Death Panel Podcast

TRANSCRIPT: Justin Feldman on Police Violence and Social Murder (Medicare for All Week 2021)

SPEAKERS
Justin Feldman, Beatrice Adler-Bolton, Artie Vierkant

Air date: 11 February, 2021 — Transcript is slightly edited for clarity.

Beatrice Adler-Bolton 00:00
Welcome to Medicare for All Week. Today's interview, Artie and I are sitting down to talk to social epidemiologist Justin Feldman. Hi, Justin, thank you for coming back to the show for this special series.

Justin Feldman 00:11
Thanks for having me again.

Beatrice Adler-Bolton 00:13
It's always nice to hang out with you. Justin is a Health and Human Rights Fellow at the Harvard FXB Center for Health and Human Rights, who studies social inequality and state violence. Some of Justin's recent research looks at how institutions like law, corporations, forensic and public health work together to obscure state accountability for deaths in police custody. So, we've had Justin on the show in the past to talk about inequality and the push to reopen during COVID. But we wanted to have him back as part of our second annual Medicare for All Week to talk about his own research. Because the topics that we're going to discuss today are more central to his body of work than school reopenings. This series this year is all about how to build the movement for health justice, looking forward, how to build power. And we have Justin here today to talk about some of the structural ways that public health and pathology helps subjective institutions of power avoid accountability and why it's important to be thinking about white supremacy, police violence and health care for people who are not free when we talk about the fight for Medicare for All. So Justin, to get us started, before we get into our main discussion, do you think you could tell us briefly about your own research and your body of work?

Justin Feldman 01:27
Sure. So I basically have two main areas of research that overlap. One is looking at inequality in health outcomes, especially looking at the role of racism, class differentiation under capitalism, and residential segregation. So how did those processes result in unequal health outcomes? And how do we even measure that—and mostly quantitative research—then the other area of my research looks at police violence, but from a public health standpoint, from an epidemiologic standpoint. One of my major studies was just trying to get a count of how many people get killed by police in the US in a given year,

because that's on death certificates in mortality data. But it turns out more than half the time it's not properly reported.

Beatrice Adler-Bolton 02:23
Yeah, I mean, that's a huge part of what we've been talking about this year as part of the series, is how there are so many points where the sort of the vital data that's needed to initiate policy interventions on some of this stuff just doesn't exist. And that's sort of part of this larger structural issue where our institutions of health and health administration, public health, and criminal justice, they're sort of framed on this verifiable, pathological system, right? But there are certain biases in the way that we collect data, which actually result in people like you not necessarily having the data set to work with to actually study this stuff. And by keeping it out of public view, we really do sort of hide the problem, correct?

Justin Feldman 03:13
Yeah. And I actually see a lot of parallels between my work on police violence and underreporting of killings by police and what's happening now with COVID, and contact tracing, using contact tracing data that's very flawed, because we don't collect better data to try to say that these businesses or these schools or these institutions are actually pretty safe, because our numbers show low transmission within our buildings. So this is what Nancy Krieger, a famous social epidemiologist, calls, "no data, no problem." Just a complete lack of systematically collected data on injuries and killings caused by police action.

Beatrice Adler-Bolton 03:59
So how bad is the problem of missing data? How pervasive is this?

Justin Feldman 04:03
So there are a few data sources out there on police killings. And one of them is the main public health data set. CDC runs it, it's collected by states, it's called the National Vital Statistics System. It has basically every death in the US there. So what I found along with my colleagues was that more than half the time killings are reported as something else. Usually it's a homicide, just like an assault related injury, what someone would report if just one civilian killed another. But then there was this other category where there's kind of contest station about what really happened. So these are cases where somebody, a civilian, is killed by police but not shot by them. So, George Floyd would be a quintessential example, where the cop's knee was on Floyd's neck, which ended up cutting off his air supply. That's a whole category of what I call deaths in custody, where those causes of death are all over the place ranging from heart disease and respiratory disease to drug overdose to "unknown," "missing," "accidental." And that's where some of my new work is focused because it turns out that in the 80s some medical examiner, forensics person, in Miami came up with a new condition called "excited delirium," specifically to explain deaths in police custody that happen when someone is on cocaine or another stimulant drug. Almost all the time, they're also restrained. And this this sort of idiosyncratic idea that started in the 80s came to take over as a really dominant explanation for these sort of mysterious, unexplained deaths that were happening while police were holding down civilians or tasing them or putting them in chokeholds.

Beatrice Adler-Bolton 06:14

So what exactly is this "medical condition" that's being used to justify, I guess—I mean, what are they trying to justify by saying that "excited delirium" somehow presupposed the death in custody?

Beatrice & Artie 06:30
Yeah, so what's happening with excited delirium is it's being used by a range of actors in this system, from coroners and medical examiners, those are the people who investigate deaths, determine the cause of death, which is a medical determination and determine the manner of death, which is either accidental or natural causes or homicide. Homicide just means—it's not a legal term, it just means the taking of a life by another through intentional action. So they're using excited delirium, to sort of—they work very closely with police. In the course of investigating homicides, in the course of investigating drug overdoses and the other sorts of work they do. And so they have close relationships with police. And there's also surveys from their professional associations showing that something like one in four, one in five, death investigators face political pressure from police or from government officials to change determinations on death certificates. That's not just about deaths in police custody, but that's one particular category, where this can and does happen. Specifically, whether it was homicide versus accidental. So excited delirium allows them to claim it was "accidental." Excited delirium is supposedly this condition where a person who is on a stimulant drug—it started out as just cocaine, they expanded it to any stimulant, they expanded it further. People with schizophrenia who are unmedicated can have this condition whereby they "have superhuman strength," are "acting violently," high body temperature, these are all actual signs people display, but not necessarily coinciding with one another, and they're not necessarily pointing to an underlying medical condition. So the claim is that there's a true underlying medical condition that can in and of itself result in death. And there's kind of two sets of claims they make: sometimes they say, "even if there was no police restraint or police action, the person would have died anyway." Wow.

