Getting Curious with Jonathan Van Ness & Dr. Uché Blackstock

JVN: Hey, curious people, I'm Jonathan Van Ness and welcome to Getting Curious. I have been curious about our health care system. You want to talk about layers, there are endless layers to the health care system. Uh but it got in a…it got in a whole new frame for me late last year; I think the experience of navigating the health care system in December really brought up for me the inequality in our health care system…that so often in the news, we read about the inequity that Black people face, brown people face uh, that women face, that marginalized communities face, queer people's face. Why is health care so unfair? How did it get this way? How do doctors experience the unfairness in their system? I mean, they all got experiences that they bring into the health care system with them. So what do they think about achieving a more equitable health care system? It's also Black History Month, so it seems like a good time for us to talk about um the health care system: the inequalities of the health care system, the ways that they show up. I'm curious about all of the myriad of ways in which this happens. Um and also the history of why that happens. So to talk about that we are bringing in Doctor Uché Blackstock. Dr. Blackstock is a physician and founder of Advancing Health Equity, which partners with healthcare organizations to dismantle racism and close the gap in racial health inequities. She is a former associate professor in the Department of Emergency Medicine at NYU School of Medicine: major. Her writing has been featured in Scientific American, the Washington Post, the New York Magazine. Her book *Legacy: A Black Physician Reckons with Racism in Medicine* just came out in January 2024 and is a New York Times best seller! Is health care fair? Let's find out now and stick around to the end of the episode where we'll reflect on what we learned and if we answered the question and how we answered the question and what I'm curious about now. Ok, let's get going. Doctor Blackstock, Doctor Uché Blackstock, welcome to Getting Curious. How are you?

DR. UCHÉ BLACKSTOCK: I'm doing really well. I'm very excited to be here!

JVN: As we get started, can you tell us about like, what is your like because you were a physician at a hospital in Brooklyn when COVID hit in 2020…which that's we're almost giving you four year anniversary vibes. I can't believe that. But what like what is a day to day life look like for like an emergency room physician or, or for a physician like you?

DR. UCHÉ BLACKSTOCK: You know, like pre-COVID, you know, the ER, is one of the wildest places. It's like, it's, but it's organized chaos, right? You see everything from someone with like a runny nose and a cough to someone coming in with a cardiac arrest, like their heart has stopped. So you see a wide breadth of pieces, it's always super exciting, it's always very busy. Um, but COVID definitely just put, put things up a huge notch. Um to the point where, you know, I was used to seeing, you know, anything. But we got so busy, you know, there were shifts where I would see between like 80 and 100 patients on a shift. Yes. Um I was working a lot of time in, in urgent care. Um and so we would have patients walk in with oxygen levels of like 60%. Um it was the first time, to be honest with you that I was actually scared to go to work because I didn't know what was, what was coming in. We didn't really understand COVID yet. We didn't have treatments for it. I was scared that I was going to bring it home to my kids and you know, my family. Um so that was a really a really tough time.

JVN: Do all hospitals…um because because so like, because, oh my God, my brain so many questions at once because like if you're a doctor at the emergency room, like what kind of doctor is that? Is that just like a…

DR. UCHÉ BLACKSTOCK: Yeah, okay. So I am. So, yeah. So we're actually, it's emergency medicine is a specialty. We are trained in emergency medicine. Um, it's a, it's actually one of the youngest specialties within medicine. Um, but our job is to really, like, stabilize very critically ill patients, like we put breathing tubes down. You know, we know how to do CPR, we know how to take care of anything from, like I said, of a cold to a broken foot to, um, someone's heart stopping…

JVN: Car accident, trauma, bullet shots…

DR. UCHÉ BLACKSTOCK: Exactly. We know we know how to stabilize all those people. We, we, we make sure they're good and stable and then we'll request like a consultation from like, you know, the trauma surgeon or the cardiologist, the heart doctor or the kidney doctor. So we really are, we call it a jack of all trades; master of none. That's what people call emergency medicine positions.

JVN: So then, like across the country does, like every hospital or every state have, like, is it all the same rules for, like, how long you're allowed to be, like, working? Or is it like New York, you can do eight hours in the emergency room. But like in North Dakota you can, they're like, work for the rest of your life, no breaks, we don't care? Or is it like standard or is it not standard?

