Vincent Munoz:

I think what we need to do is explain how our principles of free speech, free inquiry will help serve the cause of justice.

Betty Friendan:

The First Amendment, the constitutional freedom of speech and freedom of conscience that is the bulwark of our democracy.

Bettina Apthekar:

There was a passion in what was being said, affirming this [inaudible 00:00:27] what people considered a sacred constitutional right, freedom of speech and freedom of association

Michelle Deutchman:

From the UC National Center for Free Speech and Civic engagement, this is Speech Matters, a podcast about expression, engagement, and democratic learning in higher education. I'm Michelle Deutchman, the center's executive director and your host.

When we talk about open expression debate and dialogue, we often do so in the context of particular schools and fields such as law, social sciences, and the humanities. We don't talk about speech in the STEM fields or speech in medicine nearly as much, which is why today's episode focuses on expression related issues in the teaching and practice of medicine.

We are far from the only ones interested in the intersection of medicine and expression. Given both its reputation as one of the best medical schools and teaching hospitals in the country and its history of student activism, national attention has focused on the University of California San Francisco, UCSF. UCSF is unique from other UC campuses since it has no undergraduate students and instead focuses solely on its medical school, the health sciences, and its hospital system.

The national media has covered conversations that have been taking place at UCSF over whether or not medical professionals should share their political views about the ongoing war in the Middle East in clinical settings and over the role of social media. As the executive vice chancellor and provost at UCSF, Dr. Catherine Lucy has a unique vantage point for observing and considering these conversations and many others.

She's been at UCSF for 13 years and we're grateful for her willingness to join us and share her insights about these challenges which not only impact UCSF, but doctors and medical students across the United States. But first class notes, a look at what's making headlines. We are recording today's episode on the morning of October 7th, the one-year anniversary of the Hamas attack on Israel that resulted in more than 1200 Israeli deaths and hundreds of hostages being taken.

Since that date, more than 41000 Palestinians in Gaza have been killed as a result of Israel's counterattack. Colleges and universities across the country have been preparing for campus events and activities to mark the date. For many, this will be the first true test of new or revised policies put in place to regulate the time, place and manner of expression on campus. We have been following a case at the University of Maryland regarding these issues.

Over the summer, the campus Students for Justice in Palestine SJP reserved the McKeldin Mall on October 7th to host an interfaith prayer vigil. In response to pressure to cancel the event and concerns about the university's inability to maintain safety on campus on October 7th, University of Maryland's president announced only university sponsored events that promote reflection would be permitted.

In response to having their event canceled, SJP sued the university for infringing their First Amendment rights. A federal district court judge ruled in favor of temporarily pausing the plan to limit events on October 7th. The judge wrote, "The decision to revoke reservations was clearly neither viewpoint nor

content neutral. It came about for reasons that the Constitution simply does not countenance fear of disruption and anger of opponents."

In a separate case, the ACLU of Indiana filed a lawsuit in US District Court challenging Indiana University's new expressive activity policy, which prohibits expressive activity between the hours of 11 PM and six AM, even if the activity is not disruptive, such as standing silently or holding a sign. ACLU alleges that the policy is overly broad and violates the First Amendment.

While the case winds its way through the court system, a group of students, faculty and staff have hosted candlelight vigil protests after 11 PM on a number of Sunday evenings in a direct challenge to the new policy, arguing that the policy does not appropriately balance free speech and safety.

While higher ed institutions work to get things right this week and in the weeks leading up to the election, they also continue to deal with litigation related events that took place last spring. Last month, the ACLU of Northern California filed a lawsuit against UC Santa Cruz. After participating in ongoing protest activity, more than 100 students and faculty members were banned from the Santa Cruz campus for up to 14 days.

This ban included being cut off from their classes, jobs, housing, and or other campus resources. The suit argues that these bans were over broad and that those bans were deprived of their due process rights. UC Santa Cruz officials responded to the allegations by saying that the decisions they made were critical to preserving safety and the regular operations of the campus. Today is also the first Monday in October, which marks the official start of the term at the US Supreme Court, a date set by federal law.

The docket already has cases concerning state bans on gender-affirming care, a Biden administration attempt to regulate hard-to-trace ghost guns and the death penalty. According to Associated Press, only about half of the term's calendar is filled, which means there's definitely room for election-related cases should that be the need following the election on November 5th.

