Black Men in White Coats: Physicians share their stories

Featured topic and speakers
In this episode of AMA Moving Medicine, guests share their stories as black physicians and discuss the importance of increasing diversity in medicine.

Speakers

Clyde Yancy, MD, vice dean for diversity, equity and inclusion at Northwestern University Feinberg School of Medicine
William McDade, MD, PhD, former AMA Trustee, anesthesiologist and chief diversity, equity and inclusion officer of the Accreditation Council for Graduate Medical Education
Frank Clark, MD, psychiatrist and former chair of the AMA Minority Affairs Section (MAS) Governing Council
Michael Knight, MD, internist and obesity medicine physician and current MAS chair

Moderator

Willie Underwood III, MD, MSc, MPH, AMA Board of Trustees member, urologist and executive director of the Buffalo Center for Health Equity

Host

Todd Unger, chief experience officer, American Medical Association

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Transcript

Unger: Black Men in White Coats is an organization that aims to increase the number of Black men in the field of medicine through exposure, inspiration and mentoring.

Dr. Yancy: “What chills me, I think about the number of Black men who went to medical school when I did. I earned these gray hairs in 1978 when I was a first-year medical student. In 2016, the same number of Black men that went to medical school with me in 1978. Same number that enrolled in 2016. It really is simple ...”
That’s Dr. Clyde Yancy, vice dean for diversity, equity and inclusion at Northwestern University Feinberg School of Medicine.

On this episode of Moving Medicine—a podcast from the American Medical Association—doctors Frank Clark, Michael Knight, William McDade and Clyde Yancy discuss the importance of increasing diversity in medicine.

I’m your host, Todd Unger, chief experience officer at the American Medical Association.

This episode of Moving Medicine came from an AMA-convened discussion, following a screening of “Black Men in White Coats,” featuring Black men sharing stories about their lives as physicians. Here’s AMA Trustee Dr. Willie Underwood.

Dr. Underwood: The decline of Black men in medicine, to hear from some of those who have overcome the barriers to become a Black male physician leader, an influencer—we hope that you enjoy the screening of "Black Men in White Coats" documentary, those who have lived experience and navigating the path of becoming Black male physician leaders, to help us to dive deep into this discussion. I'm pleased to welcome the dynamic voices and leaders in this work who have joined us in this conversation tonight. So, I'm going to allow the panelists to introduce themselves and we're going to do that in alphabetical order, starting with Dr. Clark.

Dr. Clark: Thank you, Dr. Underwood. I'm Dr. Frank Clark, I'm an adult psychiatrist. I practice out in Greenville, South Carolina, where I serve as the medical director and division chief of adult inpatient services and consult liaison services, excited to be here and have this conversation.

Dr. Knight: Dr. Michael Knight, and I'm in internal medicine and obesity medicine, physician and assistant professor of medicine at the George Washington University School of Medicine and Health Sciences, and also serve as the chair of the Minority Affairs Section of AMA.

Dr. Underwood: Thank you, Dr. McDade?

Dr. McDade: I'm Bill McDade, I'm an anesthesiologist in Chicago. I'm also the chief diversity equity and inclusion officer for the Accreditation Council for Graduate Medical Education. I'm a past AMA Trustee and past chair of the Minority Affairs Section.

Dr. Underwood: Dr. Yancy?

Dr. Yancy: I'm Clyde Yancy. I am professor and chief of cardiology at Northwestern University Feinberg School of Medicine. Concurrently, I serve as vice dean of diversity and inclusion and I'm the associate director for our cardiovascular institute. Additionally, I serve as deputy editor for JAMA Cardiology, one of the several journal journals in the JAMA Network, and I'm delighted to be here to
help this conversation.

**Dr. Underwood:** And I'm Willie Underwood. As previously stated, I'm on the Board of Trustees at American Medical Association. I'm a board-certified urologist and I'm also the executive director of the Buffalo Center for Health Equity. Let's get started. In the documentary, Dr. Dale stated that if you don't have a seat at the table, you're on the menu. Right now there, if any, there are very few Black men who are sitting at the table. So what does that mean to be at the table? Let's start with Dr. McDade.

**Dr. McDade:** Thanks Dr. Underwood. Having a seat at the table is equivalent to the idea of diversity. When you are part of the conversation, that means that you are able to bring perspectives that other people in the room may not have. Now, what that also comes along with is having a voice. And so a seat at the table is not enough. You actually have to be able to be heard when you're at the table. And that additional leverage is the inclusion part. So being there and representing is really the most important thing that you can actually bring through a discussion of diversity, when you're in that room. There are all kinds of decisions that are being made all around you and you have to be able to be part of that conversation or else they will not be made in the best interest of you and those people who you might otherwise represent by having been there, as perspectives are very important that everybody gets a chance to be heard. Everybody gets a chance to be involved.

