids in the country were desegregated. In the
south few houses were desegregated.

>> And that really freaked everybody out.

>> All that required was this, one admit Negro doctors to staffs and numbers sufficient to make a difference. Two, admit Negro patients on a more regular basis.

>> John Gardner was very strong on using the civil rights act to desegregate Medicare. We had a meeting in John's office and he made it very clear to us that we were not proceeding quickly enough. There were 7,000 hospitals. They could clear about 5,000 of them. 2,000 hospitals needed to be actually visited.

>> With just two months left before the implementation of Medicare, northern hospitals were integrating, but only 27 percent of southern hospitals and only 4 percent of Mississippi hospitals were desegregated. Secretary Gardner needed a team to respect the hospital's existing compliance. He sent out a call to every office in HEW asking for the staff to work as inspectors. More than 700 people responded and joined this passionate bureaucratic army. The recruits included laboratory scientists, veterinarians, scientists and managers of Social Security field offices. Few had any relevant experience.

>> People had to volunteer to be on the front edge of what seemed to be an impossible task. They would be putting in hundreds of hours a week. There would be sleepless nights. There would be threats, police departments that tried to harass them. They would deal with Clan members that would chase them. So the volunteers that they got were not typical civil servants. They were a group of really impassioned activists.

>> My generation hated the government. We hated the war in Vietnam. To finally meet a group of people who were working for the federal government and who were part of an office to desegregate, it made me very proud to have that ID card.

>> They had the orientation for these investigators at center for disease control in Atlanta, Georgia.

>> Phyllis Cunningham, George and I attended with regard to getting these facilities to desegregate.

>> And they arranged for intensive training of the doctors and the social security administrative staff and the civil rights staff on what is it to desegregate a hospital.

>> So we came in, we were clearly very well informed.

>> So this was not the AMA. This was not the American hospital association telling them how to inspect hospital. This was a civil rights movement that had in fact basically taken over.

>> Our job is to inspect hospitals, write down what we saw, make it clear to the administrators what the law required, and then move on.

>> We have field teams in the south working with the hospital administrators to bring them into compliance.

>> We were going down south to desegregate the hospitals.
They had been segregated for a very long time. It's overdue that they change and now is the moment.

Our staff has been specifically instructed that they have to call the hospital administrator in advance.

We're here. We'd like to schedule a date when we can come by and talk to you, inspect the hospital to make sure that you're in compliance with title VI.

And then of course, they didn't find what we told them to look for because beds were switched.

We called it a the HEW shuffle, the department of health education and welfare at that time, the big boss, and they would shuffle beds around if they knew we were coming.

And there was a lot of switching of charts to show that they had integrated facilities. Signs were taken off doors or pictures were hung over signs on doors that said colored, white, et cetera. But anyway, there was a lot of cover up.

Federal inspectors commented federal hospital workers, maids and civil rights activists to get the information to beat the HEW shuffle.

You would know that blacks were there because they was on the other end of the building behind closed doors.

What they -- what they had NAACP for Alabama. And for him on what to live for.

African American women who worked at maids in the community picked up everything on the doctors' homes where they worked. In many instances it was fired right back.

I didn't go to a single place where there wasn't a story, a story of discrimination or deliberate exclusion, differential treatment.

Some of these white doctors who were heading segregated facilities tried to convince me it in a patronizing way that the best health care system was one that was segregated.

One of the doctors said to me, if I admitted a nigger patient in my white cardiac ward, it would kill the white patient.

We had a meeting with the hospital administrator, a fella named Dr. Gallaway who I will never ever forget. I could see Dr. Gallaway's face getting red and it was getting redder and redder until it was really bright red and when it got really bright red, he turned to me, I think he particularly resented me as a 22-year-old medical student. He said boy, let's get one thing straight. No nigger doctor is going to look up a white woman's ass in this hospital.

The university of Mississippi medical center Dr. March Madison said I know it's slow but I want to tell you as a measure of faith that we have our first integrated war. Here indeed was our first war, two African Americans, a white man and a native American, all four of them in their beds all in the same room and all four of them unconscious. So they had achieved their first
step in integration with four people in a coma.

>> The president got weekly updates on how many hospitals were being clear with only one month to go, almost 75 percent of all U.S. hospitals but less than half of southern hospitals were in compliance. The July 1st deadline was looming. As inspectors pushed hospitals to meet the deadline, they faced intimidation, violence, and death threats.

>> There were three or four instances to where I had to get out of town in a hurry, and that's just Mississippi. I finished a hospital and I had just turned it down, but I said you called me up here when you know you're not in compliance with the act. And if I come back again and you're not in compliance with the act, you won't be in compliance forever. I'll do everything I can to see that you never see another federal nickel. I was leaving town and they shot my windshield out. They missed me but they got the windshield.

>> We have 5511 of the 7,654 hospitals are now in compliance.

>> As time ticked down, nobody was really sure what the hell was going to happen. The whole Medicare program would blow up potentially. And either (inaudible) would lose the Medicare program or he would lose the civil rights legislation that had been what he thought was his legacy.

>> With only two weeks left before Medicare was to go into effect, 79 percent of U.S. hospitals were now in compliance with the law, but half of southern hospitals were still segregated.

>> We have some -- a hundred thousand people in Atlanta who are covered by Medicare, at least they think they're covered. But on July 1st if in fact the hospital is not in compliance, they won't have the benefits of Medicare.

>> Assuming that nothing changed, it didn't look like anything was going to change, a large proportion it of elderly beneficiaries of the Medicare program might be denied access to hospitals to receive care.

>> We had developed a plan that we can use public service hospitals, VA hospitals, military hospitals. Helicopters were put on alert so that if a patient was admission to a hospital, they could be flown to one of the federal military facilities and receive care.

>> In the final attempt to bring more hospitals into compliance before the deadline, president Johnson called hospital administrators to the White House.

>> Now, we know there are going to be problems. One of them arises from compliance with the laws of the land, specifically civil rights act.