Speaking of the election, for November's episode will be joined by internationally renowned election expert Rick Hassan, the Gary T. Schwartz Endowed Chair-in-Law, professor of political Science by courtesy and director of the Safeguarding Democracy Project at UCLA School of Law. Now back to today's guest, Dr. Catherine Lucy. Catherine is a practicing physician and leading national voice on medical school education.

She took the helm as Executive Vice Chancellor and Provost at UCSF in January, 2023. In this role, Dr. Lucy leads both UCSF's robust research enterprise as well as its highly ranked academic programs, comprising four professional schools and the graduate division. She works in close collaboration with the Chancellor and the leadership team to develop and implement campus priorities and vision, maintain the university status as an international leader in health science education and research, and oversee external partnerships representing UCSF's best interests across the University of California system at the UC office of the president and beyond.

Renowned for her leadership, Dr. Lucy previously served as Vice Dean for Education and Executive Vice Dean for the School of Medicine reporting to Dean Talmage E. King Jr. In these roles, she directed the undergraduate graduate and continuing medical education programs at the School of Medicine and at the Office of Medical Education. A champion of diversity, equity and inclusion, Dr. Lucy was also on the executive management team for the School of Medicine's Differences Matter initiative and oversaw other strategic projects across the campus. Catherine, thank you so much for joining us today. We are very grateful for your time.

Dr. Catherine Lucey:

Thank you so much for inviting me, and I think this is a fantastic opportunity to have a conversation with an expert such as you.

Michelle Deutchman:

Oh, well. Well, it's a mutual admiration society then. So I always like to start every episode by asking our guests about their career journey. So when you completed your residency in internal medicine at UCSF, did you ever imagine that your career would take you to leading the university at which you studied? And can you tell us a little bit about how you got to where you are?

Dr. Catherine Lucey:

I had absolutely no idea that I would end up in this particular position, and I'm so grateful that I have. I would say when I decided to go to medical school, my whole focus was to become someone's really treasured doctor. And I imagined myself returning to my hometown, Rochester, New York and perhaps practicing pediatrics, which is the specialty I knew most about because of course all kids have pediatrician.

So I imagined myself being in private practice in pediatrics, and I find myself being in academic leadership all the way across the country in San Francisco. I will say though, my work as a resident at UCSF in the '80s was truly transformative for me as well as for my colleagues. We all started our internship and residency right at the start of the HIV pandemic.

It was not known that it was HIV at the time, but we knew in fact that we saw on a daily basis young men and women our own age coming into the hospital and dying of this very severe illness, which was eventually found to be caused by HIV virus and now is gratefully a chronic disease for people who are able to access the right healthcare for that.

So I think it changed my idea about what it meant to be a doctor and what it meant to be a doctor was not only working with the patient in front of you, but understanding the world in which they lived, the experiences they had, the communities that supported them, and importantly the communities that didn't support them. And it was a tremendous opportunity to see how working with the community and community activists helped advance the research needed to find the cause and eventually the management strategies for HIV AIDS.

Michelle Deutchman:

Well, thank you for sharing that. And I know you've done tremendously impactful work in your position, but gosh, I would've liked to have had my kids have a pediatrician like you. Do you feel like you missed actually doing more? Do you still ever get to do any of that patient one-on-one or not necessarily?

Dr. Catherine Lucey:

Yeah, up until the time I took this role, I always spent time taking care of patients. Initially I was a general internist. I took care of patients in the ambulatory environment as well as in the inpatient environment across all of the institutions at which I worked.

When I moved to UCSF in 2011, my clinical work actually focused exclusively on taking care of hospitalized patients at Zuckerberg San Francisco General, which has always been my clinical home since I was a chief resident there back in the '80s.

And then when I took on this role in 2023, I realized I just cannot spend the time I would need to take good care of patients. And so I've reluctantly given that up after 40 years of spending time taking care of patients at some of the most challenging aspects of their life.

Michelle Deutchman:

But now you get to focus on other things. But before we focus on sort of current day, I want to go back to the '80s and to what you were talking about. The fact that one of the things that makes UCSF very unique is its long history of involvement both with the local community and its use of advocacy to make gains in

medical knowledge, treatment and access to care. I'm wondering if you can tell us about how this concept of advocacy and on UCSF's website it's referred to as learner activism is integrated into teaching new doctors at UCSF.