Justin Feldman 08:56
—The other kind, the other kind of claim they make is that this condition makes them "more vulnerable" to use of force that normally would not have run any risk of death. And in the way they parse it, they say that as a result, the officers wouldn't have known and it was not their fault. So coroners and medical examiners claim it, prosecutors claim it, defense lawyers for cops and for city governments claim it, and then a particularly important actor is Axon, the company that makes tasers so it's become the crux of their product liability defense.

Artie Vierkant 09:36
But I mean, correct me if I'm wrong this sort of pathologization pretty much only exists for that category, right, of deaths in police custody? I mean, this is not—I mean, correct me if I'm wrong, but this is not something that is recognized by international bodies as a disease, this is not something that's in the DSM, right?

Justin Feldman 09:59
Exactly. So the DSM, which is the Diagnostic and Statistical Manual, which is the psychiatric list of recognized conditions in the US, doesn't recognize it. The International Classification of Diseases, which is the international version of that also contains somatic illness, does not recognize it. What they

do point to, both Axon and others who are sort of proponents of the validity of excited delirium as a category, they point to this white paper from 2009—

Beatrice Adler-Bolton 10:34
[Laughs]

Artie Vierkant 10:35
Oh, god.

Justin Feldman 10:36
—put together by, I forget what their acronym is, but it's the professional association for emergency medicine and the US. And they have a white paper, and that's the closest to an official recognition they have. However, it turns out that many of the members on this taskforce that wrote the white paper, were funded by TASER-Axon.

Artie Vierkant 11:01
[Laughs]

Beatrice Adler-Bolton 11:01
Oh, god.

Justin Feldman 11:03
And because of their conflict of interest policy at the time—Axon gets away with a lot because they are not a medical device manufacturer. They're not a pharmaceutical company.

Artie Vierkant 11:15
Right.

Justin Feldman 11:16
So the conflict of interest policy did not require disclosure of their funding.

Beatrice Adler-Bolton 11:20
Wow. [Laughs]. It's kind of amazing how this pathology is being appropriated in order to justify the violence too, like as you're saying, it's not only saying that the death possibly would have been "inevitable" even if the police hadn't intervened, which is just absolute horseshit. But it's also saying that their behavior is such that it required the police to be more violent than they would have been with another person that they were apprehending, correct?

Justin Feldman 11:50
Exactly. And in the eyes of police, the techniques they're using that are resulting in these deaths are much less lethal than what they would have done in the past, which is just shoot people, which still happens, but it's not quite as common as it once was. Or beating them badly with batons. Also still happens, but not quite as often. So what I see, historically, was excited delirium sort of took off as a category once there were some Supreme Court decisions that reined in use of force a bit, especially

this Connor v. Graham case, in the late 1980s, which was a case involving—and so many of these cases involve either mental health crisis, substance use or physical disability. So, Connor v. Graham was a case where there was a black man with diabetes who needed to boost his blood sugar. So he started drinking orange juice in a supermarket before he'd paid for it. And police were called, he was acting "erratically," but really, his blood sugar was just dropping, and they beat him very badly. And that resulted in this Supreme Court ruling, where the use of force had to be proportionate to the situation that a reasonable officer would have used this level of use of force. So that did result in some level of reining in use of force, but created this whole other set of "less lethal" techniques, ranging from tasers to choke holds to what they call "hogtying," "hobble restraint," different restraint techniques that are "less lethal" than what they would have done in the past, but still poses risk of death. So what they're saying is, when you use less lethal force, there's no policy written to say that there should be no accountability, but in effect, there will never be any accountability or very rarely. They will pay, depending on jurisdictions, they'll pay civil settlements, but then they'll use this "excited delirium" defense in many cases, to sort of get out of any kind of criminal liability or political liability that could result in further, you know, restraint to police force.

Beatrice Adler-Bolton 14:11
I feel like a lot of people don't understand how functionally a lot of the communities that let's say, like have worse health outcomes, and they're predisposed to have medical conditions, which could make them, for instance, more vulnerable to being killed when attacked with force—like some of your research looks at how different areas for housing are segregated and how that actually corresponds with increased rates of environmentally triggered diseases or just diseases triggered by stress, like hypertension and lack of resources. So, part of me feels like the sort of medicalized justification is obviously just the latest evolution of this idea that people who've received violence from the state are "deserving of it." If you think about back to the era where you had escaping slaves being labeled as having "a disease" that caused them to "go mad" and that that's why they escaped, or the way that we ascribed characteristics to people at Ellis Island saying that this, you know, this person biologically would be criminal and we use that to incarcerate people or to deny them entry into the country. I feel like this is just the latest collaboration between medicalization and state violence where you have a population which is targeted for violence, and you have a state apparatus or some sort of regulatory body that's creating a medicalized way to justify this. Is that going too far to basically say that this is medicine justifying violence?