>> He said that the government is not going to retreat. And he made it very clear to them if they did not desegregate, they would not get any money.
He said, and I want you to know -- and he's pointing his glasses at people -- we ain't going to lock the barn door after the horse has been stolen. We're going to desegregate the hospitals. And he put his glasses on, and he went on with his talk. They sure remember Lyndon Johnson's direct clear statement of public policy. So desegregate the hospitals and then you'll come in the program.

Overnight thousands of hospitals desegregated. I mean, they made the decision that they're not going to run the risk of losing that funding.

You had some emergency procedures laid on in case you needed them. Have you --

We did. We have had these and actually we've not had a single call.

So the program was off very, very successfully.

Over 90 percent of the nation's hospitals and over 70 percent of southern hospitals were cleared by the July 1st deadline. The federal government's commitment paid off in only three months they had done something that no one had managed to do before, integrate thousands of hospitals nationwide and over a thousand hospitals in the south.

For all of those people that ended up being volunteers, it was an amazing period. They really felt that the first time in their careers they were really making a difference.

Johnson understood very well that the infusion of federal dollars in Medicare would be the hammer that we needed to integrate the health system. It was an insurance plan for the elderly, but it worked to open the doors to minorities.

That doesn't mean there's not tremendous systemic racism determining what hospital someone goes to, where they live or how they're treated, we shouldn't be naive. But that last step of the dignity and care at a hospital that's given to you regardless of your race or your gender or your orientation or any other of these characteristics, that is a human right, that's an American right, and we helped to achieve it by hospital desegregate.

It's so critical that we continue on this road of universal access secure, but beyond that of trying to create a kind of environment where everybody has the opportunity to be healthy. So the world has changed. And for the better, I mean.

Did not erase racial care discrimination from my health care system. The amazing work and life saving policies recounted here are not irreversible. (Film completed).

The more things change, the more they need to be changed. Okay. I'm Dr. Crystal Cash, I'm associate dean for the Office of Diversity, equity and inclusion, and it is my pleasure to introduce Dr. David Ansell.

Dr. Ansell is a Chicago-based physician, social...
epidemiologist and health activist. He is the Michael E Kelly presidential professor of internal medicine and senior vice president associate provost for the community health equity at Rush University medical center in Chicago. He is a 1978 graduate of SUNY up state, state university of New York for those who aren't New Yorkers. And he graduated from their medical school. He did his medical training at -- I'm going to say it -- the mecca -- Cook County hospital. I say that because both Dr. Ansell and I were trained there, and I feel like I was trained there during what I would consider the golden -- the golden age where residents strike -- went on strike to promote better working conditions and better pay, a concept that was very foreign during that time. He spent 13 years at Cook County as an attending physician and ultimately was appointed team for the division of general internal medicine. From 1995 to 2005 he was chairman of internal medicine at Mt. Sinai in Chicago, and was then recruited to Rush University medical center as the inaugural chief medical officer in 2005, a position he held until 2015. His research in advocacy have been focused on eliminating health inequalities. In 2011, he published a memoir of his times at county hospital called county: Life, death, and politics at Chicago's public hospital. His latest publication, the death gap, was published in 2017, and the full title is the death gap, how inequality kills. Dr. Ansell. (Applause.)

>> DAVID ANSELL: Gosh, that was an introduction my father would have loved it. And my mother would have believed it. I'm really pleased to be here today. It's a powerful, powerful film. And the title of my talk was that was then and this is now, so it's actually kind of appropriate to think about this. And actually what this is on this picture is the west side of Chicago, created a map created by residents of the west side of Chicago with all the assets on the west side of Chicago. We're going to talk a little bit more about that. But before I start, I just wanted to call attention to some -- frame this in terms of the -- what's -- where we are in this country right now. So 2019 is the quad centennial of the first slave ship to the United States, 400 years. And I think we just have to be aware that we're still addressing the legacy of that horrible national practice. This year as well is the third year in a row in the United States for life expectancy has dropped for the country as a whole. And the last time we saw life expectancy drop was 20 -- 1918, 1919 with a flu epidemic. So I just wanted to frame in those big terms because here we are in an academic medical center with -- we're here to think about health and improving health. We're talking about the legacy of segregation and such. And I just wanted to frame that. I have no disclosures. No one gives me any money for anything. They asked me in front of the Cook County hospital, because everything I'm going to tell you today I learned going
to Cook County hospital. I was a 26-year-old white kid from upstate New York. And I went to County because it was at the crossroads of everything that was right and wrong about health in America, and I went there hoping that it would be open at the end of my residency. There was some touch and go there, but I really learned everything there. And I wanted just a little bit about my background. So I describe myself, I'm a physician. I'm in a hospital administrator, I'm an epidemiologist, but I actually, my core is human rights activist. This is a picture, my mother died last year. A couple weeks before she died, we got this picture. It was from the files of a Nazi soldier who died, got passed through the folks who were doing genealogy. So my family's history, my parents were from England but my mother's family was wiped out in the Holocaust, and this is migrate grandfather, 1941, forced to pose for a picture in the cemetery. He was born in 1864. My grandfather and grandmother urged him to leave Poland, but he was a leader in his community. The following year he was shot on the way to a concentration camp, and we lost all this family, victims of racism, mass incarceration, and genocide. And coming to this country and with everything that was open to me, my dad was a doctor, and he went to university of North Carolina to do a residency in the south. And so that has motivated me. You can't come from a family history like that and then come to this country and see what was going on. Pa.