**Dr. Underwood:** Dr. Clark, please add to that.

**Dr. Clark:** Yeah, I'd be happy to. So, we know that representation matters. And one of the things that we've been hearing, I think it was mentioned in the documentary, you can't be what you can't see. As a Black male physician at my institution, health care setting, I have a seat at the table but like Dr. McDade said, it's not just enough to have a seat. Your voice needs to be heard. And with that, I think when you have a seat at the table and your voice is heard that ... why is this the diversity? A lot of times, I think people have a lot of blind spots, especially when it comes to structural racism, microaggressions, these things. And unfortunately, when you have those blind spots, you tend to have more of a kind of myopic or narrow view of things. And so when you have a seat at the table and you are able to be heard, I think that widens the landscape for people to engage in conversations that are oftentimes uncomfortable.

**Dr. Underwood:** Dr. Knight?

**Dr. Knight:** Such important points. When we talk about, you know, seat at the table, many people say, well, you have a panel full of African American men who have a seat at eight or multiple tables, as has been outlined. It's not just being there. It's being able to have your voice heard but also being able to have influence over decision-making processes. Not only being window dressing, if you will. I think a lot of times we know that the reality is when we talk about diversity, equity and inclusion, it's more than just what it looks like on the brochure. It's are these individuals integral to the operations of a business of a health care organization, of an educational institution? Do they have an ability to

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make or affect change? Are they on the agenda? So, I would say not only at the table but you need to be on the agenda and you need to be able to influence the decisions that are being made. If we really want to see representation. And we really want to see change when it comes to this issue.

**Dr. Underwood:** I do want to tell a story before we go into this. A good friend of mine, he was the deputy director of the cancer center and he goes to the meeting with the board of trustees of the cancer center. And when he got there, the director, which sat there, the chief of staff, all her hench-people, all had seats at the table with the board. And he, as a deputy director was on the side seat, literally with the staff. Okay. It was a year before he was ever allowed to present in front of the board and he was allowed to present in front of the board because the board asked him to present. Okay. So when we talk about—yes, this is deputy director, second-in-charge—treated as though he was me, who had no seat at the table, no title whatsoever. So since we do have a senior vice dean here, I want to ask Dr. Yancy. So what's your role at the table and why are you in that seat? Tell us about, and why is it important that you're in that seat?

**Dr. Yancy:** So, Dr. Underwood, again, I'm delighted to be a part of this conversation, particularly to share this discussion with my good friend, Dr. McDade, and to become acquainted with doctors Clark and Knight. This conversation is critically important because the phrase of “launch it,” is no longer contemporary, having a seat at the table qualifies as an excuse. There needs to be multiple seats at the table and apropos the question you just posed on and that it's about power. I've been in the room. It's been a privilege for most of my career because of things I've done as a clinician scientist. But the last five years, I've been a part of the leadership of a major academic medical center. I have had power and we have to be careful because power can intoxicate. But if you use power for the greater good and use your power to create leverage, and to hold others accountable, now the rules of the game have just changed. You want to be in the room. Yes, but you want to be in the room with some authority, with some presence, with permission to speak and it's about power. So what happens now is that I exert power on a weekly basis because I'm one of the leaders of this medical center. That's been a long journey. But if you look at the progress this medical center has made in downtown Chicago in the last 10 years—and Bill McDade knows what kind of numbers I'm talking about—it's not because someone, all of a sudden got religion, is because there was someone in the room holding others accountable in saying, it's time. We have to do this different way. And so that's the difference, Willie.
Dr. Underwood: Awesome. So, I'll tell ya, you know, I've been fortunate enough to be in the room a couple of times as well. Right? So, and oftentimes they've always gotten me. You see people with positions that have great titles and that appear to have power and they either don't have power or they don't utilize that power in a way to make a substantial change. Right? So, it's not being the Black mayor, is not being the Black dean, is not being the Black chairman over the department. It's about saying, “Hey, okay, now that I'm here, you put me here for a reason. And that reason is to advance the organization so help, let me help you advance the organization.” Right? Right. Anyone else want to add to that points? I'm going to free-fall.

Dr. Yancy: Here it's a free-fall response. What you just said, be very careful aligning power and authority with position, that is not a consistent observation. There is several vice deans here but none will have the same authority. There are several individuals who are associate chair, persons that have more authority. One has to pay particular attention to whom it is that has sufficient leadership traits that they're able to recruit others, to follow an idea, generate a new idea. And here is the important thing, execute on the idea and deliver a greater good that's where power emanates. And so, it really is something you have to understand carefully. So you can know, because you may find out that you are paying deference to someone with a title and that's not where the power resides.

Dr. Underwood: But I mean, do you know Jim Collins or Jim Maxwell couldn't have said that better. Dr. Clark, Dr. Knight, Dr. McDade any comments?