DR. UCHÉ BLACKSTOCK: Yeah, no, it's, it's not really standard. The only place it standards among, like, residents when you're in your training, like, you, you can't work more than a certain number of hours consecutively because you're still learning, you don't have a license, usually, you're being supervised by someone else. But for other doctors, I know a few doctors that will work, like, seven days straight and then get seven days off.

JVN: Oh, ok. That really…I've been wanting to know this for a minute and I'm, I'm just gonna confess. I do that thing where I'm like, like when people, like, when old clients of mine would be like, “Oh my kid is applying to medical school and like, they really want to do their residency,” and I’m like, I know what residency is, I got two surgeon cousins, like I'm very familiar with residency. Uh no, I'm not. So, what is that again? So med school…

DR. UCHÉ BLACKSTOCK: Yeah, I know, I should, I, I med school, I should explain to your listeners. Yeah so you do four years of medical school then after, so at the end of medical school you decide like, what specialty do you want to go into? Is it, is it surgery? Is it internal medicine, geriatrics, pediatric, emergency medicine? And you apply to residents and it could be anywhere from three years to seven years. But that's where you are um really learning how, how to be a doctor. In medical school, you really don't do that. In medical school, you're kind of in class discussions, but it's in residency that you actually get to take care of patients on your own with someone else kind of supervising you.

JVN: And then after you do that for 3 to 7 years, depending on what it is. Because I bet, I bet if it's like, your, you're like a brain surgeon, like, I bet that's like seven years. Like that one's like way long.

DR. UCHÉ BLACKSTOCK: Exactly.

JVN: So then you just, and then when you graduate, like, your little cohort of residents, like y'all are just like, “Oh my God, we did like our whatever year is like we're done.” And then is there like a little like, is there a little like graduation ceremony?

DR. UCHÉ BLACKSTOCK: Yeah, this little graduation and then people actually go wherever across the country to find like their first full time job. So, you know, some people may stay where they did residency. So people may actually travel to other places.

JVN: Prior to COVID because you had said at the beginning, like during COVID, you were seeing how many to how many patients a day, like on average?

DR. UCHÉ BLACKSTOCK: Like 80 to 100

JVN: And what was average before COVID?

DR. UCHÉ BLACKSTOCK: Probably a third of that.

JVN: So like 20 in a day or?

DR. UCHÉ BLACKSTOCK: Yeah.

JVN: Okay, so then, um what, and is it still that intense or is it…

DR. UCHÉ BLACKSTOCK: No, I mean, so fortunately it's not that intense, but, you know, he was working in central Brooklyn. We were the epicenter. So like, you know, we saw like by mid-March, we were getting hit really, really hard. And so I actually, I started writing about what I was seeing. Um because I, I, even though I'm a doctor, I actually, I like to write. Um and so I started writing about the observations that I was making and I was working in a very like, racially and socioeconomically diverse area. But I noticed like, even after a week that most of my patients look like me. So for your listeners who don't know, I have brown skin, I'm, I'm a Black woman. And so I started writing about like, you know, I think this pandemic is going to disproportionately impact Black communities and communities of color because of like the problems we already have with the health care system.

JVN: 100 fucking percent. Which leads me to like, I think it was, it was during monkey pox, I got to interview Dr. Steven Thrasher, who I'm obsessed with.

DR. UCHÉ BLACKSTOCK: Oh, that’s my friend!

JVN: I love him. And so, and his book, *The Viral Underclass* really blew my fucking mind. And it's also giving me a little bit like Celeste Watkins-Hayes vibes. Like I interviewed her about um like the HIV social safety net. And she compared it to saying that like when people are like, oh we're all on the same boat, she's like, uh yeah, like if you're in a fucking yacht and I'm on like the rose and jack fucking uh bed frame trying to balance on a fucking then, then it's the same boat but very different boats, like there's a lot of inequality there. Um so, and I'm so glad that you brought that up and, and I think, you know, Steven said it's like back with or with COVID, it was like, if you're someone who's living like a multifamily home, like multigenerational home, like if you don't have the access to the resources of like grandma and grandpa have their own house and the kids, like, then you're gonna be running into, especially with like a respiratory illness, you're going to be more uh vulnerable to this.

DR. UCHÉ BLACKSTOCK: Yeah, absolutely. And so that's what I saw in terms of my patients. I mean, like I saw mostly essential workers and service workers. So people who

had jobs where they had to interface and interact with the public where they had no choice. And for a lot of the service workers, we know like they're more low income workers so they're less likely to have paid sick leave. Um they're less likely to have employer sponsored health insurance. And so, you know, I saw a lot of like delivery, you know, delivery people um you know, come in with symptoms because they were not able to, to work home remotely. So those are like the issues that like Steven talks about like this, you know, group of people that are just more likely, because of their social circumstances, to be a exposed to the virus.