Justin Feldman 15:56
I do think there are some parallels there. And now that's actually something in my discussions about what what are the historical precedents for extended delirium as a condition and "drapetomania," which is a condition you mentioned about supposed mental illness resulting in enslaved people trying to escape, that was something that was in medical texts back in, think, the early 19th century. So there are various forms of what I'd call victim blaming within the medical establishment and that is something that goes way back. And at the same time, the history of epidemiology actually has a tradition within it that has sought to push back against that. And if you go back to the very beginning of the field, back to the time of Frederick Engels, he actually, his book, The Conditions of the Working Class in England which is about the midpoint of the 19th century in the industrial slums of Manchester. He's citing work showing different mortality rates by neighborhood type. So, poor neighborhoods had higher rates of

death. And he's coming up with this concept called "social murder," which I actually cited in a recent piece in Jacobin, about the role of workplace exposure in coronavirus transmission. The concept of social murder is essentially that the ruling class puts people in harm's way such that they are vulnerable to premature death that could have been prevented. And then you have, somewhat less radical people, but still doing these studies of differences in health and mortality by neighborhood because the first mortality data—the first health data we had wast mortality records. And this guy [Louis-René] Villermé, in France, also doing similar work, showing higher death rates and working class neighborhoods, and connecting that with dangerous conditions in the factory. So you had even then these sort of debates over whose fault—who should be accountable?

Beatrice Adler-Bolton 18:26
Right.

Justin Feldman 18:27
For these unequal death rates. And in the US, there were debates, and in the British Empire there were debates, about whether there were these "inherent racial differences" causing premature death versus differences in social conditions. And then you had that even in the absence of a racial analysis, where you just had what we'd call "white workers" today, there were debates around morality and vice, sort of these early eugenic arguments around the working classes, just producing, you know, they have all these heritable conditions, they just keep making more children, and they just keep going down the line.

Beatrice Adler-Bolton 19:16
Yeah, I mean the determination that someone was somehow independently "biologically defective" is I think one of the biggest tools for avoiding state accountability.

Artie Vierkant 19:26
Just a classic fallback, really.

Beatrice Adler-Bolton 19:28
Yeah. I mean, you see it in so many different structures of eligibility and determination. You see it in the way that we frame health finance in this country. You know, if you have a good job, or you make a lot of money and you have benefits, then you get good health care. If you don't, if you're poor, then you don't get good health care. And we sort of tie these things up to an individual's ability to participate in the capitalist economy and that becomes your sort of measure of whether you're marked for survival or not.

Artie Vierkant 20:05
Well, also, I think that's one of the reasons we wanted to have this conversation within the context of Medicare for All Week, for example, because we talk about the term social determinants of health all the time, which are basically, there are other meanings to this term, but in a simplified way for how for how we tend to view it, it's a very important avenue for understanding all the different ways that health care, public health, and a number of other social welfare factors, make it so that really, so much of the entirety of the political economy feeds into how your life chances are determined, [and] feeds into your overall health. And I guess in terms of the context, you know, I guess one of the one of the questions

that we always have about that is what would it take for accountability to actually be foisted on the state or be forced on—

Beatrice Adler-Bolton 21:09
Right. [Laughs].

Artie Vierkant 21:09
Because we have a litany of examples within healthcare as it's traditionally defined, but when you start to think about examples like someone's a diabetic, and it leads to them directly being murdered by police, over a set of events that are directly tied to—obviously not just tied to the lack of health care provision, but the lack of health care treatment for the diabetes of that individual certainly was a huge contributing factor, right? So, you know, I guess the question is, in a context like the one we're talking about where we can talk about, like, excited delirium as the thing put on a death certificate all we want, but I think it's very telling that, for example, as far as I can tell, at least, about as far as some public health departments have pushed it is to list murders by police as quote unquote, "legal intervention," right? And I mean, I feel like that terminology itself says something.

Justin Feldman 22:16
Yeah, I don't know where that term comes from, exactly. Which is, if anyone should know, it's me, because my doctoral dissertation was about that.

Beatrice & Artie 22:29
[Both laugh].

Justin Feldman 22:29
At some point, I figured out I would have needed to have gone to the World Health Organization Archives in Geneva to figure it out. So that's the diagnostic category. That's when someone's killed or injured by police. It's under the ICD called "legal intervention.'

Beatrice Adler-Bolton 22:48
It's absolutely wild to frame death in the custody of the state as "legal intervention"—

Artie Vierkant 22:54
They put "legal" right in the name.

Beatrice Adler-Bolton 22:55
Yeah, the continuation of life was just legally intervened in.

Justin Feldman 22:59
Yep. And it actually used to be called 'injury by intervention of police," which is a little more descriptive, and I really don't know why it got changed. I think it was changed sometime in the 60s or 70s.

Beatrice Adler-Bolton 23:14

I think we see how pathology is weaponized all the time. And I think what these sort of determinations are often used to justify is the lack of accountability and just continued inequality. And I think people don't necessarily—like you hear unequal health outcomes, and you think maybe increased rates of cancer or heart disease or something like that, and I don't think that people necessarily always think about what the actual material impact of that is in people's lives and how the continued lack of accountability actually just perpetuates and allows this system of labeling and sorting and violence to continue.