Dr. Knight: I think we also have to be mindful when we think about understanding why you were placed there. We also have to understand that certain individuals may be placed in a position I'm not given the tools to necessarily be effective or the tools to really advocate. And they're really there for a viewpoint. They really there for how it looks. Right. And I think for all of us, we have to be aware of that. How many times where we've been asked to come into the room and we really have to speak to those individuals who are appointing us, who are leading, “What is it that you would like for me to bring to the conversation? Do you want me to be here and really express what I believe can be effective? Are you really looking for my viewpoint or are you looking for me to be a go-between to deal with the fires as they arise and put them out and keep everyone happy?”
I think that's a reality that we also have to talk about because that is a challenging position that many individuals are placed in where they think they're coming in, because people want to hear a viewpoint and they actually want you to, to make things edible and receivable to others and kind of be that face. So it's … there's this … we know the reality is that there's politics involved in a lot of things and a lot of organizations. And it's about understanding how organizations work, how power works, how influence works but then also being able to navigate that. And that's a learned discipline when these individuals on this panel and individuals who've learned that have been successful in their spaces. It's not something that necessarily comes naturally for us. A lot of us weren't trained on it, how to navigate those spaces but it's incredibly important.

Dr. Underwood: Yeah. I tell you raised an interesting point. I was in a meeting in the board room and I was speaking on something, trying to move an organization specific direction, and someone sent me a text message and text message says, “Do you really think they want to hear what you have to say?” And the answer to that was no. Dr. Clark?

Dr. Clark: Yeah. You know, I agree with everything that's been said, and Dr. Yancy, I'm a former Feinberg alum. So I appreciate how far we have come. Because it wasn't always that way when I was at Feinberg. I also appreciate the sentiments that Dr. Knight talked about, navigating those spaces is not something that we do learn about it but I think it does require mentorship and sponsorship. And so I've had the opportunity … Dr. McDade has been a mentor for me throughout my career. And I can text him or he's somebody that's always going to encourage me, and I've had other mentors who I can call on. So I think when you … when we are trying to navigate those spaces because it's hard when you're the only one.

So, for example, I'm the only Black male faculty and leadership at my department. And every day I recognize that as I step into our health care system and how I am going to navigate those spaces. Obviously, I have some wonderful allies and people that want to see me in those spaces, but also at the end of the day, now that I'm still a Black man in leadership and what that comes with a lot of, it comes with a huge price. And so, I think it is important to have that mentorship and sponsorship when it comes to navigating those spaces because we can't do it alone.

Dr. Underwood: So Dr. McDade, hearing this, how do we use our voices, our positions, our opportunities to tackle this problem that we have, right? Where we don't have enough Black men in medical school, we want to increase the numbers. We know who the gatekeepers are. So what are some of the tools and discussions that we can have that sort of tackle that issue?

Dr. McDade: So there's a myriad of problems that exist in that regard. Rhea Boyd actually talks about a performative stage in which organizations make statements, make appointments, create offices without any power or any direct meaning or intent to accomplish things. The next phase she talks about as a representative phase in which you increase the numbers of individuals is what you're discussing right now. The final phase, that maturation phases of the substantial phase in which
there's actual execution of those individuals, you've empowered now by bringing into the organization. And that initial group actually can now think about how you're going to make change in what you're trying to accomplish. I really view that the work that we do with respect to manpower and the numbers that we're talking about really amounts to, can we eliminate health disparities through workforce solution. And if we can bring more numbers of people into an environment, then we're going to have a greater chance of increasing the access that people who now lack access to care, who are those who bear the greatest burden of health disparities.

Dr. McDade: We'll have that impact. And my thinking on that one is that there are so many different ways that we can attack it because there's so many problems in society that lead to that deficit of African American men in medicine, you can start with our educational process. You can start with the wealth gap that exists between African Americans and others in society. You can look at how bad it interplays with income and property ownership. I mean, there are all kinds of things that kind of factor into the deficit of individuals who are there but even those people who are there, aren't sure shots. When you get them to college, if they're able to get to an excellent school, that's going to be a feeder for medical school. You have to make sure that you don't lose people anywhere along that pathway who are interested in medicine.

And we can lose people for all kinds of reasons. Then once they apply to medical school, we can lose them in medical school. And then once they're through with medical school, we've got to match them in the residency programs and during residency programs, we can still lose people. So that pathway is capable of deviation from that pathway, from the very start, all the way to the very end. And we have to garden against those individuals deviating from that pathway through mentorship, through support the resources every step of the way. And if you want to go into greater details of where those losses occur, we can have conversations around that but you have to get enough people into that initial pathway on that pathway, and then not lose a single person from that pathway until they get to the very end.