JVN: What was the risk to densely populated urban places in 2020? Like, can you set the stage for like, how fucking serious that was? And like, if you saw, like, I mean, there were like young doctors that were dying, there was like, it was, and it wasn't…

DR. UCHÉ BLACKSTOCK: It was scary and it's almost a surreal. I mean, I know that even before I went to work, I literally would hear ambulance sirens multiple times an hour, multiple times an hour. Um, and when I would get to work, there would be a line of patients waiting to be seen and I spent a lot of time in urgent care, which is where less seriously ill people come. But because the ER's were so overcrowded, we got a lot of sick people coming to us. And I remember, and I write about this in my book, I write about how I, I had several patients including an older black man who came to the ER, short of breath, fever and I said you need to go to the, ER, like I'm, I'm calling an ambulance for you to take you from here to the ER. And he was like, I don't wanna go, they're not going to treat me well. Plus the ER's are packed and they were packed because we, you know, they were packed door to door like it, it was just something we had never seen before.

JVN: So, like how, so can you tell us like how there was and is a lot of mistrust around COVID and just like mistrust and misinformation for the Black community. How has that happened?

DR. UCHÉ BLACKSTOCK: Yeah, and it's interesting, it's like one of the reasons why I actually like started using my platform more um during the pandemic to make sure I was sharing accurate and responsible health information. Because what happens when there's already like this broken bond of trust between certain groups in the health care institution: people are not going to seek care when they need it and they're going to go to other sources of care. So or not even of care, other sources of information. So we know definitely social media, people will actually read things on social media, think it's true and you know, follow that information or follow that guidance. Um I had a number of patients who would tell me, "But my barber or my hair stylist told me…ex wife if I drink this tea, you know, I won't get COVID." So I'm like, oh wow, we're actually listening to non-health care professionals about this new virus that I know that we're getting more and more information—I know we don't know everything about it—but at least maybe you wanna listen to people who actually have a background in that area.

JVN: Well, I don't know if you know this, but I just saw on TikTok that uh in King Louis' Day, the barbers were also surgeons. They called them barber surgeons. Um but y'all, I feel like in this century you got to ask the doctors, don't ask your hairdresser about your COVID or your butthole or I mean, I guess sexually, yes, but not health wise.

DR. UCHÉ BLACKSTOCK: Right! I know. And so, but, but we just saw how social media like played such a big, big role in spreading misinformation. And there were, there were always like a few accounts that did it, that really had pretty large platforms that were able to

disseminate this information. And it's really unfortunate because people, if they follow that guidance, are not able to protect themselves as much. But again, that's based on this legacy or history of distrust, right? So the problem is, it's like when something happens, like the pandemic all of a sudden, how can you tell people, “No, no, no, trust me, trust me. I'm going to, you know, I'm going, I'm going, I'm telling you the correct information.” So we have to think about these things before a pandemic happens, we have to think about engendering trust with all these different communities before, you know, before something devastating happens, not during!

JVN: Can you give us other examples of like ways that you've seen not to like, but just you're like, “I'm a fucking doctor: these are the myriad of ways that I see health inequality show up on a day to day basis.”

DR. UCHÉ BLACKSTOCK: You know, we're the only high income country that doesn't have universal health care. But we have like the very worst health outcomes and it's not just among Black people and people of color, it's among everybody. Like we are not doing well as a country health wise. And you know, people, we need to just look at that disparity like we're spending billions, but then people are still dying. So for example, like life expectancy; when COVID hit life expectancy in all high income countries dropped. But since then life expectancy actually has picked back up in all of those countries except guess where? Here! It actually continues to go down for all racial demographic groups, much worse for people of color. And that's because like, you know, I don't know, I, I don't think universal health care is going to be the one solution, but I think it's gonna be part of the solution. We have 30 million uninsured people and then the people who are insured, many of them are underinsured, meaning they can't pay their premiums, you know, they can't, we know we know so many people actually who are diabetic, they have to ration their insulin. Um, you know, um, so they make decisions about, you know, should I buy this medication or should I buy my groceries? Like, and those are, those are people who are insured. So that should never be the case.