But this is my talk. I'm going to talk about health care's historic harms. That was then, this is now. And what can we do to heal, I call it repair because the verb represent reparations would be the noun. But as we saw in that film, racism and white supremacism is the foundation upon which American health care has been built. And you saw from that separate doctors' offices, separate hospitals. I remember seeing signs like this as a young kid in the south. This is Charles Shrew who's a black physician, help nationalizing blood bank in the United States. But blood was segregated. You saw that. And this was a sign to sort of teach people that black blood and white blood were actually the same and it didn't really matter to the dying soldier. But actually it was illegal to give black blood to white people or white blood to black people. And we -- scientific, racism, this is just one feature of it. But that was then. I just want to say a little bit about going to Cook County in the 1970s and some of the things that were occurring. So it was very clear when you got to Chicago that Chicago was not only a segregated city but despite the civil rights movements, that the hospitals were segregated in the city of Chicago. And by the way, largely still are in heinous, insidious, and I would call hateful, hateful ways. Well, Cook County was a hospital that was almost a hundred percent minority of hospitals. And when we were
residents, we saw the rise in the uninsured in the United States and in Chicago. And we saw the transfers of patients to Cook County hospital from other hospitals. And when these patients showed up at these other hospitals, they got a wallet biopsy, and then they were transferred to Cook County and a group of us said we should do something about it. And they were people who were sending to Cook County were people like everyone in this room. They were nice people. They were raised by nice parents. They probably went to church, synagogue, or moss beings, but they were told by their hospital administrator if someone didn't have insurance, send them to County. We did a study on it. It got published in the new England journal of medicine. Bob Schiff from here was the lead author on it. It contributed -- I went to testify before Congress, and it contributed to the only form of universal health care we have right now in the United States is the right to emergency care. But it's one -- I just want to describe a patient who was in this study. A woman in terminal -- terminal part of labor, ten centimeters dilated, breached delivery, foot in the vagina, transferred to county, no insurance. And our OBs would tell us about women who died of maternal deaths because patients were transferred to County because they didn't have insurance. It turns out 90 percent of the patients were black and brown. Something that was, you know -- what else would you expect? So this was in the -- that was 1987. The last Chicago hospital officially desegregated its ward -- see, the hospitals were integrated, but the black people were in different places. And Michael Reese hospital, 1982, that was when Michael Reese desegregated. So we have a legacy of this.

But it goes deeper than that. In the -- in 2002, these are reports that came out in 2000, is unequal treatment reports. So this was the by the internal medicine, 2002 and they looked for every condition for which there are treatments, therapies for, and they found that black and brown people and oftentimes women got unequal treatment for the same condition all across the United States. So that was about 20 years ago that that report. And this other report was in 1980, the United States. We realized if we're going to impact life expectancy, we have to address the unequal life outcome experiences of minorities in this country. And so in 1980 we said we were going to try to reduce health disparities by 2000. And then we're going to try to eliminate them by 2010. So the goal of the federal government in this country to address life expectancy gaps was to eliminate health disparities and we have not even come close to it. This is now. So where are we in terms of an overall country, in terms of life expectancy? Well, this is looking at 1980, who turned 50 in 1980, turned 50 in 2010. This is the richest Americans to the poorest. And you see the richest Americans have done quite well in life expectancy. It's gone up five years. But you can see the
poorest Americans, life expectancy has dropped. And for the other groups in between, it's not really moved that much. So as a nation, from our health, we are failing.

But here's another fact of life expectancy. If you're rich -- and I'm not talking about super rich. But if you're middle class and upper middle class, it doesn't matter where you live in the United States. But when you're poor, location matters. So where you live in the United States dictates when you die. And you can see here, this is from an article by an economist that if you live in New York City or San Francisco, you live longer if you're poor than if you've lived in Detroit. And imagine other cities, now Birmingham, Chattanooga, other cities as well, these life expectancy gaps are quite large. And about five years, actually of life expectancy for poor people. So when people talk about public policy and what difference public policy makes and where you live, it makes a giant difference.

So this is now, large racial gaps in health outcomes persist. This was the cover of the New York times mag magazine. We know that unlike any other developed country, we're seeing a rising maternal mortality, particularly for black women. People have seen the story of Serena Williams who had a pulmonary embolism. And what women will say to you is people aren't listening. Our doctors are not listening to us. And it's a life and death crisis. In our Chicago area, infant mortality deaths in the first year of life have not budged in 20 years. And so it's a national crisis, and there's a huge degree of urgency around this.

I will say, too, about America's hospitals, we have an inch inherently an Apartheid health care system to this day because the doctors who take care of the minority patients in this country are different than the doctors who take care of white patients. So 80 percent of black Medicare patients are taken care of by 20 percent of the doctors who are likely to be trained differently, working in community health centers, working in different settings and therefore different access to care. And these doctors report they have more trouble getting access to specialty care, other kinds of services. If you look around the star system, you know, the Medicare star system, CMS, star systems and all kinds of problems in that star system. But it turns out that if you are a majority minority hospital, you're more likely to be one or two star in quality than if you're a majority white hospital. There have been studies on heart surgery done across the United States. This is the Medicare database. Everyone has Medicare. And it turns out that black people who get heart surgery are a third more likely to die. And if they're in a black -- a minority hospital. In fact, white people who get their care in those hospitals are more likely to die as well. And it's tied to quality of care and other things as well. So
we -- despite the gains that we've had, we've institutionalized racism in very, almost invisible ways until you step back and you begin to look at outcomes.

A few years ago an epidemiologist at Sinai, added up all the black deaths in Chicago. And these are the excess black deaths that occurred in Chicago simply because black people did not have the same health care outcomes as white people. And this is one year adding up all the deaths, front page of the sun times, and that's 3200. Does that number remind any one of some national event? 9/11. So 9/11, 3200 people died. It was a terrible tragic event. Since that time we spent 5 trillion dollars in Iraq and Afghanistan because of that disaster. And this is an annual disaster in Chicago, these numbers of excess, excess deaths, one city. That number nationally is probably between 60 and 80,000. So that's a huge -- this is excess black people's death.