Dr. Underwood: Yeah. And it's very hard because we're talking about overcoming 400 years of a systematic, systemic process that was designed to make sure that the individuals we're talking about never hadn't simple education, let alone a complex education and not like with us, with multiple graduate degrees and making these accomplishments. Right. So I'm going to throw something out and cause this is, to me, this is interesting. I thought about this literally today. When a Black student doesn't do well, all the Black students aren't doing well, right. That's how they describe it. You saw that at Georgetown Law School, right. Becomes an overwhelming stereotypical thing. But if a white student doesn't do well, it's just that white student not doing well. And if a Black student does exceptionally well, it is just that Black student doing exceptionally well. They don't say, “Look at Willie, look at Bill, look at Frank and see how good they … Clyde, right? Michael, they're superstars. Oh, what may be among that other patch of other Black students that we've been ignoring and didn't want to let in there may be, other superstars there as well.” So, how do we put this in a framework and a conversation that can go downstream so that when people see us, they see the other young Black
males sitting in their classroom and realize that they're actually us and we are them.

**Dr. Yancy:** So Willie, I'll start with this one because what you've capably of described is the pernicious presence of bias. We are accustomed to calling it implicit bias but I think it’s also explicit, meaning that there’s an overt effort to exclude certain people but subconsciously there is a presumption that certain people are not appropriate to be in places where they are, but you’ve also touched on the solution. There’s a whole field of psychology known as positive psychology, that literally is a space where you try to introduce a positive bias. That is a say, if you supplant the negative bias but the positive stories of a Bill McDade, of a Frank Clark and you get the narrative to focus on these kinds of success stories. And you cause that momentary pause. The next somewhat time someone is making an instant judgment about another underrepresented minority medical student, “Oh, but Bill McDade, wow.”

You begin to see what it takes that kind of positive psychology, that positive bias that does something very important. It shifts the thinking in a place where people are more favorably inclined. The explicit bias I worry about are the people that adamantly insist that there’s no problem. And that is all a meritocracy. And in everybody has the same equal chance. And as Bill so capably described, beginning with childhood, many people start off with so many barriers, overcome the idea of an equal chance is a non-sequitur. And so I think if we start thinking about positive psychology bullying, we can start making, I think a fair difference, in this area. I want to get back to the question you posed though, that Bill answered because one of the other ways to think about what do we do about the overarching problem. Let's use a sports analogy.

It's just shots on goal. I mean, if you take only a handful of shots and you play in hockey, you don't lose, you need a lot of shots on goal or a lot of kicks up at the net, if you play soccer. If you plan to win, it's shots on goal. That means we have to think, you use the word downstream, I think we have to think about upstream. We have to start at the earliest possible place. We can encourage STEM and then we can encourage college matriculation and the right level of support so that there are more people making application because what chills me, I think about the number of Black men who went to medical school when I did. I earned these gray hairs in 1978, when I was a first-year medical student. In 2016, the same number of Black men that went to medical school with me in 1978. Same number that enrolled in 2016. It really is simple. We need more shots on goal.

**Dr. Underwood:** I tell you, I love that, that phrase, right. You know, the shots on goals. It’s simple, it's something to see. So I'm going to—and you touched on two things—and I'm going to tie them together with this next question, unless someone would specifically comment on what was just said.

**Dr. McDade:** Let me just add one thing to it, if I can. And that is, I think we have to think about that first question around leadership and then how that plays into that second question of representation. What, Dr. Yancy has been terribly successful with at Northwestern is he was able to diversify the thinking of the people who make the decisions about selection very early on in that process. And
they've been working at it over 20 years and it doesn't happen because the people who are applying change. It happens because we think about what barriers were placed on folks and the normative sorts of things that we think of as excellent and how that needs to shift in order to really assess excellence and bring in people who are going to make a difference. And I think if we don't do this reverse ideation with respect to our roles, as leaders in institutions, in blocking the progress of people who run that pathway into medicine, then we're doing a disservice to the process.

**Dr. Underwood:** So there was something that I used to say in medical school is that I started on the start line but my classmates started where it's a hundred yard dash and they started 75 yards down and they beat me by a yard and they're turning around and saying, “Look, I'm faster than you. I'm better than you.” I'm like, wait a minute. No, that doesn't add up. Right. You know, cause then if we started equal, I would have smoked you, I'd have been home asleep by the time you crossed the finish line. So yes, this leads us to sort of the next point that I also want to put into this conversation. So when reflect upon the *JAMA* podcast on structural racism, there were basically two camps that sort of comes out of this conversation. One camp uses the platform as a tool to suppress the truth altogether. So it's the truth of the history of the country, the truth of how we got to where we are. And then the second one believes that we are in the midst of a post-racial, post racialism, which means that racism no longer discussed no longer exists in this society. So let's sort of break that down a little bit and see how that plays into our … the current state of affairs that we're in.

*Dr. Clark,* I'll go with alphabetical order.