But then when we, when we look specifically at Black people, like the, the stat I always use is that even myself with, you know, I went to Harvard for undergrad and medical school, even with those degrees, I still as a Black woman am five times more likely to die of pregnancy related complications than my white peers who are college educated. And so people will say, well, what's that about? Because you have, you have good insurance. You live a pretty good life, right? But what that's about is a few things. One: a lot of times we're not listened to and that doesn't matter about your socio-economic status. We saw what happened to Serena Williams and she had her blood clot, right? She previously told her medical team she was having similar symptoms. No one listened to her, the blood clot traveled to her lungs, she almost died. So if that happens to Serena Williams, that can happen to any average Black woman. But the other thing that we don't talk enough about is actually how racism causes a wear and tear on Black bodies. It's something called, it's something called weathering. The public health researcher, Arline Geronimus, she termed that expression, weathering. So anything, living in any chronically stressed condition, whether it's living under poverty, whether it's living with racism causes this wear and tear on the body that prematurely ages it, that makes it susceptible to developing chronic diseases or delivering a baby early or having complications when you're delivering a baby, right? And so there's, that's more invisible like we don't see that, it's more covert. And so I think people, because it's more covert, people are probably like, no, I don't believe that. But there's a lot of really great data out there that shows this weathering process, you know, shortens the lives,

the lives that everyone deserves to lead full, beautiful lives, but it shortens the lives of Black people in this country.

JVN: Well you know, it just makes me think about that thing on like the football field where it's like explaining privilege and then it's like to go to the 10 yard, like, so it's like, I'm a white queer person. But then when you put like an um Black queer person, Latino queer person, like, like or if they're trans and queer and like, it's just more things that like get layered on it, that makes it harder for someone to not judge you, listen to what you're saying and then like get the care that you need!

DR. UCHÉ BLACKSTOCK: Right, which is why I always talk about like, what's the responsibility of like medical schools and health profession schools like really to make sure they're educating our future physicians and health professionals to care for a diverse patient population, like diverse: racially wise, gender, sexual orientation. Like we need to have like any patient needs to walk in with us and feel seen, heard and appreciated. Like it's, you know, it's so important, but, you know, medicine is one of the most traditional and very conservative uh disciplines. It takes a lot to create change and we see that it's needed now more than ever.

JVN: So what have you noticed about equity in our health care system since the beginning of COVID? Like it's because you said earlier, like other countries are getting better, we're getting worse. Is, is there some silver linings? Is there or is it just really bad?

DR. UCHÉ BLACKSTOCK: Well, I mean, there are some really wonderful things that happened during the pandemic. Like the Cares Act where basically people could get tested for COVID and not have to pay, people could get COVID treatments and not have to pay. We know the funding for that ran out and Congress never renewed it, right? You know, there, there were so those kind of things like that's like a piece of universal care, right, universal health care. Like we saw and we saw that in states that had Medicaid expansions, people actually did better when it came to COVID because they had, they had health insurance, they could go to the hospital.

JVN: Crazy, how that works!

DR. UCHÉ BLACKSTOCK: Yeah. No. Yes, exactly. So there, there are all these things that we know these policies that we know, I always call them health in all policies. Like we know that having paid family and sick leave makes people healthier because then they don't come to work sick, one and then two, they stay home with their whoever a family member is sick to help them get better. Like these are things that just like are really beautiful, thoughtful policies to have. But in our country, in the US, there is so much political will against having it it's almost like, you know, people think about these called entitlement programs. They think people are not going to work, want to work as hard. You know, our people are getting free, free things. And it's like, no, no, no, you want a health, we want healthy, healthy, healthy people.

JVN: But even that free thing, it reminds me of like, tell me if this is true or not. But it's like, I, I remember in like, um, some speeding class that I had to take because I got a speeding ticket in like Phoenix in like the early aughts and I had to like go take this like speeding class and that they were saying like, “Oh, if you think that you're like, well, I want to drive myself to the bar because I don't want to pay for a cab. So you're saving the $20. But then if you get a DUI you're paying 10,000. So you actually really just spent way more money trying to save

it.” So when I think about with our health insurance and just our health care, if someone is under insured or not, insured; cannot pay. So let's say someone got into a car accident, they go to the hospital at all. They get like a leg surgery, they get like stabilized in their insides. Like it's like some open stomach thing. It's like a really intense surgery. I've seen surgery bills for like family members of mine that have had surgery or cancer treatment, it's like a million dollars, $600,000; these insane prices. So when someone gets that amount of surgery and they can't pay because they don't have insurance, doesn't what happens with that? Isn't that like why everyone's insurance is so fucking high because…

DR. UCHÉ BLACKSTOCK: Yeah, it increases premiums. Yeah. So it's just like it leads to everything being more expensive. But also the other thing is if we had universal health care, part of that is having an emphasis on disease prevention. So you know, we end up in this country seeing people with like full on diabetes, full on high blood pressure, heart disease. We don't want people to get to that point. Like we need to invest more in public health prevention so that people just are healthier, so they don't develop these diseases we’ll actually end up, we end up spending more money treating them.