Justin Feldman 23:58
Yeah. And there's just so much emphasis on individual behaviors as—and genetics—as the sort of two main factors that are driving unequal health. And it can be very hard to get people out of that mindset. When everything out there is reinforcing that those are the causes, that it's irresponsible behavior and going to social gatherings, that's what's spreading COVID, that really, if everyone just could behave themselves and wore a mask, or two masks on top of each other, then everything would be better. You can see this unfolding in real time where none of the people with access to media or sort of official channels of communication about the pandemic are right now in the US calling for a paid shutdown to lower transmission and all of the emphasis is on individual behaviors. Thankfully, we haven't seen that much about genetic explanations. But even still, there was a paper in some high level medical journal, claiming that black people have more ACE2 receptors in their nose, and that's why they're getting COVID at higher rates.

Beatrice Adler-Bolton 25:24
[Laughs] Jesus christ.

Justin Feldman 25:25
[It was] this very small sample that was just really making these bolts claims that were unwarranted.

Beatrice Adler-Bolton 25:30
I mean, this is just such a common thing, right? This is just part of the larger justification for not providing health care to people, really, is that we say like, "Oh, you've got to lose weight, you've got to exercise, you've got to do self care. And these are the ways to really improve your health." And we don't talk about the finance side. And I think this is why policies like Medicare for All do see so much resistance, because, essentially, what it would do as a policy would disrupt a lot of the excuses that allow the state to avoid accountability for death and despair.

Justin Feldman 26:14
Yeah, and I'll just reflect for a moment on my time at—I was faculty for a time at a large academic medical center in New York City, that I will not name—

Beatrice & Artie 26:27
[Both laugh]

Justin Feldman 26:29

It bears the name of a major early Trump supporter who is a billionaire, and who called Bernie Sanders "Satan" a few years back. I had access to their patient data for a study I was doing. This data set was every single person in their health system who lived in New York City, who was ages 18 to 64. So largely not Medicare-eligible. And this wasn't really the purpose of my study, but I just looked at the data, it's like, two thirds of these patients are white. One third of the New York City population of the same age is white. And then there were practically no Medicaid patients to speak of. I think it was under 2%. And even fewer who are uninsured. What do you have in New York City is these well funded academic medical centers, heavily subsidized by the federal government, all through, you know, NIH grants, that's it, that's a major source of funding, and all sorts of other ways, but who are not accepting Medicaid patients, and they're not accepting uninsured patients. And then at the same time, you have the city-run hospital system. And they are taking care of people of color in New York City. And they're doing so with far fewer resources. And early on in the pandemic, there was a study looking at how long did it take someone to go to the hospital after they felt sick from COVID-19. And for white people, it was like two or three days, and four black people is like nine days. And there's various reasons, explaining that. But it's not just about—Medicare, for All is not just about fixing the problem of uninsurance. It's about fixing the problem of this sort of health care apartheid that exists because of these completely different funding mechanisms that underfund some hospitals and overfund others.

Beatrice Adler-Bolton 28:43
Yeah, exactly. And I think this is why you see such virulent opposition and such focus on a "pay for" question, because oftentimes when you hear people saying, "but how do we pay for it?" what they're really saying is, "but I don't really want to pay for health care for people who aren't white" because the health finance system is part of the principle architecture that perpetuates white supremacy, because what it does is it distributes resources, more than anything else. Health care is the distribution of resources. And when we starve populations of resources, and then subject them to surveillance, oppression, violence, environmental concerns that affect their health, and then we blame the individual for their personal actions contributing to their death, what we've created is a system where the state can just say it had no hand in this person's death when it actually is in fact completely responsible for constructing the death of the individual.

Justin Feldman 29:43
And it's also interesting to think about how—and you both might have even more insight into this than I do—but the birth of Medicaid and Medicare helped to racially integrate hospitals in the south, and there are some other factors and court court orders and that sort of thing. But these public insurance programs can play a really beneficial role in breaking down structural racism, even as they still allow some of it to persist, it's not going to cure everything. But then our heavy reliance on a private system helps to reinforce the segregation.

Beatrice Adler-Bolton 30:27
Yeah, exactly. And I mean, one of the things that's always really telling is also if you look at how healthcare is distributed to people who aren't free, to incarcerated people, where you have cost sharing at that level, you have people who are warehoused by the state who are being, who are getting sick because people get sick in the natural course of their life, but prison is disabling, prison and jail, make people sick, the conditions that people are warehoused in cause medical problems, as we're seeing

with COVID. Being in prison or jail [means] a pretty high likelihood of catching COVID because of the conditions of how we're allowing community spread to go through these congregate facilities. And so the fact that we still enforce cost sharing on people who have their entire lives taken away, I think, is a really interesting problem, but it's absolutely disgusting to think that what people object to when they don't want everyone actually to have the ability to have health care is that they think that some people don't deserve it. And that's sort of just baked into the way that we evaluate health and the way that we've evaluated populations since the beginning of this country.