Dr. Catherine Lucey:

Yeah, so I think that the idea of physician as advocate is really centuries old. I want to remind people of Semmelweis who was a physician in Austria who recognized that the cause of maternal death from infection was the fact that doctors were going directly from the autopsy labs to delivering babies. And in fact, Semmelweis actually identified this through a series of studies, basically was kind of run out of town because it was such a fanatical view at the time.

But of course now we know the importance of hand-washing and preventing infection, but it was a really radical idea at the time and he suffered because of his radical idea, but the rest of us actually have benefited from that. So advocacy for physicians, particularly for public health and for the things that impact direct patient care has been really part of the profession for centuries.

It was very evident in the HIV AIDS pandemic when there were regrettably some physicians even in San Francisco who refused to take care of patients with HIV or with this what they call gay-related immunodeficiency syndrome when it first started. And other physicians had to really lobby their colleagues and step up to the plate.

And so even at the time when in fact no one knew what was the cause of HIV, they didn't know how it was transmitted, they weren't certain whether physicians themselves would be susceptible for caring for patients. So in fact, caring for patients with this illness became a form of advocacy in of itself.

And of course many things changed as a result of the pandemic. It's interesting that before the HIV pandemic, we didn't routinely use gloves when we were drawing blood and things like that. So we learned over time that sometimes being faced with a crisis such as this can actually improve healthcare for everyone as you're paying attention to what's happening around you.

Michelle Deutchman:

I like hearing about a silver lining that is coming out of really tragic circumstances. And clearly part of a medical student's experience at UCSF is learning how to advocate for systematic changes to address inequities as you've just described in our healthcare system. I'm curious how you and others discuss and train students about when these roles of doctor and activist are merged and when they might be more separate.

Dr. Catherine Lucey:

So I think an important part of understanding the physician's role as advocate begins with understanding your role as advocate for the patient in front of you in the exam room. One of the most important promises we have is to do no harm, and that is the responsibility of a physician to always focus on what is going to be best in moving the patient in front of you from a situation of suffering to one of relief from illness to health.

And that requires that you focus all of your energy and attention in the exam room to the patient in front of you regardless of what's happening in the world outside. Now, obviously patients' lives are complicated and they bring them into the exam room and if this is something they want you to discuss with them, then I think you have an obligation mostly to listen and respond to their concerns.

You certainly can't engage in advocacy in the exam room with a patient in front of you without their permission because that would likely cause them distress and therefore harm them. So the primacy of the doctor-patient relationship in the exam room is one where the patient's needs always come first, and that

can sometimes be very challenging depending on what's happening in the environment and also the distractions that you may feel as a physician.

A lot of us have learned over time that the most important part of the encounter is before you enter the exam room to clear your head and your mind from what's happening so that you can actually be fully present for the person as you enter the room and strive to help them feel better. So I think the first thing we teach is the importance of the doctor-patient relationship. Secondly, I think that there is a role for physician advocacy.

As I mentioned, this is centuries old and we've had many situations since Semmelweis and since HIV, I would point to the issue of Covid where physician's advocacy was really critical in helping people understand why it was important to be masked, to counter misinformation about Covid vaccines, to advocate for institutions going into communities of need rather than requiring communities of need to knock on the door of the health system.

Those are all forms of public health advocacy that I think were really critical during the Covid pandemic. And so our good examples of how advocacy can impact the health of communities and by extension the health of patients in front of you, but it can also help the physician themselves. I think one of the most important things frontline workers engaged in during the Covid pandemic is the need to stay healthy and be healthy so that they could continue to care for the patients in front of them.

And that required us as physicians to continuously advocate, please stay home if you don't have to go out, please wear a mask if you need to go out and please get vaccinated to protect not only your neighbors but the physicians and nurses and everyone working in the hospital who is responsible for caring for you.

I think a bigger issue comes up when we see things such as structural racism consistently negatively impact the health of our communities. And so I will say when we have worked with our students at UCSF around issues of structural of racism, very often they have been the instigators in that work. I remember very specifically a die-in that was held in December of 2014 to protest not only the deaths of many black men at the hands of police, but what they saw as the institution's failure to take up this cause as a critical aspect of caring for communities of black and brown people.

What I would say is we call it learner activism, but I'd like to talk with the students about how activism may raise awareness about it being an issue, but what you really need to do once you have an activism event is to engage with all around you to design a different system or design a different process. And so when we think about the types of activism that a UCSF is known for, it always is followed by advocacy and collaborative work to redesign systems that have not been appropriately designed in the first place.