JVN: Let's set the scene: in America today, infant mortality rates and maternal mortality rates are highest among Black women and Black men have the shortest life expectancy of any demographic group. The Hippocratic Oath which all doctors take before they begin practicing is all about doing no harm. So how did we get here?

DR. UCHÉ BLACKSTOCK: I know right. How did we get here in 2024 2024 where despite advances in research innovation, technology over the last 20,30 years especially, we actually are seeing even worse numbers like worse. And I think that speaks to how deeply embedded systemic racism is in our healthcare system and in our other social institutions in this country. Like I think people, like we say, oh people to say, oh no, socioeconomic status, no, because we know socioeconomic status is not protective, right? Like did I already say that I, you know, even you know, I'm still more likely than my white peers, right, so to die of pregnancy related complications. So we need to think about what happens when black patients again interface with the health care system, right? Are they being listened to? So we know what one example is pain, there's this issue of pain and equity. Um and we actually saw it with the beginning of the opioid epidemic when Black patients were less likely to be given prescriptions for pain medications, but white patients were more likely and then they actually unfortunately developed addiction to it, right? So people say, oh, that was protective for Black people. I'm like, no, it wasn't because when your pain is not treated, when your pain is not treated, that impairs your quality of life. When your pain is not treated, you're missing an underlying reason for that pain. So the doctor is not doing, you know, a deeper dive into why you're having that pain. You, it actually impacts your emotional well being, you become depressed and anxious. So, you know, but we we we see that repetitively even in pediatric patients that you know, Black and Hispanic pediatric patients with appendicitis are given less pain medication than, than white kids. It's like, oh, how can that be?

JVN: Do we see other ways that the Hippocratic Oath promise is not being kept for the Black community, specifically?

DR. UCHÉ BLACKSTOCK: You know, that that's such a, it's such a great question. Yeah. I mean, I think it, I think most of it is and how people are not listened to when they seek care. Um you know, I talked about the, the wear and the tear. But I also think that doctors need to understand this is for any patient, like when you're talking to a patient and they're in your

exam room, like it's not just you and them; it's your patient's family, it's their employer, it's where they live. If you're not thinking about like all the other factors that make people healthy, um then it's not like you have to have a solution to all of that. But if you don't, if you don't know that your patient is housing insecure, if you don't know that your patient is um not having access to healthy foods in their neighborhood because there's no supermarket because it's a food desert, right? Um if you, if if you are not like thinking about all those other other factors, what we call the social determinants of health and only thinking about prescribing a medication or telling someone you should eat better, that's not holistic care that we should be providing people. Like we need to make sure we understand everything that's going on with our patients because that's really how we can be the best physicians to them.

And I think also when it comes to Black patients, we really don't understand the history as much. So, for example, like, you know, I talk in the book about redlining. Redlining, you know, with a policy in the 1930s that graded neighborhoods just solely based on who lived in those neighborhoods. If racial and ethnic minorities lived in the neighborhood, it's a “D” but mostly white and affluent, it was an “A” and what those grades reflected was your ability to get a federally backed mortgage or mortgage insurance. Well, fast forward from the 1930s to 2024, when you look at formerly redlined neighborhoods, those are neighborhoods that have the very worst health outcomes. You can have differences in life expectancies of like 30 years between two neighborhoods that are next to each other; one was red lined and one wasn't. And that's because when you deprive communities of resources or opportunities for generational wealth, supermarkets, you know, we know that schools are funded through tax bases from property taxes, all of that impacts health. So we need physicians, health professionals to think more holistically about what makes their patients healthy. And I also think it's an obligation for us to be advocates for our patients. Like we can't just think about what's happening in the exam room; if there are policies that are going to improve the lives of our patients, we need to be out there, whether it's protesting, speaking in front of Congress, sharing our knowledge to improve their quality of life.