Justin Feldman 31:47
Oh, yeah. And incarceration is unhealthy, whether it's a prison, jail, immigration detention. There's been research, before the pandemic and during the pandemic, not just on how infectious disease can spread within incarceration facilities, but also in the sort of spillover effects that they've been having. And there's sort of growing evidence, there's a couple of studies out there, looking at the role of jail and processing in and out and the sort of failure to eliminate pretrial detention is spreading COVID in communities. My colleague Seth Prins and someone else I know, Sandhya Khajeepteta at Columbia, they've been using data from Rikers Jail in New York City. And just looking at how people who are incarcerated there are being treated during the pandemic, and they're still running capacity at pretty high numbers, they could be letting out more people under existing law. And they also haven't been testing people upon arrival, which is very dangerous. They've only been testing people who display symptoms upon arrival. And we know that a lot of people either aren't symptomatic yet, or will never go on to develop symptoms, but can still spread.

Beatrice Adler-Bolton 33:17
So one of the things that you mentioned earlier, in our conversation was how.. I feel like one thing that that people don't want to talk about often is how research institutions and hospitals and scientists are complicit in this system of labeling and sorting for premature death. And they're part of the general system of avoiding accountability and upholding medical apartheid.

Justin Feldman 33:45
Oh, yeah. And it happens at every level. And sometimes it happens pretty blatantly. And for reasons that are very much in line with institutions' bottom lines. And sometimes it happens in more subtle ways, and in ways that can be more easily changed through education. Just thinking back to, so, it's funny to think about the faculty orientation I had where the leadership for this academic medical system was presenting to us—apparently, every year they give a little political message. In my year, they were justifying hospital closures.

Artie Vierkant 34:23
Oh, god.

Beatrice Adler-Bolton 34:24
Ohhh.

Justin Feldman 34:25

[Laughs]. Which is now, looking back on that now, it's like, wow, if they didn't close those hospitals, we'd have more beds and be in a better shape for the pandemic. But of course, it's better for their bottom line. And then, I wasn't there, but a colleague told me she went to the orientation the following year, and that was the year, you know, that Bernie was taking off in the primaries. That year's political message was "Medicare for All would be terrible."

Beatrice & Artie 34:58
[Both laugh].

Justin Feldman 34:58
But then I see it happening in more subtle ways. So, epidemiology for one, let's say public health research and medical research, I think it's important that lay audiences, people without training, who read those papers, or read about those papers in media. Any one study may not be particularly rigorous in itself, and always deserves some level of suspicion and doubt. It's very hard for someone without strong research training to be able to evaluate the methods and strength of a paper. And that often includes the journalists who are writing about these.

Beatrice Adler-Bolton 35:44
Mhm.

Justin Feldman 35:44
And that's one level. And another level is that science has theory. The sort of, you know, intellectual schema for understanding how the world is organized, how to fit in uncertainty, how to generate hypotheses. But if you are a biomedical researcher, if you are an epidemiologist, by and large you're not getting any kind of education about theory. So these subtle, you know, these worldviews that you have by just living in the world, and by being socialized as a researcher, as a student, you can be emphasizing genetic factors, or behavioral factors in isolation from the rest of society. And that can figure into how you generate your hypotheses, how you do measurement, how you interpret your results, the kinds of actions you call for. And that can result in a whole whole range of problems. Often you see genetic explanations for racial differences and things like response to particular drugs, pharmaceuticals. There are more sophisticated ways of talking about how genetics affect—because genetics do certainly affect some drug reactions or health conditions, but it's a lot more complex, particularly how it maps to race, which is social categories, rather than biological categories. So these are not even necessarily issues that someone would be exposed to in their entire eight years of education or more between undergraduate and PhD, the people who are doing these studies.

Beatrice Adler-Bolton 37:32
Yeah, I mean, I feel like a lot of the resistance to creating pathways for more people to get education in these areas, like if we were to eliminate college tuition across the board in the United States, for example. Or we were to make healthcare more accessible to people by removing different types of payers, so anyone could go wherever they wanted, or for instance, as we talked about in our interviews for this series with Arrianna Planey, and Adam Gaffney, so much of healthcare access is not about paying for it. It's about the geographical distribution of resources. And currently, I feel like the lack of data is used to sort of justify not acting on distributing these resources better. We talk all the time about,

you know, rural healthcare in the United States being such a big issue and people really needing to think of rural health care. And yet, you know, as you're saying, there's still this trend of hospital closures, you have the consolidation of resources for research and development that are in major metropolitan areas, some hospitals in the United States have only one or two physicians who are there at any one time. And yet, we sort of treat this healthcare system as if it's one unified body when it's actually a bunch of discrete, small pieces of this really fractured web. What do you feel like something like Medicare for All could do in terms of just upending a little bit of that data collection to give researchers a better picture of actually what's going on within the health of the population in the United States? Do you feel like better interventions could be designed? Or do you feel like there's bigger things structurally, that also need to come as a change with Medicare for all in order to try and achieve better health outcomes?

Justin Feldman 39:26
Yes, I think it's a bit of both. I know in the past, you've been talking about [how] there's no good data on autoimmune disease prevalence in the US because we don't have these national health registries that they have in other countries. So there are critical questions that we struggle to answer simply because we have such a fragmented healthcare system that leads to such fragmented data collection. So that's an issue. But I really think the benefits come in creating new state apparatuses, new forms of state capacity. In the UK, everyone has a unique National Health Service identification number which they can use to do things like administer vaccines, prioritize vaccines, like look at the vaccine distribution, whatever. Every state that's creating vaccine priority categories, the most privileged people in those categories are getting it first. Because everything's on a first come first serve basis, basically. And then ultimately, people are excluded. When the state is running things rather than, at least the last mile, handing it off to private providers in the kind of haphazard way, when the state's keeping track of people you have a rationality that can be imposed in all sorts of different programs that you're running. And I'll just add that it's just so easy to create a strong primary health care system. And it's not expensive. If you look at what happened in China with the barefoot doctors and in Cuba, in the Kerala State in India. These [were] poor countries at the time, poor areas, that were able to develop these very strong healthcare systems that yielded very good outcomes, simply because they were divorced from the profit motive. And, you know, the more we can go in that direction. It's absolutely absurd that we have such a wealthy country, that we aren't able to provide such basic things to people. But it also is because we're such a wealthy country, and capitalist in sort of extreme ways, that we aren't.