So where you live -- I showed you nationally where you live dictates when you die. It's true locally. And it's -- it's hyper-true locally. You know what's happened to hospitals is there have been many hospital closings over the last number of years and the hospitals that have closed have closed because they've had financial difficulties. And the reason they have financial difficulty is that the people coming to them have financial difficulties. And a hospital like Rush or Northwestern, even Loyola, University of Chicago, can capitalize because they have a mixture of people coming in and someone with very, very good insurance. But it turns out that the people who have been forced to live under conditions where they're going to be poor are disproportionately in this country minorities. And because of that, when they get sick, the health insurance they cover in their neighborhoods -- and they go to these hospitals -- may not sustain the hospitals. The hospitals can't capitalize. They can't buy equipment. I get this example because I spent 30 years in safety net hospitals on Chicago's west side in the last 14 years at Rush, I call it one street, two worlds. Same doctor, same patients. And we conducted what was, I would call an litmus test on health care in America on one stretch of avenue. And I'll give you some examples of what this meant because my patients have come with me. So in my 30 years at County and Sinai, and I was like head of general medicine, head of medicine, zero of my patients who needed an organ transplant ever received one, zero. It wasn't one. It wasn't two. It was zero who got an organ transplant. And yet the organs that went to the transplant centers came from the patients, black and brown, in our ICUs. And you know, same doctor, one street, two worlds. And it was only when I got to Rush did I realize, gee, I had this idea that if folks like Crystal and I came to County and we worked there, that that would be enough, that if nurses went to places like County and Sinai, that would be enough. But it's not enough
if the whole system is really organized in a way and rigged in a way to disadvantage whole groups of -- whole swaths of society over others. So this was -- if I lived on the north side. It's a woman -- we started a breast cancer task force in Chicago to address breast cancer mortality. I'll tell you a little bit more about that in a second. And this is one of our patients with breast cancer. And part of what we do is navigate people who come into a higher quality places so that we try to navigate them from poor care to better care. And this is what she said. If I lived on the north side -- and the studies have shown it's not race. It's place. And it's racism that drives this. We did -- when we first released data on breast cancer outcomes in Chicago, we showed this mortality gap. In the 1980s, there was no gap and by the 1990s, the gap began to grow. And by the 2000s, black women in Chicago are almost twice as likely as white women in Chicago to die from breast cancer. And when we presented this data, some of our colleagues at an academic medical center on the south side of Chicago said it was biological. You know, the reason was it was the biology of the breast cancer and they say, well, black women get worse breast cancers. They're undifferentiated and they don't have receptors. So we showed the gap in Chicago, a giant one, compared to the gap in the United States, compared to the gap in New York City, which was quite small. And then we asked this question: What happens to black women's genes when they cross the Allegheny mountains. But the point is that this is critical right now. This is how structural racism works day in and day out.

So this is now how have we done in our hospitals? So how are our hospitals to go in terms of representation? So these are from the American hospital association. This is in two periods, 2011, 2014. 90 percent of the board members are white. And now it's 90 percent of the board members are white. Well, it's 88. We're making great progress. And by the way, it's a group of old white men, still hospital leadership. How about in our executive leadership positions? Who's running our hospitals? I guarantee you in almost any hospital health system that has a chief diversity officer, that's a position for a minority, you know, guaranteed. Oh, yeah, who's black and brown and leadership? Okay, this is the time. Chief diversity officer, come on out. But you can see we're doing very poorly in all these other leadership categories. So all of these years -- I don't know, since the civil rights act and since the Medicare thing, we're still dealing with the impacts of this is how structural racism occurs. Think about, too, who's around the room making decisions? And what decisions you make when you have around the room and who feels comfortable speaking out? If you're a -- if you're one woman in a room with all the men, you don't often feel comfortable speaking up. If you recall' one black person in a
room with all the white people, you don't necessarily feel comfortable.

So how many of us are using data to improve disparity? So 20 years ago, there were all these gaps, the answer to medicine report on the gaps in health care. Hardly any of us are systematically using data to identify where we have gaps in health care outcomes and using it to improve.

And this is another -- do we have a community based diversity advisory committee? Mostly no.

So this was from the Boston globe. This is about Boston. Color line persists in health care. This was an article and this is true across the United States, that Boston medical center treats more blacks in Boston. And so there's big gaps in breast cancer, big gaps in colorectal cancer in Boston and in Chicago because the institutions themselves are still segregated. So how can hospitals heal historic harms? This is some recent history in the United States. So this is Charleston. And when Charleston happened, that horrible event in the church, around Rush, we said people are going to come into work on Monday, many of our workers are black people who have been in church yesterday. There's this terrible church shooting. We have to say something. We have to say something. So we put a letter together and we sent out and we did things, had a vigil, said this is not consistent with our values. It's not what we believe in here. And then people remembered this. It's Charlottesville. And if you remember the chant, Jews will not replace us. And we said, that just went on. We have to say something to our employees. And one of our folks said, you know, we can't just do like thoughts and prayer stuff without saying what are we doing in Rush to address racism in our own institution? And so rather than just send out we decry these horrible events, we rolled out our new five-year diversity inclusion plan that includes getting to demographic parity and leadership because we said, oh, it will take us about a hundred years before our senior leadership at Rush reflects what the population looks like. And if we don't accelerate this by actually deliberately going out and recruiting people for leadership positions -- I'm not saying have the pool be, you know, inclusive, but actually getting people in leadership. So we rolled out our five-year plan.

So here's the fact of all of our institutions. We've not moved the needle. We've not done the work within our institutions. Moles of the programs we had at Rush we looked at were not designed to move a needle on any outcome. This is our work on breast cancer. You know, what we did was we went to hospitals and we made them share quality data with us. And what we found was the hospitals that served minority patients in the majority were worse quality. And there they were sometimes simple little things. They didn't have a specialist.
didn't have the right equipment. And we actually moved to get -- improve the quality of these institutions by having folks share data. But the other thing we did, when a woman had a breast cancer and we found her at a hospital that didn't have the kind of facilities, we navigated her to a different hospital where she could get the -- where she could get the treatment. And what happened as a result, this is ten years later. After we started this, we said this is not biological, not to say biology isn't important. This was structural racism. We named it. And black rates in Chicago have dropped. The gap has narrowed in Chicago. It's still too high. But there's no other city in the United States with a large black population which has seen a reduction in mortality. So what we did was we named root cause, the cause of the breast cancer mortality gap was racism. And we named it. And a lot of people are uncomfortable. So I actually think people of my gender and complexion should be speaking out about racism. And it was important to not just have the reaction to that word but think about it in a different way, is it ever acceptable that a woman on the south side of Chicago should have a different outcome for breast cancer simply because of her race? And I think we'd all agree that's not acceptable. And here's another one. Was it ever acceptable that a baby born today on Laramie, on Chicago's west side, is seven times more likely to die this next year than a baby born in Lincoln Park? It's unacceptable. And there's an urgency to fix it.