JVN: So, can you talk a little bit more about the history of uh why Black Americans might distrust the medical system?

DR. UCHÉ BLACKSTOCK: Yeah, I mean, it's a series of things. I know most people have heard…so I don't, so I typically don't like to call it the Tuskegee experiment. I like to use like the formal name. It's a US Public Health Service Study of Syphilis and the Untreated Black Male because it was the US Public Health Service, which is now known as the CDC. They're the ones who orchestrated it. I know. And basically a study on these, you know, men in rural Alabama, these Black men, low wage workers who were told that they had bad blood. So they were diagnosed with syphilis just told they weren't told they had syphilis, they were told they had bad blood and they were part of this study to see what happens to people when you don't treat them, treat their syphilis. So, the syphilis was allowed to advance.

JVN: Neurosyphilis.

DR. UCHÉ BLACKSTOCK: Heart affects the heart too, yeah. And, and they

JVN: Gave it to their partners!

DR. UCHÉ BLACKSTOCK: Their partners and the baby and their babies were born with congenital syphilis. And so even in 1947 it started, it started in 1932 the study, and even in 1947 I believe when penicillin, the treatment was discovered they were not given the

treatment and the study went on until 1972, actually, when a black epidemiologist at the CDC found out about it, it was like, I need to tell the AP, Associated Press about this. AP broke the story and they stopped, they stopped the study right away.

JVN: In 1972!

DR. UCHÉ BLACKSTOCK: Yeah, 40 years.

JVN: So we were purposely not treating Black men in Alabama with their fucking syphilis that caused like infant deaths, permanent disfiguration like to their community. OK. So what was really screaming for me as you said that is, because I've done a lot of HIV advocacy work, a lot of times I feel like I have people who will say like, oh, but, you know, like, you know, it's like the, the Black men and the Hispanic men, like we really, you know, they're just not listening. And so that's real and it's like, that just makes a lot more sense why…

DR. UCHÉ BLACKSTOCK: Why you wouldn't trust like, and, and then also you wouldn't trust like the medicine that you're getting: is this a medicine that's gonna work or is it not going to work, you know?

JVN: And the government's never apologized for that or like really made…

DR. UCHÉ BLACKSTOCK: No they did. Bill Clinton. Clinton did Clinton issued an apology to some of the um the living participants of the study. Like, I think maybe the 1990s, maybe, yeah.

JVN: After WWII, President Truman was serious about creating a national health insurance program system. What was the historical connection between the civil rights movement and legislation for health care for all? Uh did racism get involved in dissolving support for that legislation? Like what was that about?

DR. UCHÉ BLACKSTOCK: Yeah, so, so part of it was so, so Truman actually, yeah, he did propose universal health care, but it was the American Medical Association, which is the oldest and largest organization of physicians, and actually can I tell you they have their own history with bias and racism. They didn't allow black doctors in for a very, very long time. Like not, not until like the 1900s. But anyway, they lobbied against it because they were concerned that Black people, even Black people would get health care, because up until that point, health care was only employer sponsored and only certain people had the type of jobs that where they would provide health insurance. So the American Medical Association, which is a, you know, physician organization, but they were also worried about losing profits as well. So there's that financial piece as well. So they, they lobby, they spent and they still spend millions of dollars lobbying against universal health care. So that's what they did. But also of note, in 1964 we know the Civil Rights Act was passed. The year after that Medicare went into effect. In order for hospitals to get Medicare funding, so that's funding, um basically, for the elderly, elderly can get care without having to pay. Um, in order to get federal funding, hospitals had to desegregate. So that Medicare, so Civil Rights Act 1964, then Medicare legislation essentially forced hospitals to desegregate and to provide care for all patients. There were still a lot of hospitals that tried to get around that. But if you wanted to get federal funding for your Medicare patients, you had to desegregate it. So that's like the impact of the Civil Rights Act.

JVN: So that's good. That was good.

DR. UCHÉ BLACKSTOCK: Yeah, it was, yeah, it was good. But it's like, why do we have to do all that?