Beatrice Adler-Bolton 41:55
Right, and this is why I feel like actually the counting of deaths, and the kind of research that you do is so important, because healthcare isn't just keeping people alive, it's also the accounting for death and the justification for death and accountability. You know, I think so often people are—their own biology is blamed, as you're saying, and ultimately this is also [part of] a profit motive as well.

Justin Feldman 42:21
So, there's this question of accountability. And I was talking about accountability for police violence. But there's also questions of corporate accountability. We in the US don't have strong social welfare supports.

Artie Vierkant 42:39
Right.

Justin Feldman 42:39
But what we do have, or what we're supposed to have is a system whereby if someone's harmed as an individual or as a group, you can get redress through the civil legal system, through lawsuits. And one thing that happens by not having good data is it's harder to make the case that, for instance, a corporation's actions are harming people. You can think about cancer clusters, for instance, and there's all these disputes. This is a very contested area of research: are there areas where there's particular forms of cancer that are above levels you'd expect due to chance? And if so, are they attributable to particular industrial sites in the area? Or, you could think about COVID-19. We don't have great data on where people got coronavirus, partly due to the underfunding of public health infrastructure. So you have this sort of poor quality contact tracing data, and we talked about this on earlier episodes, that really understate the extent to which places like schools or, if you're thinking for profit, restaurants, or gyms, or whatever particular kinds of locations, they're understating the contribution of each of these locations to transmission overall. And you have industry groups that are saying "it's not us just look at the data." And they're arguing this in court, and in many places, restaurant associations in particular are being successful in their lawsuits to keep their businesses open and keep making profit. Rather than, you know, if we had really good public health infrastructure we could be designing studies that would more definitively test the contribution of each of these types of businesses to the overall pandemic

Beatrice Adler-Bolton 44:45
And I think also when it when it comes to the idea of "health spillovers" from police violence too, there's there's definitely an incentive because of the way that we finance state and local governments to avoid accountability for, you know, the state or local government being responsible for the deaths in custody, correct?

Justin Feldman 45:04
Oh, yeah. I mean, when the public comes to see police's actions as unjust and avoidable, it can create serious outrage. Justified outrage. And all sorts of political consequences that they would rather avoid. So they want to obscure away the death, or the injury, or the action, in whatever way possible. So they've not done basic things, like there's a group that creates a standard death certificate for the US. They could put a "death in custody" checkbox on it. But they haven't.

Artie Vierkant 45:47
Right.

Justin Feldman 45:47
And they probably won't. In my research on this the state of Colorado were the only ones who actually did put a "legal intervention" checkbox on their death certificate. But it only lasted a few months—

Beatrice Adler-Bolton 46:03
Wow.

Justin Feldman 46:03
—because that's a style with elected coroners. And the coroners were not happy about it.

Artie Vierkant 46:08
How does that system work exactly? Because I feel like coroners and other public health officials who are part of that whole kind of ecosystem of—which is obviously you know, innately, a political category as pretty much any public official would have to be—how do these appointments work? And what do they do?

Justin Feldman 46:33
This is such an important issue with really important implications both for the criminal legal system in general, and for police violence in particular. So, back in medieval England—

Artie Vierkant 46:45
[Laughs].

Justin Feldman 46:45
—back in medieval England there developed a system called the coroner system. Basically, the King of England didn't want to concentrate too much power in the Sheriff. So he created a separate office called the coroner that would allow the king to dilute the power in these different areas of the country. So, one of the Coroners' responsibilities was death investigations. And that system transferred over into colonial present day US. Coroners, first, in colonial America, they were appointed by the crown. They came to be either appointed, or very often elected at the county level, but typically not requiring any particular education level. And there was a lot of corruption in the system earlier on, people being paid off to make particular determinations, for example. Or they'd compete with each other. And I heard stories from New York City of coroners fighting over bodies, because they got paid if they were the ones who get to do the investigation.

Artie Vierkant 47:57
[Laughs].

Beatrice Adler-Bolton 47:57
Oh my god.

Justin Feldman 47:58
It was the slowest reform movement you could imagine. Starting in the early 1800s, to replace coroners, elected coroners, with some new position called a medical examiner, someone who is not elected, but rather appointed and has a medical degree. Though there's still problems with medical examiners, too. They're quite often not board certified, and they're also subject to political influence. But it's something. But these are the people who are making determinations about deaths that will result—even if it's the death of a civilian—result in whether or not the person's charged. There's also cases around particularly death of children under similar mysterious circumstances, and police can also pressure coroners and medical examiners to make particular determinations depending on whether or not they want to criminally pursue a person who may or may not have been involved in a child's death.