So we took this map to our board. I was chief medical officer, and I said, okay, ten years, that's enough. Today I'm going to end my career like I began it at County. I said we've got to actually get something done here. It's really important that we move the needle on this. This is unjust. There's an urgency to it. So we showed this map to our board of directors. If you live in the loop, you can live to be 85. Actually in some areas of the loop, you can live to be 90. Okay? But the life expectancy on average in the loop is 85. And if the loop were a country, it would be ranked first in the world. Think of Japan. Number one in the world. But if you go down the blue line seven stops to west Garfield park, life expectancy plummets to under 69. Actually in some areas of Garfield park, life expectancy is under 65, some neighborhoods within Garfield park.

The last time in United States life expectancy was under 69, 1950. Seven stops, seven decades of life expectancy. We showed this to our board. As an epidemiologist, as a county doc, as someone who worked at Sinai for ten years, this was not new to me, but somehow, I think with all the stuff going on and the federal government, people said this is our city. Oh, by the way, this is under Democrats and I think President Obama came from Chicago, right? So this is our city. These are our outcomes, 60 year life expectancy gap. And we said to ourselves that if
we're really about improving health, we've got to do something different than we're doing.

So here's a fact for you. 16-year-old teen-ager lives in west Garfield park, life, has a 50 percent chance, a little more than 50 percent chance of living to the age of 65. What's the cause of death? Why is it?

>> Gun violence.

>> DAVID ANSELL: Gun violence. No, it's not gun violence. Now, gun violence is a problem. Don't get me wrong. But heart disease and cancer, number one and two cause of death in Garfield park is cancer and heart disease, diseases for which we can have early detection, we can treat. Yes, violence is a problem. When you see that, our mental maps, I've done this talk a lot of times, but he's smiling, too, he's not even threatening, right? Our mental map when we see a young black man, that's where our minds take us. Imagine -- this is true, the sociologists have proven this -- we all hold a collective unspoken mental map about neighborhoods. And when we think collectively a neighborhood is bad, those neighborhoods deteriorate. And what determines what makes a neighborhood bad is the race. What determines our perception is the racial and integration status of the people in the neighborhood.

So we took this to Rush and we said you know, there might be a lot of the business ROI, what's the ROI on this, you know, saving lives. We say gosh, our most costly patients come from these neighborhoods. And we found the diabetes and hypertension, they cost more if you live in Garfield park. And then we named our employees our first community. And we found that almost 20 percent of our employees who live in Garfield park are taking money out of their pension day in and day out because of hardship, rent and eviction. What's it like to come to work when you're under financial distress? It turns out we said when do you not take money out of your pension? How much per hour do you need to make at Rush before you stop doing this? $22 an hour. So don't tell me a living age is $15. At our institution, it's 22. So we said we've got to do something differently. So we've created this collective race -- racial health equity framed approach your neighbor, called west side united. And we said we have to not only improve health and health care disparities, so we have to begin to measure them and look where we have gaps and improve them. But we as an institution have an obligation around economic vitality on the west side, educational outcomes in the neighborhood environment, and the idea is to holistically address these conditions that create poor health.

Think about this. You can take a drug for cholesterol lowering. If everyone in America took a drug to lower your cholesterol, Statin, we would gain collectively 20 minutes on our lifespan. But if you could simply move somebody's life...
experience from Garfield park to the loop, you gain 16 years. I say we should all move to the loop. But the idea here is -- so racial health equity frame collaborative, and why do we say that? Because these are historic injustices. It wasn't as if the west side just disintegrated or that it rained on the west side, there was acid rain. No, these were acts of affliction. These were acts of desperation. These were acts of removing capital from those neighborhoods. And this is what happens when you turn neighborhoods into neighborhoods of concentrated poverty. Now, there are many poor white people in Chicago. Don't get me wrong. This is not exclusively a race problem. But there's not one poor white neighborhood in Chicago and that means that that poor white child is exposed to conditions that gives her a chance, and it's a different chance than black kids get. And you've got to say when you get out of a neighborhood like this, you are so resilient to make it through. It's not that people don't survive this. They can. But the collective experience is not there. And you can see how it drives -- who gets insurance, what kind of insurance they get. So county care, which is the largest Medicaid insurance in the city and in the county, Loyola doesn't take. Loyola doesn't take county insurance. Now, they don't pay very quickly and they don't do this, but these are the kind of things, and who are the people who have county care? What's the complexion? So this is a way that structural racism works, what insurance programs you take. But believe me, we don't take Blue Cross for primary care. And so there's ways in which these policies that we make, that seem fair on the surface are actually exploitative. So there's six hospitals we got into this west side united. We listened to the voice of the community. We figure out how do we take our capital and begin to invest in these neighborhoods because we've been there 180 years, and we never invested in the neighborhoods. And now we're beginning to invest in these neighborhoods. And we asked the questions what if community groups and hospitals would come together? What if community residents had a say and where the investments go? We used community leaders to say what should we invest in rather than us? What do we know? What if hospitals could leverage their strengths to sort of eliminate the food gap from the west side and the north side? And what if every high school student on the west side could have a mentored experience by like someone in this room every summer? We said, well, how many high school students are there? 20,000. 20,000. Right now with hospitals are taking 300. 32,000 students in the city of Chicago get paid by the city to do a summer job. 29,000 are with the city of Chicago. The prior institutions haven't stepped up. But what if we could do that. What does it mean to mentor somebody? It's huge. And so the mission of this is to build healthy communities and the aim is to reduce this life expectancy gap by 50 percent by 2030.
We are huge -- if you took all these institutions on the west side, we'd be the largest corporation in the State of Illinois. And for the first time the institutions are working together to intentionally change conditions on the ground.