And so I think activism without advocacy is often just noise. And it's a little bit like social media these days where people screaming to avoid and use bumper sticker phrases, that may raise awareness of a problem, but true solutions to the problem really require that people advocating for something work with existing systems to redesign them.

And that's what we've done in medical education and health care at UCSF with many, many interesting, interested, committed people. Some who were late to understanding the concepts of structural racism but now once, we talk about something being a threshold concept, once you fully understand what structural racism is, you cannot not see it.

And we have been always careful, however, to tackle issues in a way that impact the institution, the university, the medical school, the healthcare system, and to commit first to doing what we can do to redesign our environment, to be as welcoming, as inclusive, as equitable and opportunity as we can as an institution that cares for patients and educates the next generation of healthcare providers in four different disciplines.

Michelle Deutchman:

I just wrote down activism with advocacy because I think that is such a brilliant way of talking about it because I think sometimes people think those are synonymous and sometimes people only think of one of those.

You had mentioned misinformation on social media, and so I'd like to talk a little more about that because certainly one of the huge differences between the '80s and '90s is the advent of the internet and social media.

And I'm curious if you can talk about either or both positive ways it's helped with creating systemic change in medicine, but also some of the ways that maybe it's been counteractive.

Dr. Catherine Lucey:

Yeah, I think social media, as you say, is it's neither all good or nor all bad, right? I mean, I think this is part of the challenge that we face though in social media is that often it takes a very complex topic and attempts to make it into a binary one.

And that's where again, I would say activism and advocacy often differ. So in activism, you're right or you're wrong, you're on the right side of the issue or you're on the wrong side of issue. In advocacy, you're working to help others understand your viewpoint, to listen to their concerns and address them, and to hopefully arrive at a strategy that allows you to move forward to a better future.

So social media is really well-designed for activism, and sometimes that activism is good. For example, there have been lots of ways in which, again, I'll relate to the Covid pandemic, doctors took to the social media to talk about the importance of what was happening, to help explain things, to use their social media pulpit to encourage people to do things correctly, like get a vaccine or stay home if they didn't have to be out and around in large groups and things like that.

However, social media also is unfiltered so everyone on social media has a voice and they can in fact talk about things that they're not expert about, and it's very difficult for people to understand what's true and what's not. So I think that the lines between truth, mistakes, misinformation, disinformation are very blurry and it's very hard for the average person to understand what is factual when information about health is provided by a wide variety of individuals.

I would say too, I think you are the experts in free speech and civil discourse. One of the challenges with social media is there are no conversations in social media. Freedom of speech is really designed to allow people to have their own viewpoint, but to debate them in public square. And you can't really debate on social media. I guess you can, but it doesn't happen in real time.

And most people are not in social media listening to change their opinion, particularly as is it's designed now, because the more provocative you are, the often more likes that you can get. And there's a little endorphin that kicks up when you sort of see, oh, I have all these likes. So I think that free speech in the social media era has been challenging because there is no opportunity really to engage in thoughtful conversation because it's all asynchronous, right?

It gets out there and it's out there forever. So even if you changed your mind and later on wanted to repost differently, your track record is still out there for others to see. So it's an effective tool when used well. It's also an extremely effectively negative tool, one when used poorly.

Michelle Deutchman:

You are singing my song about some of the challenges of social media and conversation and the binary. I'm going to not get on my soapbox right now because we're focusing on your expertise. And in fact, what you were just saying made me wonder a little bit about this whole idea of expertise.

Medical professionals and health professionals go to school and go through so much rigorous training. And right now a lot of that is being placed in doubt by people getting on social media with a quick

missive that sort of throws doubt on areas of science. And I'm just wondering how that gets managed and talked about in the classroom and in the clinical settings because I imagine it must come up.

Dr. Catherine Lucey:

When it comes up is really in guidance to students, residents, faculty, about taking care with social media platforms and social media information. You'll see on social media board-certified physicians disagreeing with one another, and that causes a lot of fury sometimes from people who are saying, how could you let this person be posting this about Covid?

And this other person said, well, how can you let this person be posting this about Covid? And I think that this is an example where we try and say to our students and our residents, if you have a debate, a medical debate about a particular set of recommendations, the place to have that debate is not in social media.