**Dr. Clark:** Thanks Dr. Underwood. Yeah. You've touched on to two important points in terms of the two camps. So I think a lot of times, and I'm going to bring my expertise in psychiatry here. You know, we all have these defense mechanisms that we implore at times when things are uncomfortable and it's a way to kind of cope with whatever's going on in our lives. And I think what we're seeing in one of those camps is pure denial. We know that that is a defense mechanism that is often employed. When we see things that are presented to, and we say no or to minimize things. And I think you have a lot of time, a lot of people out here that are doing a lot of minimization and denial as it relates to, I'll use the camp of we are in a post-racial society.
That couldn't be more around a more erroneous statement. So, I think about Isabel Wilkerson's book “Caste,” and she highlights a good example of how, of many examples but one I'll use is when Barack Obama was president for two terms. People thought that, obviously, that was a beautiful thing in our country and people thought that we made progress but Barack Obama disrupted the caste system. And when the caste system is disrupted that can impact people in a lot of ways who are used to being at the top of the caste system. There's a lot of defensiveness that comes with that and there's a lot of fragility. So I think again, as I alluded to early on is that there has to be, the blind spots have to be … people have to be aware of the blind spots. There has to be cognitive flexibility, so to speak or that mental agility for people to, one, identify a problem and two, to say, “Okay, I've identified it. And even though it makes me feel uncomfortable, I need to change the way I think about things.”

Dr. Underwood: Okay, I think it's Dr. Knight.

Dr. Knight: Yes. You know, I think this is another important point again, you may say, if I know that systemic or structural racism exists and someone else doesn't believe it is that much big of a deal, we are all … I have an ability for our own decisions. The challenge here is when your beliefs on a platform can actually be dangerous, right? We know that to address inequities in health, to address workforce diversity issues, to address all of these things, we have to start from the basics and we have to start by acknowledging that it's not a level playing field. If you believe there's a level playing field, there's no point in us having any diversity and inclusion efforts. There's no point in us doing work around health disparities. Everyone has the same opportunity for optimal health. Everyone has the same opportunity for educational advancement.

And so when you have an issue at that fundamental level, you can't just be quiet. You can't just stay silent because that is actually a very … not just challenging. It's not just a difference of opinion. It can be a very dangerous issue. And so, again, it's not … it's about working together so that we can at least be on the same page and understand these things. A lot of times, as Dr. Clark outlined, individuals become defensive because they feel like the finger is being pointed to them. They are being identified as the root of an issue, where someone who has created an issue and they say, “You know I just was doing my job. I was born into a situation. I don't feel like I've caused this. Why am I, why is the burden on my back?” And again, it's going back to the language, is going back to understanding the fundamental issue. And even if you are not the cause of it, do you have a role in rooting up, rooting the barriers to care, the barriers, educational advancement, the barriers to equity. And I believe that all of us have a role in that but we cannot take them be an active participant being anti-racist or in addressing inequities if we don't even believe that they exist. And that's why that was a huge problem.

Dr. Underwood: Dr. McDade.

Dr. McDade: Yeah. I'll just think, pull the opinion of our colleague, Dr. Camara Jones is past president American Public Policy … Public Health Association, rather. And what Camara Jones does is
describe racism in three groups. There’s institutional structural racism, there's personally mediated racism, there's internalized racism and she does wonderful allegories that you can Google her on YouTube. And I think they’re quite insightful in thinking about the different types. So Eduardo Bonilla-Silva, who's a past president of the American Sociological Association, a Duke faculty member. Well, he talks about structural racism, but it's your first racism without racists. And that's really what we're talking about. It's so ubiquitous sort of omnipresent racism. That's everywhere in society that is so in closely entwined in the fabric of society that we don't even know it's there. It's the normative things that we say are important when there's no basis for it. And we don't understand how those norms situations are really the result of privilege of the dominant class.

And so if you're thinking about, how do you think about racism and structural racism in society, Dr. Jones asked the question, do fish feel wet? It’s so much in part of what we are doing and what we think in our society. And we don't see it. And because we don't see it, it's very easy to ignore it and deny that it exists but you can measure structural racism by outcomes. Not individual actions but by outcomes of groups in society that have been lost. Their potential has been lost because of this racism. And that's really the damning thing about racism that is, in fact, you lose the potential of a segment of society who would be capable of contributing if given access and given opportunity.

Dr. Underwood: Awesome points. So, Dr. Yancy, you would add to that?

Dr. Yancy: Just a little bit because I think that all of my peers have address really important dimensions of this. And the disclaimer, of course, is I am a JAMA editor, specifically JAMA Cardiology. So I've got some insight perspective here but, nevertheless, the missed opportunity here, and we should all think about this. The missed opportunity is no longer the post-mortem, the missed opportunity is the teachable moment because it's pretty clear that there is dissonance within our society about these incredibly important issues. It's pretty clear that we need to reestablish the correct vocabulary that's appropriate for us to use when we're addressing these issues. And it's pretty clear that we need to explore the current state of health inequities, which no one can deny and try to understand the root causes. I think if we begin to take that approach, everything becomes different.