JVN: In 1965 though? Like that, that wasn't like, I think it's another thing that people if there's still like, I, I guess like, because I was raised, I reckon with this a lot in my second book, *Love That Story*, like really realizing like how I was raised, who raised me, like my maternal grandmother, like was from Raleigh, North Carolina. Like there was a lot of like in like racism that was just like past that I didn't even understand or like name it as such. Um but that is one thing that I just, you know, when I would try to explain to her or like my father or anyone who I, you know, have these conversations with is like, it really blows my mind. Like the thing that really like made me go like, like how can you even argue with this: Back women didn't gain the right to vote in the United States until 1965 which is literally their families, their family interests, like what they thought should happen, that's like 200 years of not getting to like vote your fucking interests. Like reparations now I'm flipping this fucking table over like these c*nts!

DR. UCHÉ BLACKSTOCK: Um well, let's flip it together!

JVN: Let's do it. Um so okay, so you, so in the book in, in your book, did you go more into like that whole like civil rights movement and like that legislation? Like, do you talk about that history in there?

DR. UCHÉ BLACKSTOCK: Yeah I talk about it a little bit, a little bit more in the book.

JVN: You guys get the fucking book!

DR. UCHÉ BLACKSTOCK: Yeah, by the way, I didn't mention it's a, it's a, it's a new, it's a New York Times best seller. It's been on the New York Times list the last two weeks.

JVN: That is huge! OK. So um and did you do the audio book too?

DR. UCHÉ BLACKSTOCK: I did, I narrated it myself. It was so much fun. I loved it. I fell in love with my book all over again.

JVN: Her new book is available now. It's *Legacy: A Black Physician Reckons with Racism in Medicine*. It just came out in January, best seller. Rapid fire: last segment. How long did it take you to write the book?

DR. UCHÉ BLACKSTOCK: It took me a year and a half.

JVN: OMG, a year and a half. Um And you and everything that you shared with us like you break, that was just like a little teaser, honey.

DR. UCHÉ BLACKSTOCK: Yeah, that was just a little teaser. Yeah, but, but I wanted to say people like the book is about like my own personal story as a second generation Black woman position, my mother, my twin sister and I are the first black mother, daughter legacy from Harvard Medical School. And so I use our experiences to talk about these large, larger systemic issues. But also I end the book with a call to action: what people can do to make a difference.

JVN: Which do we need to read that for that? Or is there anyone who you're like, you should just do this and read the book?

DR. UCHÉ BLACKSTOCK: Yeah okay, so I would just tell people to, you know, the most, most important is to look at what's happening in your communities or other, you know, other communities around you, Black communities, there are a lot of community led efforts: birthing centers, um groups dealing with climate crisis, we know is related to systemic racism. So I want people to look at hyper locally, locally, so they don't get overwhelmed. Donate to Black-led organizations, volunteer with Black-led organizations, all those organizations at a neighborhood level impact health. So you can make a difference by knowing what's happening in your area or other areas close by.

JVN: If you're a young med student or you have a young med student in your life. Uh, what is something you'd recommend that they do…rapid fire?

DR. UCHÉ BLACKSTOCK: Oh, my goodness. I,I,I would recommend that they get together and question everything that's in their curriculum. Look through their curriculum, say, is it dealing with the history of medical racism? If it's not, you demand that your administration puts that in the curriculum.

JVN: Okay, and also you guys, it's rapid fire because Uché has a fight to catch, not because I could like keep her for 17 more hours, but she's like got fucking shit she saving the goddamn world. Uh what even is single payer, universal health care and could and what could that look like in America if you can do that in like three sentences?

DR. UCHÉ BLACKSTOCK: Yes, a single payer, universal health care is when like one public entity or, or agency manages all of the, the funding and payments for health care. And so it doesn't have to necessarily be a public one. It can be public. But also I want people to understand single payer, you can still have a choice about what doctors you see. Um you know what specialists you see doesn't mean that someone's going to determine all of that for you. But we know that and it could potentially save a lot of money and a lot of lives.

JVN: And if someone has just like fallen head over heels butt-crazy in love with you and your work as I have over the last hour, uh where are you the most active on social? Where can we follow you if we want to just like see your work or do I have to give you a lecture about being on TikTok and making lots of videos?

DR. UCHÉ BLACKSTOCK: No. So, so I, I do have TikTok account but I'm mostly on Instagram, Uche Blackstock, MD and I'm on X formerly known as Twitter Uche underscore Blackstock.

JVN: Ok. Well, I'm really on Instagram a lot. So if you could please just like show your face, tell us about things, tell us about your work like we would just love to see it. So Uché thank you so much for coming Getting Curious. I love you so much. I I'm, I feel like I got such bad ADHD in the middle of that. I, I want to have you back. I just… did we do good? Was I I just love talking to you and I want to have you back. You're just incredible. I feel like we just like tap that we just like scratch the surface like I wanna go so much deeper. Uché thank you so much for coming on Getting Curious, catch your flight. I love you so much. Thank you for coming.