The place to have that debate is in a conference room or in a paper that you publish in a journal or at a national meeting of a professional organization. It's not a conversation that the public square should have to weigh in on or vote in on in order to decide that. That's not the way science works.

Science works where scientists show the data, challenge one another, engage in really important disagreements. That's how science gets advanced. And over time, sometimes the views change because of the scientific conversation that's happening. So I think there are plenty of opportunities for people to debate the situations in medicine and science that people may have valid reasons to disagree with.

I'm not sure it's well served to do it on social media because I think that it can very easily lead to escalation of misinformation if people aren't careful about how they present their viewpoints as being, this is my view, others disagree. That's probably a good disclaimer for people to get used to, but you have to realize that if you put MD after your name, sometimes say, people will say, oh, a doctor said this on Twitter, so it must be true.

Michelle Deutchman:

So we've talked a little bit about some of the potential pluses and some of the harms of social media, and I'm going to hook into that word harm because do no harm is a key portion of the Hippocratic oath. And I know there's been some conversation as of late, especially about whether or not doctors should be putting aside their political advocacy in order to prioritize patient needs.

A little bit about the rub that you were talking about before. While some people feel like it might be harmful to share your political beliefs, but other people feel like it's harmful if you're not calling out the things that you see in the world that are harmful. And I'm wondering if you could just talk a little bit about this debate and we'll go from there.

Dr. Catherine Lucey:

I think it's a particularly challenging debate on campuses that have health systems and campuses where you are educating future nurse practitioners, dentists, pharmacists, physical therapists, physicians where the workforce is being educated in order to sustain excellence in the care delivery of patients.

So I think that once again, I want to say that physician advocacy or health professional advocacy is part of who we are and particularly around public health threats in your own community. However, I think when you're in an exam room with a patient, your focus has to be on that patient. And if you are saying something or wearing something that creates uncertainty on behalf of that patient about whether or not you are going to be their advocate, their own advocate, their advocate, that's a problem.

And I think that you never really know who the next patient is in your room. And you might have, for example, when I was a general internist and I was taking care of patients, I would take care of them for years and so I knew them and very often I learned a lot about their views and their beliefs, and I was able to sort of engage with them, meet them where they are, understand the community in which they live,

their beliefs, and I could use that to make sure that I was addressing their concerns without disrespecting their own viewpoints or without bringing my viewpoint into the encounter with them because it's really not about me as the doctor, it's about what the patient needs.

So I think we have to be really careful about that. I know a lot of the conversation recently has focused on what about wearing buttons or attire in solidarity with a particular oppressed group? I think it's problematic in the doctor-patient relationship in the healthcare environment, I would just say perhaps a health professional-patient relationship because you really don't know whether that the person in front of you will be offended at the least or frightened at the most by buttons that actually demonstrate your particular political viewpoint about something that isn't right there in front of you in the patient's room, and the patient's needs.

I think that there's lots of controversy here about that because buttons have been historically something that we've used to communicate to our patients, you are safe here. Take for example, the pride flag. That's been something that has been worn at UCSF for as long as the pride flag has been around, particularly during Pride Month. And one of the questions we had is, should we continue to allow providers to wear any kind of button on their white coat, on their nursing uniform, on any lanyard that you wear around your neck and has pulled your ID badge?

And there are those who would say, absolutely, we want to use those buttons to signal our understanding of the need for us to pay special attention to groups that have been historically marginalized or excluded by the healthcare system. And others would say, I'm not sure that's such a good idea because the absence of wearing a button then becomes viewed as potentially a political statement in its own right.

And so you don't really want a situation where people will only seek out a provider or only feel comfortable with a provider wearing a button that endorses their right to healthcare because every patient deserves high quality, equitable patient-centered, culturally congruent care by a provider who at the moment is thinking nothing about anything other than what that person in front of them needs.

And I think when we use buttons to signal what we believe in, there is no coat that actually I could put on that would have as many buttons as the types of identities of patients that I have that come into the office on a regular basis. And I think in the care environment, the safest thing is to assume that every provider is going to provide that kind of compassionate, culturally congruent and patient-centered care. I'm not sure buttons signal that. And I do know that there are situations where buttons can be viewed as very harmful by some patients.

So if we really want to talk about do no harm, then I think we really have to be careful about how we express our advocacy for particular groups in the healthcare environment. Now, if you're out and about in the community, if you are on campus going to a rally, even on campus going to a classroom, I think in that environment you're surrounded by people with whom there is no power differential.