So how do we do this across ourselves? You know, 50 years after Medicare, civil rights act, we still have structural racism, inequity, giant inequities. We're going the wrong way in life expectancy, 400 years after the introduction of slavery, we still have these gross unacceptable inequities. So how do we reorganize ourselves? And I say you know it's one thing to have the overt racism of Charleston or Charlottesville or the anti Semitism of Pittsburgh. It's another thing to have unconscious biases where we do those automatic thing that we have to correct myself. I think it's way worse that the day-to-day practices of our institutions perpetuate these inequities silently, complicity. We're all complicity in this because we don't step back to sort it out. So this is -- how do we do this? One is you have to make health equity a priority. You've got to create structures in place of structures to address it within your own organization. It can't just be in the Office of Diversity. It's got to be a strategy. Eliminate institutional racism and other inequities in the organization. Sexism and other things that are going ton. Ableism and other types of things, and develop partnerships with communities.

So I spend a lot of time within my own organization outside naming racism as a root cause. It's not the exclusive. It's not the only thing we need to do, but we need to talk about racism is primary because it's the foundation on which our health systems were created and the health inequities we see are largely driven by conscious, unconscious, and institutional processes that perpetuate this. So it's really important that white men in leadership talk about this and all of us in leadership get comfortable about talking about this.

This is two famous basketball stars from the 1960s. Bob Kuzi, son of Irish immigrants, New York, captain of the Boston Celtics. This was the best organization ever, winning championships and bill Russell, a black man from Louisiana facing really overt racist attacks every time they were on the road. His house was broken into, defiled, human excrement on his bed. Two years ago Bob Kuzi, who was captain of the team, never said a word. All of those years they won those championships sent him a letter, and among the things he said, you know, I never really put myself in your shoes to understand what you felt. I should have done more. I wished I had done more. So none of us want to be in the situation 50 years from now -- I probably won't be around, but the idea that 50 years after the civil rights legislation that we could do more. So this requires particular leadership within health care organizations. Number one, name institutional
racism. Ask how it's being perpetuated. Develop strategies to disrupt it. Inclusion at all levels of decision making and there are other things we need to do, working for universal health care and many other things.

So one way to think about making an equity assessment -- this is a simple rule of thumb -- about any policy decision that's going on is how does this policy or procedure that we've just put in place mitigate or exacerbate historical injustices that have white on top, black and brown on the bottom, wealthy on top, poor on the bottom? It could be a policy about a Medicaid. It could be any kind of policy you're doing. And what are we going to do to mitigate it? And there's ways to organize doing these health equity assessments. We're trying to put something, propose something to be taken up through Rush leadership. Because if you don't in an organized way look at how decisions are being made and what the outcomes of them are, if you don't have a frame that's an equity frame, it's got to be race, gender, age. I mean, it's got -- there are many pieces of it. But actually this is a framework that people are using around the country. And I'm just going to read you the first one here. It says which racial ethnic groups -- you could say gender or age group -- are most affected or would be concerned about this policy that we're making.

So I'm going to end on this note. There's a formula that I've used for my work through the year, narrative plus data plus action equals change. This is a billboard that Chicago's department of public health put out to get kids to get a flu shot. It said I'm an outbreak, and someone tea sided to change the message, the narrative around this is critically important that we get it right, that we tell stories about this. We look at our own data to back up about how inequities are being perpetuated. And let's change outbreaks, especially this terrible outbreak of inequity into something of beauty, equality. Thank you very much. (Applause.)

>> I just also want to take this opportunity to introduce Dr. Caryon here, Paul. I invited him to come, old school doctor who went through all of this transition of how we became doctors and the amount of dedication it took during the time that he was going through this to become a physician. And he's a cardiologist on the south side of Chicago trying to fight some of those health inequities, especially cardiac -- cardiovascular disease, heart failure, hypertension, and is the only cardiologist that I've ever met who will be there at 11:00 at night with pictures showing a patient the whole evolution of heart failure and how to improve their lives. So I just wanted to make sure that Dr. Caryon -- (Applause.) That's him right there. He didn't -- wave your hand.

>> JAMES MENDEZ: For the sake of time, we're not going
to sit at the tables. We're just going to have Dr. Ansell answer some questions. So do you have some questions? Dr. Cash.

>> AUDIENCE MEMBER: I have one question. Having been a long time west side medical center inhabitant having started at rush, can you speak to the gentrification of the medical center and how that's impacted both the emphasis on health as people are being dispersed around the area and the impact it's had on those poor brown and black communities that sort of -- that at one point surrounded the medical center.

>> DAVID ANSELL: I think the last number is 200,000 black people voted with their feet in West Chicago between census. Chicago is losing population and it's becoming also -- I mean, this affects everybody in the city. I think the problem with gentrification is the terrible problem. The city council just got an equity assessment. So racial health equity assessment I talked about that we have to do, you know. We have to put on all of our policy, the city council got rated. And it's available. You can just Google it and I think they got like D's or F's. So we live in a city in which the real estate policies are ones that they -- that they're going to accelerate as sort of inequities. In fact, the Atlantic had an article that said Chicago is a city -- is as if New York Manhattan crashed into Detroit because we have the largest group of young people making over a hundred thousand dollars a year. People are flocking into the city and at the same time these giant gaps. It's -- there's a group out there right now that wants to have a tax on real estate. So -- on real estate transactions for affordable housing. So unless we really organize around affordable housing -- and that includes Lang land banking and other things like that, gentrification is a macroeconomic event. East Garfield park is already gone. It's already been gentrified. But it's actually our public policies in the city around housing, that all the aldermen actually have pretty much bought into that we're going to actually accelerate this problem. There's not enough affordable housing. The tax structure is such that it, you know, that real estate developers or major companies are advantaged. I know people have seen the documentary the area. The area about Englewood and how they're coming in and knocking down, condemning all the houses and knocking people out. It's a big problem, very apparent where we are right now compared to what it was. But it's actually public policy is driving us. The solution is land banking land trust and really aggressive affordable housing policies. But we're very weak in the city of Chicago. So it's likely to be perpetuated. Yes.

>> AUDIENCE MEMBER: Regarding disparities in health care outcomes and mortalities in those poor neighborhoods, don't you think it's more a matter of economics versus racism? It just so happens that the most people who live in those areas are
minorities that are black and brown. If you put white minority poor people, poor immigrants in those places, then they probably have the same outcome and you couldn't say it's race, but it would be economics.