We have to understand—and as a child born in 1958 and growing up in Louisiana and the deep South with innumerable experiences and what deep, painful hateful segregation feels like—we understand that the core of racism or racist is an ugly experience, something that nobody wants to own, but the science, the social science behind this is critically important because when institutions by way of their configuration unnecessarily limiting one cohort and enabling another cohort, it's not dressed up in a white hood anymore, but it's still the same consequence and maybe more damaging because it has a profound economic, personal and social impact. I'm really drawn to this notion that as we begin to understand that there are barriers based on the structure of our institutions and our policies that we forget that people created those policies, people created those institutions and I'm drawn to this quote from C.S. Lewis.
I'll just give you an excerpt, just give me 10 seconds. “The greatest evil is conceived and ordered in clear, carpeted, warmed and well-lighted offices, by quiet men with white collars and cut fingernails and smooth-shaven cheeks who do not need to raise the voices.” C.S. Lewis, he's conveying the notion that that's where the evil resides. It's not that overt system. It's the people in the mindset of those that created the system, which gets me to wrap a loop around one more point that's still on the table. We talk about Black men and white coats extensively. We talk about diversity. We talked about shots on goal but let's remember the real diversity. The real diversity that we're looking for is the diversity of thought. We want people in the room that are capable of thinking differently. Frankly, I don't care what they look like. I just want them to be capable of thinking differently. And that's why I say if you go back to the JAMA podcast—fast forward, past post-mortem and realize that the teachable moment there was an opportunity to reeducate and have a deeper, better understanding of how we got to that point and what we do differently.

**Dr. Underwood**: As everyone was so trying to tie all this together, I'm going to tell you a story. You know, when I was running the Robert Johnson Clinical Scholars and we were reviewing applicants coming in, one of the faculty members had a resident who was at a small program, not an academic program. And of course, we had some real high-level scholars from most of the top institutions in the country. And he said, I'll put this person up ahead of everyone. Now we have people from Hopkins, Duke, Yale who had 15, 20 publications had published in JAMA had published in the New England Journal of Medicine. I mean, you know, amazing individuals but he took that one applicant and he said, this is from a little place, Kentucky or whatever it was.

And he said, he's published one paper. I put that one paper up against all the 15, 20 publications from Hopkins, Yale and Duke or whatever. I sort of went back by that. And this is what he said, which was amazing. He said, look at what it took for this individual to publish this one paper compared to, if you at Duke, at Yale, at Hopkins where you have an infrastructure around you and publishing 1,520 papers, although it's meritorious, although it's difficult, although you did a lot of work. We're not taking that away from them at all. But however, it was 1,000 times easier than this individual to publish that paper because they had to do work that the other individuals didn't do. Right. And we should give that because this is what we're looking for. People with that kind of desire for excellence. Right. And he laid it all out and pushed that person got interviewed and went on to do well and was accepted as a scholar and did great things.

Right? So that's a different thought, right? When we talk about different ideas, different thoughts, how do we look at these things like merit? How do we look at people’s backgrounds? How do we look at what they bring to the table and ways that we’re trained not to look at, right? Because people are still talking about, “I don't see race.” And as physicians, of course, we see race. I see everything. Person overweight, they're overweight. I know you overweight, “Oh, I don't really see the overweight.” You weigh 500 pounds. You overweight. You know, I see that, right? You breathing poorly. You having trouble breathing. I see that as well. Right. You're lean, you're healthy. And if you don't think a
surgeon, I'm looking at people to operate on, I'm looking at this individual, who's lean, healthy, runs every day exercise compared to someone who's the exact opposite of that, which one you think I want to operate on. Right. Cause I know my outcomes are contributed to the protoplasm of the individual who I take care of. Right? So now if you put bias in an app and other comments in an app, because I believe they're sick because they're Black or they're smoking or whatever. Now my whole dynamic can change as an individual. Right. But if I don't acknowledge that these things exist in my thought process, then I make bad decisions based upon that. Right. And put other people in positions where they get this broad care because of it.

**Dr. Yancy:** So Willie, let me tell you about the story you just shared with us. So many of us are in this space and if you listened to some of the commentary from Valerie Montgomery Rice, she talks about enhancing the test scores with the more holistic review. You just gave us the best example of a holistic review, where someone looked at the work output, qualitatively, not quantitatively and then evaluated what it took to accomplish that work output, and then change their judgment about that individual because of a holistic assessment. So what Dr. Montgomery Rice is advocating for is yes, keep the MCAT, keep the scores. That's fine but add a holistic review. Account for what it took for this student to get where they are and think about how that will factor into success going forward. People try to water down the importance of a list of review as a way of progressing to some mean. It's not, it's a way of elevating to find the really best talent out there because that's what's necessary, people that can overcome adversity. I much rather bring people in and train them as a cardiologist if they failed a dozen times already because they've got perseverance, they've got resiliency and they will keep working. And that's what you look for. So you just gave us the best example. That's one of the past forward holistic review.