And in fact, if you are wearing a button and I'm sitting next to you and I don't understand that button or don't understand what it means and I can engage with you in a one-on-one position where I'm not feeling particularly vulnerable because I'm not sitting there in a hospital gown waiting to be examined by a physician.

So I think that the difference for me in the environments that we live in is that campus is an opportunity for people to gather who are at similar levels and can actually have those conversations that First Amendment was designed to support. The healthcare delivery system and particularly the exam room I don't think is the right place for us to use buttons to signify our activism or our advocacy.

Michelle Deutchman:

That is a very helpful distinction and I appreciate your really drawing that out. I think my only follow-up was the power differential between a faculty member and a student, which would be in the classroom setting and how that comes up or do you feel like that's part of the educational process?

Dr. Catherine Lucey:

Yeah, I think that you're really right on target with saying there is a power differential there. It may in fact stymie conversations if for example, a faculty member is wearing a particular advocacy T-shirt cannot be certain that your students all have the same level of passion or commitment as you do or even are on the same side of a very complex or nuanced issue.

I think as faculty, our obligation when we talk about complicated and complex issues is to always bring in information that helps people understand the complexity of that, which means not just sort of presenting something as this is the right viewpoint, and I want you to embrace this viewpoint. Teaching is not about telling people what to think. Teaching is about teaching people how to think. In order to teach people how to think, you often do have to bring in tensions.

There's a whole educational theory called transformative learning theory that's all about what they call managing disquieting dilemmas, and I just love that phrase, disquieting dilemmas because in order to manage a disquieting dilemma, you have to surface it. You actually have to be able to say there are challenges here, there are nuances here, there's complexities here.

And what we need to do is be able to show you all sides of the situation, not both sides, all sides of a situation and help you navigate through those to arrive at what we hope is an understanding that advances society, that doesn't undermine it.

Michelle Deutchman:

Every classroom should be like that ideally.

Dr. Catherine Lucey:

It's hard though. It's hard, right? Because faculty are humans. The students don't always think so, but they are. Faculty are human and all of us have different viewpoints, but entering a classroom as a teacher, it's not the same as entering a patient care room as a physician or as an advanced practice nurse, but entering the classroom, you have to keep reminding yourself, all of these people in my class come from different lived experiences.

All of them are coming to us with strong viewpoints already. My job is to help them think. And learning is really about taking in new information, comparing it to what you have in your brain already, and then advancing your understanding of the situation. So that's when true learning happens as opposed to telling people, memorize this for the test.

And medicine by definition, anything involved in health sciences is all about teaching people how to continuously learn, how to confront new information, how to look and see if the old way of treating gout or rheumatoid arthritis or cardiovascular disease should be changed based on this new information.

So teaching people how to think and incorporating new information is really the foundation of what we need to teach health providers for the future. Advocacy is just another one of those elements that we have to help people understand because to understand the elements of advocacy, you have to understand how different humans are going to address this and understand this and feel this as it impacts potentially their health or the health of their communities.

Michelle Deutchman:

One of the other things I wanted to draw from was when you talked about how if you wear pins regularly, then the absence of a pin might be read to mean something. Sort of like when universities make statements, then unfortunately the absence of a statement can be read as some people say, well, silence is complicity, those kinds of things.

And so I kind of wanted to talk a little bit about this idea of institutional neutrality, which has become very popular especially in the last year as universities have tried to weather the things that have happened

on and after October 7th. And now a lot of people are adopting the Calvin report and trying to be even more strict about neutrality.

And I'm wondering, given all of the things that you've already shared with us about the connections between the community and the world and medicine, what factors are considered when UCSF decides if and when to speak with its institutional voice? And certainly one, a perfect example I felt like was what the Department of Obstetrics Gynecology Reproductive Sciences said in the wake of the Dobbs decision, and I'm sure you have many other examples that you might be able to share.

Dr. Catherine Lucey:

Yeah, I think that this is an issue that I think over the past year has become very top of mind, but was always on the radar even before that, I'll say when we started as a medical education program, so not institutionally, but as a medical education program at UCSF in and around 2014 and '15 when the issues of police brutality came up, we started talking about those with our students and we started sending messages because our students said they needed someone to recognize that events that happened like the death of Michael Brown or the death of Philando Castillo, when that happened, it was extremely distracting for students.