And then, back to the excited delirium for a moment, and data collection, this is a little bit of a pivot. The latest in excited delirium is that it's being diagnosed in the field, essentially, by the police themselves—

Beatrice Adler-Bolton 49:23
What?

Artie Vierkant 49:24
God.

Justin Feldman 49:24
—who are calling paramedics and pressuring the paramedics to administer, forcibly administer, ketamine as a treatment for excited delirium. In practice, there's no or little to no oversight of this process. So there's now there's been a little bit of media investigation. They've found cases where the person who was dosed by the cops, or by the paramedics at the behest of the cops wasn't even exhibiting signs of what you'd consider excited delirium, if you buy into it. But they're just using it as a sort of way to subdue and punish people. And often these people end up intubated in hospitals. It can be pretty dangerous. Basically everyone gets the same dose, which is, depending on your size, can be a very high dose. There was one, Elijah McClain, in 2019 was a black man in his early 20s who was forcibly dosed with ketamine and ended up dead later that day. And there's no good data collection on how often is ketamine used in the field? And what are the outcomes for the people who, you know, who get forcibly dosed? How often is excited to leave them cited in police reports? We have such a fragmented system that either doesn't collect data at a national level or even a state level, or does so only voluntarily. And tolerates a lot of underreporting.

Beatrice Adler-Bolton 51:06
I feel like all of these components are things that you don't necessarily hear reported about when the conversation of abolish the police or defund the police comes up. No one's talking about how the data collection part of it is something that people are being resistant to, because that is something that state and local governments don't necessarily want on their conscience.

Artie Vierkant 51:30
Well it keeps it easier [for them] to brush off demands like abolish the police.

Beatrice Adler-Bolton 51:33
Yeah exactly.

Justin Feldman 51:35
Oh, yeah, definitely. And it has been heartening to see, in some of these police reform bells, which aren't always the greatest, at the state level some of them have included components that require better data collection, particularly California's. But there's always struggle. It's good to have that data. At the same time, anyone who analyze that data is going to, if they do it in a critical way, is going to face pretty vehement pushback on what the data actually means. And then it's actually very difficult to analyze data from the criminal legal system in ways that analyze bias. It gets to some complex

statistical issues. But if you don't account for the process of policing itself, it's very easy to miss racial bias, for instance.

Beatrice Adler-Bolton 52:33
I feel like actually abolishing the police is one of the biggest health care goals we should have as a country because even if you don't know anything about the police and you've just sat down and listen to this conversation I think it's pretty clear how responsible they are for harm in the community.

Justin Feldman 52:51
Yeah. And they're used as a way to deal with people who are sometimes really struggling with issues ranging from mental health crises that they can't get compassionate care for, to substance use, to physical disability and its manifestations. And they are not able to deal with those things. But state capacity, essentially, in the ways that it interacts with civilians, is prisons and police and courts. That's what we've invested in. And we've divested in these systems of care. And these are arguments that go way back. There's this sociologist Loïc Wacquant who's talked about, basically, if there's some kind of social problem you can medicalize it, you can socialize it, or treat it through sort of social determinants of health, or you can criminalize it, and he sort of traces that out. But so often in the US the things we've done have been pushing towards criminalizing problems, or, as I've been discussing this hybrid intertwining of medicalization and criminalization.

Artie Vierkant 53:26
Right. Exactly. Right, exactly.

Beatrice Adler-Bolton 53:27
Mhm. Well, the medicalization is used to justify that the criminalization is somehow humane.

Artie Vierkant 54:11
And that's such an important point, these things, abolition and a movement like health justice or Medicare for All, obviously a lot of people who talk about both do acknowledge and talk about and emphasize the overlap between them, but really understanding them as part of a continuum whereby, you know, we focus so little on social public health supports, and we focus so exclusively on punitive measures that the state actively is creating many of the harms that otherwise it should be seeking to redress, right?

Beatrice Adler-Bolton 54:51
[Laughs]. They're so intertwined and a movement for health justice cannot ignore the systems that the state uses to avoid accountability, I think is really an important thing to have underlined. Maybe as a final topic, you've been doing a lot of research looking at how a lot of these structures of inequality are correlating to COVID deaths recently.

Justin Feldman 55:17
So I have a few different studies I'm working on, one of them was published as a preprint, and some of them are still in process, looking at who is being affected most in the pandemic in terms of dying of COVID-19. And I'm sure you've talked about it on the show before, and probably everyone listening will

know that there's just massive racial inequality in rates of COVID-19 deaths. One of the things I found is basically, no one who's white and under 65 is—not no one, but very few people—who [are] white and under 65 are dying. The rates are extremely low. And I think that kind of points to why such a high level of death is being tolerated. Where the people who are dying are institutionalized, disabled, old people of color. And if you're not in those categories, you know, the risks are pretty low, or have been at least up to now. And I found that if you're a person of color, particularly Indigenous, Black, or Latinx, your risk of dying from COVID is this same of a white person 10 or 20 years older than you—

Artie Vierkant 56:41
Jesus christ.