**Dr. Underwood:** Any comments, anyone else?

**Dr. Knight:** I also think that the biggest, biggest point in that, in addition to that is that we as physicians know, it's not just a test that makes someone a good physician. Okay? Anyone who's been on an admission committee, I've seen some wonderful sky, high, highest numbers I've ever seen. And you interviewed that individual. You've seen the recommendation levels and it's a whole different story. We know that to be an effective physician, there's a many, many pieces to that. Your commitment to service your resilience, your commitment to the community, your diversity of thought, not just what you're bringing to the table but what you are also teaching your classmates. We know medical school classes that have diversity. It benefits all the students, not just those future patients. And so when we think about it like that, that's a whole different conversation. I don't just want everyone who had a perfect score on the MCAT.

Did anyone—what background, how can you add something else to the conversation? We learn from each other. And we work with each other as teams in health care. And so when you start moving that, it's not saying, “Oh, we're not looking for excellence.” No, but excellence does not equal the highest score in the book. Excellence equals yes, medical knowledge. Yes, academic ability, but also service,
also commitment, empathy. Alright. Understanding of cultural and ethnic diversity and the needs of our patients. Those are also excellent. And I think when we have that conversation, then we’re not going and say, “Oh, we don’t, we don't value excellence.” No, we actually do value excellence but our definition of excellence is different. And once we get to the definition, then we can get on the same page about what it’s going to really take to diversify our physician workforce but also have an output of physicians that are ready to address the health inequities and address the health challenges that our communities continue to face.

Dr. Underwood: Well …

Dr. McDade: The idea of using these standardized tests, sorry Dr. Underwood, with the standardized test scores as a measure of quality, I think is problematic. David Ash wrote a paper back in 2009, published in *JAMA* and looking at outcomes of obstetricians training programs. And he looked at the quality of the programs based on the USMLE Step 1, Step 2 scores. And then you can try to compare that to whether or not the physicians who graduated from those programs practice at a high level of quality or low, lower level of quality. That is where the complication rate is low or the complication rate is high. And what he showed is that the USMLE Step 1, Step 2 scores don't correlate very well with who practice with the higher quality of care, lower complication rates. What matters is the actual complication rate of the residency program in which they train.

So if the residency program had a low complication rate, they practice with a low complication rate and that persisted for 17 years after they graduated from the program. If they practice with a high complication rate that persisted for 17 years. So what we need to do is to improve the quality of education that we provide our trainees. And that's what really determines how successful someone's going to be as a physician. Not those individual things that we put a lot of emphasis on because they're easy to measure Step scores or MCAT scores, but it's really to make our own, our own practices better in the training environment because that training environment is so influential on an individual's subsequent career.

Dr. Underwood: I'm going to ask, I'm going to throw one more question out but I wanted to take three minutes on this. We've somewhat touched on this. That's why I think we can do this in a short period of time. Dismantling the current narrative of why we don't have more Black men in medicine addressing the root causes and dispelling the myths. Any comments?

Dr. Clark: Well, I'll take that, I'll start off. So, you know, I think the narrative is media, I'm not going to blame the media for everything, but I think how the media portrays Black men is not always in a positive light, if anything is in a negative light. It's rare that you turn on whatever you watch, CNN, Fox, MSNBC and see Black men, Black excellence. You don't see that, you hear about there was another shooting. I'm from Chicago. So, that that's every time, people come up to me, “Oh, you’re from Chicago. And it must've been a horrible place to grow up in. It's pretty rough.” The media does a great job of portraying Black men in a negative light. That narrative has to change. There are plenty of
Black men out there that are intelligent, that want to do something with their life and are doing things with their life.

It's just not highlighted. Imagine if you changed the narrative, imagine that there was a segment on each news station every night, where you highlighted a Black man or Black woman. They don't have to necessarily being, wanting to go into medicine but if you highlight it that each and every night, you had a series. They used to have that on … There was a—Bill McDade knows this—WGN used to have the extra effort award and ABC used to have Harry Porterfield. I happened to be both of those at one point. It was highlighted back in the day, if you did something like that and you highlighted Black excellence, imagine the draw that that would have, if that was played in the barbershops and that was playing in the hair salons.

And that was playing, you know, if faith communities knew about that and people were talking to about that at school. If that was being streamed on YouTube or TikTok videos or whatever you want to call it, these days, you can change the narrative. But again, when people see things it's that cognitive flexibility or the lack of it, so if you keep getting the information that is getting poured down your throat every day, and it says Black men are not about anything, they just want to play sports. I was an athlete. I ran track and cross country in high school and ran in college. I'm a doctor. You can be both. So I think there has to be a narrative change. And I think that it starts at the grassroots level.

**Dr. Underwood:** It's open. Anyone else?

**Dr. Knight:** I'll continue that. Dr. Clark, you outline the way the biases that not only are present but also nurtured by what we see, but I'm going to take it a step going forward. So now you've had this thought that African American men may not be high achievers may have a lot of challenges, takes a lot of work. Then my motivation to invest in these youth, to invest in communities is going to be low because I'm already coming in here with a bias that the level of achievement is not going to be there. When we talk about and I know we're going to come to that question. When we have a school, a medical school say, “Okay, we want to increase. Why don't we have any more Black men coming into medical school?” It's a "go to the admissions committee, let's talk to the admissions dean and say, “Well, you know, the Black men that come across my desk, don't look good on paper.”