And I'll say another one of the Tree of Life Synagogue Massacre and other events that were really shocking and targeting specific people who shared identities with many of our students. And so our students felt like it was important for the administration to recognize that something that happened has caused a great deal of distraction and pain and suffering for them, and they may not be at the top of their game.

I think part of a challenge in medicine is that our students go to class every single day. They're in the class from like eight to five. It's a very fast-paced curriculum, and what they needed was someone to say it's okay for you to take the day off and just engage in some self-care. And what we try to do is use messages to communicate not only to our students that we see you, we understand this traumatizing or triggering for some people, we want you to feel comfortable taking care of yourself, but also to do the same for our faculty who sometimes had the same experiences but others were just not as aware.

And we wanted our faculty more broadly to understand, hey, something happened in the world that was very distressing for our students and we need to make sure that we're taking good care of them as we're helping them develop into this really important role of a healthcare provider. What we tried to do with those messages is acknowledge the pain and suffering, talk about why this was important for us to talk about and then try and provide something educational for the people to, if you want to read it a little bit more about this or if you want to understand the roots of this problem.

So we tried to make it into an educational missive, I would say part of the education that students got. And it worked very well, and in fact our students even helped us turn that strategy into a formal program that we use called the Racial Justice and Social Trauma Protocol. It's not quite the right name, and which basically says we activate this when we think a large number of our students are being negatively impacted by something that has happened. One of the challenges we have found though with these institutional messages is that not everyone agrees with them.

And some people in fact have found them offensive. I can remember very specifically being visited by a very passionate individual who was a resident in one of our institutions who disliked a message that I had sent out that focused on issues of structural racism. And by and large, it makes you think like, all right, well, I think this is an obvious right answer to this situation, but they aren't always obvious right answers to the situation.

And part of being an institution is to make sure that you're trying to support everyone and in an environment where there are deeply polarizing concepts at play, such as what we've seen in the last year, when we try and support one set of individuals, another set of individuals has become very, very frustrated by that. And what we have done in exchange like many institutions have been to try and walk

the line more finely, in which case people are basically like your message is so neutral that it's insulting to everyone.

There was no point in you putting out a message about some of the issues that have come up. I will say that Carol Chris from Berkeley gave an interview I think in the New Yorker back in December where she talked about the differences in institutional statements and also challenges to institutional statements that she's seen.

And we've certainly seen that in that people have really wanted you not only put out a statement, but to use their statement, their words, and if you don't want to use their statement or your words, then there's these accusations of being complicit. So what we've tried to do is focus our efforts to things that are happening right on our campus and calling them out. For example, anti-Semitic graffiti, calling that out is anti-Semitic and inappropriate or anti-Arab hate graffiti, calling that out as anti-Arab hate.

Or something that we are deeply, deeply experts in, for example, the Dobbs decision, as you talked about, the Dobbs decision affects women everywhere and we are a healthcare environment. We need to pay attention to reproductive justice for all people, and that is deep in our ethos, but it's part of our requirement as being a physician to do no harm and it's harmful to women when you don't provide them with the opportunities to access healthcare that is evidence-based and necessary for them at a particular moment.

So the Dobbs decision, I'll go back to HIV, HIV advocacy was really important. Covid advocacy was very important, and anything that's happening on our campus is important and merits attention. But I do have to say that I think I've never been a big fan of the Calvin issue of institutional neutrality. I feel it's too stark particularly for a healthcare environment.

But I think there's some value in each institution trying to make an a priori decision about under what circumstances will we issue an institutional statement and what circumstances do we not? And then I think we have to let people know about that. I think part of the challenge is things have been moving so quickly in this past year that it has been difficult to make informed decisions not in the heat of the moment and communicate those not in the heat of the moment.

Michelle Deutchman:

Thank you that like all of your answers, was so thoughtful and so nuanced, which I think we need more of. And I guess I've just been thinking about some of the things that you said, which is about always connecting to education in the statements and also the focus on messaging to and for your community, which seems to me to be one of the things that I think in the last year sometimes got lost, which was seen statements that may have been written not necessarily for people in the community, but as a response to things happening and pressures outside the community.

So I think that is helpful to think about and I tend to agree with you. I think the Calvin report is a little too, all or nothing, and I have to believe that there's a way to not, as the saying goes, throw the baby out with the bath water because I do think it is important for students and faculty and staff who are living and working in this environment to be seen, especially in times that are challenging, and this has been a very challenging time.