>> DAVID ANSELL: So that's an excellent question. But they just don't happen to be there. So that's the problem with that statement. Listen, poverty is a thief, and it steals life itself and it's always been true. But it's not by accident that people have been put in this situation. It's actually deliberate policy that's created these neighborhoods. And you can go back to the great migration, the neighborhoods that were closed off in the city, the inability of people to get mortgages, the contract buying, the red lining, all of the stuff that has left these conditions today, many years later. And then there are plenty of good jobs in these neighborhoods, and loss of businesses. And it was actually the exploitations so I don't use words anymore, I don't say this was the result of red lining or this was investment because those don't really describe what happens. I think it this is a result of systemic intentional racism because what happened was people moved into these neighborhoods because there were jobs and then the business -- then white flight occurred and then the businesses moved out. They didn't all close down. They moved out and they went somewhere else. And I think it's actually -- it is who's being assigned to poverty in this country disproportionately. So in this country, black people, native Americans, Latinos are disproportionately assigned to neighborhoods of poverty. And so then the poverty itself leads to the outcomes. So I do think we do have the name racism but not exclusively so. Yes. Hi.

>> AUDIENCE MEMBER: Hi, thank you for an amazing presentation, first of all. My question is one of the impacts that we didn't touch on much is the impact of trust. So among the community. So now that we're rebuilding the structures, how can we also rebuild the trust so that these communities are now going to see the doctor, are participating in clinical trials, are being proactive about their health. Because the system is work -- working on the system is one part of it but then if you build it, they will come does not necessarily pertain in this case.

>> DAVID ANSELL: That's so critical what you said. So we have developed -- we've earned -- we have very well earned mistrust. The system that was built on white supremacism and racism, including all the false science around it. It's not just Tuskegee. There was a medical diagnosis during the era of slavery called draft-o-mania. Anyone know what draft-o-mania is.

>> AUDIENCE MEMBER: Flight dementia?
>> DAVID ANSELL: Yes, what happens is if a slave wants
to escape, there must be something wrong with them. But we fought it with a breast cancer diagnosis so we have very, very well earned this mistrust and you have the Serena story and other stories, you have to say even if I have wealth, I have to be really careful so we have to break down those barriers of trust. And we understand unconscious bias is -- insofar that your care is different, it's just as bad as conscious bias. So I think we have a lot of work to do. What we've done, this west side united, we feel like we have so much earned mistrust, that if we're going to move ahead with a community oriented approach with the institution investing in it, that the power has to be actually shared with community leaders. And I think until we accelerate our diversity inclusion policy so that people around the table at institutions who are making decisions reflect honestly the make up of the population, we're never going to get to that next level. But I think trust is a giant hurdle for us.

>> JAMES MENDEZ: For the sake of time, three more questions, the person in the middle there holding up her hand forever. Yes.

>> DAVID ANSELL: You can yell.

>> AUDIENCE MEMBER: I was really impressed by and supportive of your plan for increasing diversity and leadership on such a short time frame. And I was just kind of wondering what effect you think that will have on racial health and disparity and what, if any, effects that could have on the bias that is present in a physician-patient relationship if you change kind of the top structure, do you think that trickles down to such intimate discussions between a physician and a patient.

>> DAVID ANSELL: There's a lot in that question. You hope this gets better. One is our CEO talks about diversity inclusion, and you know, this -- think about this. You want to hire someone for a job. I know somebody. Who do you know? You know someone who's like you. Why do you know someone who's like you? Because all you've been is surrounded by people like you. So that is a very powerful structure that unconsciously works within organizations. Here's why I think we've got to -- one is we put that out there as a plan. We have to achieve it. I'm going to tell you about one area of victory. We're looking for very senior leadership position. I went to our CEO and our COO and said we should only -- we are so deficient at our senior leadership that we should only look for a, you know -- we should not actually look for a white person for this job. I'm going to try to be polite about this. We shouldn't even -- so what people say is make sure the pool is diverse. If you have the pool is diverse and I still have my own bias about women and stuff, it's very hard to do this. But I do think I've had black people in leadership tell me in my own organization that I can say something in the room that they don't feel safe saying. And if you're the
only person in the room and you've gotten up into leadership, it's a tenuous position. It's a psychologically and maybe an economically kind of tenuous position. And I think you need lots of voices in that room before people feel really comfortable.

I have to actually in this process I'm going to say deal with my own racism. So I said why for many years did I talk about discrimination and disinvestment. Why didn't I just say racism? Why didn't I say white supremacism. And I'm a quality guy. So why? Why? Why? I didn't want to offend anyone. Who was I offending? Well, the people in -- you know, that was around me. Well, who were they? A bunch of white guys. Well, why didn't I want to offend them? Well, they invited me into the room. Well, why did they invite me into the room? Well, I was good but I didn't scare them, you know. Well, why didn't I scare them? Because I was shut up. I didn't say anything. And I realized, you know, as a child of a family, wiped out in a horrible set of events, you know, privilege feels really good. You want to be in that room and until we institute -- so there's a huge resistance to change even when you make a policy like this. But I think that's really necessary that we do it quickly and we get people around the table. We'll make better decisions as a health system when we're getting the voice -- more voice of women, more voice of people of color in our organization. But I have to say we as an organization, while we are intentional about it have a long way to go. Will that trickle down to the front lines? We have a lot of work to do at the front lines. We talk to our EVS staffers, the white doctors don't even look at them, don't know who they are. And our low wage employees in our institution, largely black and brown people, really have a very different experience in our organization than those higher up. So we have a lot of internal work to do in our organization. What we're trying to think to do is how do we begin to organize these convocations of small groups to talk about people's experience and how is racism and sexism and ableism working here now in our organization? What can we do together to overcome? Because it's not just the policies and procedures and it's not just the numbers. It's the climate. So the climate of -- I've had people come to me, brown, black people come to me, and some say this is the first time I've ever worked in a white space. And I'm going to talk to our CEO and say do you know people of color that come to Rush? I felt that when I went to Rush after being accounting at Sinai. It's a white space and white people don't feel it's a white space. It feels threatening. We have a lot of work to do but it starts with having these discussions and dialogues and having leadership do it but allowing the voice of the front lines of these organizations about what people's experiences are day in and day out, and then how do we change it.