Justin Feldman 56:42
—there's just absolutely tremendous inequality in the age that people are experiencing risk. And then, in terms of not collecting good data, there's all this politics of data collection, which has sort of been a theme of this episode. We don't collect good data on socio-economic conditions of the people who die, or at least it can take a while before it comes out. There is education, reported highest level of education, reported on death certificates. We don't have that yet. It'll take a while to get. But I was able to use data from Chicago and Cook County in Illinois, to show, within racial groups, who's dying in terms of people living in poor neighborhoods versus people living in wealthy neighborhoods. So you have Black and Latinx people dying at very high rates and at much higher rates than white people. But even within the black community, those who live in, in poor neighborhoods, are dying at higher rates than those that are living in wealthier neighborhoods. Same thing for Latinos. And then I originally thought that white people in poor neighborhoods were dying at high rates, too. But that turned out to be an issue with how Cook County reports their deaths. They were taking a long time to update their race data. So they basically put someone as white until they got evidence otherwise, and they've been so busy they haven't been processing it. So—

Artie Vierkant 58:20
My god.

Beatrice Adler-Bolton 58:21
What?

Justin Feldman 58:21
Yeah. [Laughs]. Yeah, so it's kind of a wonky technical issue, because it does look like the county, maybe through the health department, rather than through the medical examiner office, is reporting better race data. However in general, we know nationally, that people who are either Latino, Asian or Indigenous, frequently get misclassified in mortality data as white, thereby understating the inequalities. But that's just to say that what I found is even poorer white people in Cook County are dying at pretty low rates. So there really is beyond what income and neighborhood poverty data is capturing, there are these profound racial differences. And we can see in housing segregation and occupational segregation, these are things that sort of to a degree transcend socio-economic differences. So even middle class black people tend to not have the same degree of housing wealth as white people for all sorts of historical reasons and are more likely to live in multi-generational housing and in crowded

housing, and even more so with Latinos who are more likely to be immigrants living in crowded housing. So it's not—people often ask when you talk about racial inequalities and health, "Oh, is that just because of differences in economic attainment?" And that explains part of it. But not the whole thing.

Artie Vierkant 1:00:05
But certainly not all of it. Yeah.

Beatrice Adler-Bolton 1:00:07
Yeah. I think also it speaks to the fact that, as you're saying, data both sort of reflects ideology and codifies these prior beliefs about race being some sort of biological determinant of health or health outcomes.

Artie Vierkant 1:00:27
Well, let's put it this way, if you have completely fragmented—you know, I would hesitate to, people use the term of health care system, and I would hesitate to even use that term because that implies a degree of thoughtful planning and control, I think, or at least kind of mechanisms that work well together. When you have systemically underfunded public health systems, when you have no real healthcare system to speak of other than a number of competing private companies. You know, that's a lot of different avenues for a huge variety of forms of systemic racism. And you know, I'm noting that you're not going far enough to sort of call it systemic racism, necessarily, but I guess, you know, I don't know. I'll say that.

Justin Feldman 1:01:20
Oh, yeah.

Artie Vierkant 1:01:21
—as a podcast host and not a researcher.

Justin Feldman 1:01:25
People want me to say that word, to me it's so obvious!

Artie Vierkant 1:01:29
Yeah.

Beatrice Adler-Bolton 1:01:32
[Laughs]

Justin Feldman 1:01:32
I forget it's not so obvious to everyone.

Artie Vierkant 1:01:35
Yeah. I'm a huge fan of saying the obvious dumb thing.

Justin Feldman 1:01:41
I've even been criticized for not—but like, to me, it's, of course, it's racism!

Beatrice & Artie 1:01:48
[Both laugh].

Justin Feldman 1:01:48
And I forget, I forget that's still—living in a world, you know, my own imagination, where that's just so obvious you don't have to say it.

Artie Vierkant 1:02:01
Yeah.

Beatrice Adler-Bolton 1:02:02
No exactly, it's like the only planning that has gone into our healthcare system is how to uphold white supremacy, and that's about it.

Artie Vierkant 1:02:08
Yeah, we also we have we have that problem a lot here where we'll rattle off terms like cost sharing, and, you know, talk about very specific facets of Medicaid or something like that, and it's easy, after a certain point, it's easy to kind of forget non-assumed context.

Justin Feldman 1:02:08
Yep.

Beatrice Adler-Bolton 1:02:26
[Laughs] Right. I really appreciate this conversation, because I think it's really important to consider all of the facets that need to be involved if you're trying to refigure the political economy to reorient around health, where we treat every individual is having a right to survival, which is not how it is now, unfortunately. As we've talked about, there are numerous systems that basically just exist in order to do exactly the opposite. Justin, thank you so much for joining us today. It's been a pleasure.

Artie Vierkant 1:03:01
Yeah.

Justin Feldman 1:03:02
Thanks for having me again. And probably my last time, because I've said literally everything that I have to say.

Beatrice & Artie 1:03:08
[Both laugh].

Justin Feldman 1:03:10
But it's been great. Thank you so much.

Beatrice Adler-Bolton 1:03:12
No, I really appreciate it. Where can people find you if they want to follow you and your work?

Justin Feldman 1:03:17
So you can find me @jfeldman_epi on Twitter. I also have a recent piece in Jacobin. If you search for Justin Feldman, coronavirus, occupational disease, or something like that. It's all about how workplace exposures are being understated in the pandemic and that individual behaviors are being overstated, and what that means and this sort of implications for racial inequality, etc.

Beatrice Adler-Bolton 1:03:47
Well, Justin, thank you so much for joining us. We really appreciate it. And thank you for listening to Medicare for All Week. As always. Medicare for All now. Solidarity forever. Stay alive another week.