Dr. Catherine Lucey:

I also want to point out that the Calvin statement was originated at a time when universities were much homogeneous with regards to both their faculty and their students. It's easy to be neutral if you are confident that everyone around you already knows how you think and what you're supposed to think.

It's much harder when you're dealing, as we are now fortunately, dealing with incredibly diverse student bodies, incredibly diverse faculty, incredibly diverse patients, and so who all do need to believe that their institution sees and feels their pain. But I think there are different ways that we can communicate that we

see and feel their pain. Unfortunately, we've kind of gotten into the habit of expecting that that gets communicated very broadly in broad-based messages.

And in fact, it probably is better to be known for the institution that reaches out to those we know who will be injured, distressed, harmed by current events. I hope we can get to that level of institutional empathy and trust in that institutional empathy that doesn't rely on broadcast message for all issues.

Michelle Deutchman:

I was going to say we always end our episodes by sort of focusing on somewhat of a to-do for our listeners. Based on the things that we've talked about, is there something that higher ed professionals who are the ones largely listening to this might take or do or think about as it relates to our conversation?

Dr. Catherine Lucey:

I always tell people I'm not an expert. I'm just here to as a colleague, to talk a little bit about our own experiences and my own reflections on those experiences. You're definitely the expert in this field, but I would say that the most important thing one is to work on trust in your institutions with your ... and not necessarily at the institutional level.

People aren't going to trust in the chancellor, but at the education level, the faculty level, your students need to trust that they can be who they are with you and that you will listen with an intent to understand and perhaps change your mind and to model that. That's so important. So becoming a trustworthy institution, a trustworthy faculty member, that's where I think a lot of support for people in times of distress comes.

You want them to turn to you and to understand that regardless of what they feel, you are still going to be there to support them. A second thing I would say is decide in advance what you want to do. And I think oftentimes that's a rose-colored retrospective scope. We sort of say it's always easy the Monday morning quarterbacking, but I do think that spending some time now saying, this is how we communicate concern, this is when we will communicate broadly and this is why we make the decisions that we make.

Guiding principles as it were for institutional statements that aren't necessarily binary, we never do or we always do, or we only issue statements that are neutral, in which case you have to ask yourself why have a statement at all if it's totally neutral. But I think all of us could make decisions when things are quiet about the best ways for us to communicate concern, a need for advocacy with our environment.

And then the last thing I would say is it is so important for us to understand the power differentials. One is the doctor-patient relationship, and you brought up importantly the faculty-student relationship. And when there is a power differential that makes it that much more important for you to be careful about what you say and when, because some of us have louder voices than others, and we have to make sure we understand that and don't abuse that in the roles that we have in institutions.

Michelle Deutchman:

Thank you. I think those are all such important points, especially going back to trust the building and rebuilding of trust that's going to need to happen, especially after this year, both on an individual level and there's a lot of studies about the loss of faith in the trust and institutions and even in the value of higher education. That's so important.

And I just feel really grateful that I have had the privilege to talk with you and learn from you and exchange some ideas. And I think it's going to hopefully be really helpful for people to be able to sort of think a little bit more about how these issues come up in healthcare and in sciences, because I think largely the debate doesn't focus on that. And I'm just really grateful for your time and want to ask if there's anything else that you want to add before we have to close.

Dr. Catherine Lucey:

No, thank you so much for this. I really appreciate being asked to do this, and also I appreciate the work that you're doing. So wishing you strength, endurance, resiliency, and hope to see more of your work going forward.

Michelle Deutchman:

Well, thank you and to you as well. That's a wrap. Thanks again to Dr. Lucy for joining us for this important conversation. Every voter should know where to find the tools and information they need to cast their ballots with confidence. That's why we're celebrating National Voter Education Week here at the UC National Center.

All week long voters across the country can take part in a nonpartisan campaign to make sure they're ready to show up in force with this fall's elections. Celebrating National Voter Education Week means helping voters find their polling location, learning what's on the ballot, and making a plan to vote and inspiring others to get involved.

Each day is an opportunity to help yourself and others prepare to make your voices heard. Take these steps and learn at nationalvotereducationweek.org. Tune in next month following the 2024 National Election for a conversation about democracy and voting with legal scholar and professor Rick Hassan. And in the meantime, go vote. Talk to you then.