DR. UCHÉ BLACKSTOCK: Okay, hank you so much for coming and I want to say Thank you so much. Thank you so much for having me. This was a lot of fun.

JVN: How obsessed are we with Doctor Uché Blackstock? In fact, when a health care system is uh fully and absolutely and totally based on capitalism, it is going to leave your uh

public, your people, the the health of your people open to so much uh gonna make you very susceptible. Um and you know, it's like that short red haired lady said in *The Weakest Link*, “you are the weakest link.” Um I feel like our health care is that: it is one of our weakest links, the way that our health care shows up for our people. The way that we take care of, of people, really is one of our biggest weakest American links and it's gonna make the universe say goodbye uh to us because we are not doing great. Um I think the other really important thing that we learned here is that when people don't trust their sources, they look for information elsewhere. Uh you know, from their friends, their hairdressers, you know that that part hit home close. Um they look for really important information elsewhere where maybe those people don't have the fullness of the information that they need. So the link between mistrust and then accessing and gaining misinformation is very real. UmsSo the other thing there is that it's really when, when Doctor Blackstock said to us, we need to work on engendering trust, uh wow: I mean, we, we really have engendering gender down pat in this society, but we do not have engendering trust down very, very well. Uh, so that's, and we have to do that between pandemics, not only when it's an emergency. So, so that was, uh a really interesting important part to nail there.

Um I think, you know, as so many episodes that we've learned on Getting Curious and not to be like, you know, we've learned this so much, but it's, it just is so true. I mean, racism leeches itself into every facet of our society, our health care system is no different. There's several ways um that Doctor Blackstock shared that with us. And I'm, I know in there, in her book, she goes so much more into so many of them. But the US Public Health Service that created the syphilis experiment also known as the Tuskegee experiment, that didn't end until the 1970s and it was started in the 1930s. And that just, you know, if you are a white person who has ever thought or if you're anybody who's ever thought um especially white person, you know, why don't they just take the vaccine or you know, why don't they just take prep whatever it is there is real generational trauma there. And I don't think there are, you know, if we were gonna compare that to Twitter, for instance, I remember someone told me once you have to tweet about something like four times before anyone really knows how important it is. It's like, you know, one apology by one President Bill Clinton in the ‘90s isn't enough to fix all that. And really, it's like every administration needs to say that so many times to start to earn that trust back.

And even through COVID, we had so many Republicans who were undermining, we just had so many politicians who were undermining that trust and continue to undermine that trust at every turn, which I think really points to the crisis of information that we are in when we have a whole party who is married to sowing chaos and division in terms of like making its constituents, not believe in what um scientists say we're really in a world of her. And I think part of why a lot of those politicians are so able to um continue to sow that distrust and, and, and cherry pick that information to create misinformation in terms of like why people shouldn't trust the government, it's because the government hasn't done a really great job at um rectifying its mistakes and correcting its mistakes. Here's some other, the most interesting things we took away from this conversation: we're the only high income country without universal health care. We are the only one and our health outcomes are bad for everyone. It's bad for everyone. Also, why is health care so expensive and what happens when someone can't pay their bills when someone is uninsured or underinsured and ultimately is not able to pay their bills? What happens to that? And is that part of why health care is so unaffordable in the United States? Like why is the economy of our health care so

fucked up and is it possible to fix it? That's what I wanna know. Um so, wow, Getting Curious y'all, I love you. Thanks for listening.

You've been listening to getting curious with me, Jonathan Van Ness. You can learn more about this week's guest and their area of expertise and the episode description of whatever you're listening to the show on. And honey, there's more where that came from. You can follow us on Instagram @curiouswithjvn. We are doing the most over there and it is so much fun. You can catch us here every Wednesday and also make sure to tune in every Monday for Pretty Curious! Still can't get enough? Subscribe to Extra Curious on Apple podcasts for commercial free listening and our subscription only show, Ask JVN, where we're talking sex relationships and so much more. Our theme music is Freak by Quinn. Thank you so much to her for letting us use it. Our engineer is Nathanael McClure. Getting Curious is produced by me, Chris McClure, Julia Melfi and Allison Weiss with production support from Julie Carrillo, Anne Curry and Chad Hall.