>> JAMES MENDEZ: Okay. Two more questions, not three
questions in one, okay? (Laughter).

>> DAVID ANSELL: Way in the back up there, corner.

>> JAMES MENDEZ: Okay. Those are the last two, one in the corner and --

>> DAVID ANSELL: And I'm happy to take questions afterwards. I'm hungry but no big deal.

>> There is food.

>> AUDIENCE MEMBER: What are your thoughts about a narrative regarding the idea simply more minorities or underrepresented people in medicine, lowering the standard for the admissions criteria? As (inaudible) competitiveness of the program.

>> DAVID ANSELL: What do I think of that? I think it's the craziest thing I've ever heard in my life. First of all, scores don't correlate with anything. You know, to a certain point it does, but it has nothing to do -- actually the quality of medicine in America would be enhanced -- so it got enhanced when we got women, women into medicine in America. American medicine was enhanced because we have the same argument about women. Women couldn't take it, they were not qualified, they weren't durable. They cry. You know. I actually think -- I think medicine in America across the world will be enhanced. So here's a study that was done many years ago. It turns out that U of I, the white students, tend to go out of state. So there's a state school, they follow the white students, they follow the black students. The white students, you know, graduate from the state school and went out of state. The black students -- and this is true across America -- stayed and are more likely to serve underserved communities. So if our public policy in this country is that the underserved need more service, then I feel our medical school classes with black and brown folks were more likely to stay in communities and serve. In fact, that -- to me that's great public policy. So I just don't think it holds any water. People -- it's almost universal that when you start talking about race and application, people start throwing things up like standards, and I think it's a false conversation. I think it's inherently racist in its notion and I think these cutoff scores actually perpetuate historic injustices that have white on top and black and brown on the bottom. And we should just get rid of them and it's been shown by the AACP.

>> JAMES MENDEZ: One more question before we have Dr. Callahan close the event.

>> AUDIENCE MEMBER: Yeah, thank you again for speaking. Tangibly, you know, as medical professionals, future medical professionals, health care workers, what can we do in clinics when patients are right in front of us to combat institutional racism?

>> DAVID ANSELL: So here's what I'll say. One is you can't just be a doctor or a nurse or a health professional without
practicing consciously social medicine and social nursing. Now, nurses are way more oriented towards social nursing than doctors are towards social medicine. And every time -- so we all are working in situations where you have a patient and you don't know what to do and you've really got to just be an advocate on the individual level for the patient but more than that take the problem that the patient's presenting and universalize it and do something about it. And if there are more of us actually stepping into these things and playing a role in your own institutions to address the inequities that we all have, but to play a role nationally, and particularly in the fight towards universal health care. So there's so many different places that we can make a difference. But if every one of us just took -- pushed the status quo, if those doctors in that film had not -- those folks hadn't done what they had done, we would never be here. And so there's a lot more work to do. We've come some distance. There's a long way to go. But it does require activism. And the first step in activism, the first step is the voice in your own head that keeps you from speaking up. It's not anyone else. It's the voice in your own head that keeps you from speaking up. And you have to -- because all of us have been raised to be nice boys and girls and not be disruptive and everything. But I want to tell you if you want to get stuff done and have an impact, you're going to have to be disruptive and you're going to have to speak. Thank you, everyone, for having me. (Applause.)

>> MARGARET FAUT CALLAHAN: So before we conclude our program and enjoy the rest of the evening, I want to take a moment to extend a very hearty thank you to our own historian, Dr. James Mendez, who did a really (inaudible) (Applause.) Great job of framing that impactful movie that we watched. It really, I think, hit all of us in different ways, but it was quite remarkable. And then of course always to Dr. David Ansell for his time with us tonight, sharing his expertise, his personal story. We are so appreciative. You know, this evening fits really well and aligns really well with our university's strategic plan 2020 where we call out the university to work in the area of health disparities, where we're leading our health equity collaborative from this campus, and I think it's really important work. I'll put a plug in. We're right now looking at applications for the next round of funding for our projects within our community. So please look for that call. But it's important that we continue to do this work and it's important that we hear from leaders in our community that can help us learn a great deal.

Dr. Ansell, on behalf of the president of the university and the executive council of diversity and inclusion and our planning committee that did a remarkable job tonight, I have something to share with you, if you could come forward just a little. A gift from all of us to you.
David Ansell: Thank you.

Margaret Faut Callahan: You know, I was very fortunate. I had an opportunity to work with Dr. Ansell for a number of years when I was at Rush. I also was at County for awhile. So I feel like there's so much that we have in common. But honestly, the work that you've done in this area really is so instructional for all of us. So we're very, very appreciative. I know that everyone here agrees with that.

So if you could just bear with me for just a couple of closing remarks, you know, as we close the program, I hope you can pause to reflect on Dr. King's powerful and lasting legacy as it relates in his connection to our Loyola Jesuit mission where we speak about being in service to others as very core. Across Loyola and on this campus especially, we are committed to not only recognizing health disparities but also doing research, building partnerships, and working together to transform our communities and working within our communities with our community members to really make a lasting and impactful difference. We are tremendously proud of our faculty, our staff, and our students who commit themselves to learn and serve beyond our campuses and our neighborhoods around Roger Park, edge water, Maywood and really all across Chicagoland. So all of the work that you're doing is something that we all need to be proud of and support.

In midst of times of despair, we can find hope and strength in recognizing the inspiring work of many and renewing our own commitment to this work to purposeful and meaningful deeds for those that live around us. Indeed is the late brace Lee wrote on her final reflections of her life which intersected and were inspired by Dr. King, she wrote, "We are the leaders we've been looking for". So I ask all of us to leave here tonight, reflect on everything that we've heard and we've learned and really make a commitment to the next steps that we will make in this journey in terms of the vision of Dr. King. So now I ask you to join us for some refreshments up in the atrium, and we can continue dialogue about these important topics. Thank you all very much for being here. (Applause.)

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