And the ones that do look good are going to other schools, right? So then what's the next conversation, oh, we're going to have a scholarship program for the high achieving college students. Right? Many of those students were achieving high anyway. Right. But then you have to push it and say, well, what about the students that aren't doing well in college? What about the high school students? What about the elementary school students? And now your span has gotten so big that you say this to really address preschool, kindergarten, elementary school education is going to just take so much work, so much money and maybe they don't even want to achieve, so why are we investing? I mean, that's a lot of the conversation if we were being real about it, that is happening because we know that when you're coming with an unequal playing field, an unequal start, it's going to take work.

URL: https://www.ama-assn.org/delivering-care/health-equity/black-men-white-coats-physicians-share-their-stories
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It's going to take work so that any child in any zip code in any family situation that wants to be a physician can be a physician. I would say today, that is not the case. That is absolutely not the case. And for that to be the case, that's going to take a lot of investment. That's going to take commitment at every level. And until we, as a society, are ready to make that commitment, we're going to continue to have this conversation.

Dr. Underwood: Well, we did commit a lot to get us here, right. There was a lot of commitment, a lot of effort, as we sort of said. So let's flip that commitment in the opposite direction and let's transform the nation. I think Dr. Yancy, you want to say something?

Dr. Yancy: I think Bill was about to speak and I'll be happy to follow.

Dr. McDade: I appreciate that. Thanks, Dr. Yancy. In the movie, Dr. Okorodudu talked about the stage and stadium as the two things that we really see for our futures as young Black men. One of the things that always impressed me and I was on the admissions committee, 17 years at the University of Chicago when I was a faculty member there. And one of the places we would go to recruit every year is that the Annual Biomedical Research Symposium for minority students, the ABR CMS annual meeting. And if you ever televised that Dr. Clark, that would be an amazing thing to see—2,000 Black, Brown and Native American individuals sitting in a room talking about science. So every morning there's a breakfast session. There have tables with themes. There's molecular genetics at one table and there's molecular engineering at another table. There's chemistry, physics and all the biomedical sciences, all in one room.

And to see these Black and Brown and Native kids, all getting together, talking about science and their research that they'd done during the course of the previous summer that they were going to present during poster sessions is the most amazing thing that you've ever seen. And no one would believe that it actually existed, except that I'd been to about 15 or 20 of them over the last couple of decades. And the fact is that there are people out there who need to see this, who need to know that it exists, who needed to see that level of excellence on the part of people who look just like them. And I think that's part of the problem that we don't think that anybody else is doing this kind of work. And in fact, they are, and we just have to get more of it out there and put that image out there instead of the negative images. It's like Dr. Yancy was saying, replace the negative with the positive models of cognitive, cognitive cognition about what people can do. Dr. Yancy?

Dr. Yancy: I'll be pithy because I don't want to overlook that. I'll just say one thing. We've been talking about something very important about increasing the number of Black men that are going to medical school but we've missed one very important statement. We're talking about culture change and culture change almost always starts at the top. A leader has to stand up, own it and articulate it and say, this is a part of our mission. We will, from this point forward, respect this kind of composition of our classes, this kind of performance. And we will commit the resources to execute on the mission. Everything you've heard is tinkering around the edges of working in the middle, trying to live up, trying
to win this by ones. Dr. Underwood, we need to win this by hundreds. And so there's got to be leaders to step up and say, we needed to do something different. Here's a pop quiz. How many Black deans, other than Morehouse, Meharry, Drew, exist and Howard. How many Black deans of medical schools exists, besides those four?

Dr. Underwood: Two? Yeah. Yeah.

Dr. Yancy: That tells you where the problem is. It's not even representative even at the minimal level.

Dr. Underwood: And in addition to existing outreach in the middle and high schools, and how might a medical school really connect with the communities to improve recruitment and retention of students from diverse backgrounds?

Dr. Yancy: I'll jump in this because we've been talking to the community particularly over the last 15 months and the community gave us response that nobody was prepared for, but it was what we needed to hear. You know what, don't come to the community to raise awareness, come to the community to invest. That's when we'll start paying attention to what you want. And so if you think about that, every medical center wants to expand, wants to evolve. Go to the community, support the public schools, create additional science programs, create outpatient facilities that provide quality care, create entrepreneurial opportunities to elevate the economic platform for the community. And do not tell me this can't be done because every major medical center is looking to expand and paying, whatever money they need to pay, to go to resource rich areas that will increase the bottom line. How about going to socially resource rich areas that really want to tap into what you have and make a better life? So I think the way we do this is we get institutions to invest in communities, not wait for the communities to come downtown. We need to go to the south side, Frank and make the investment there.

Dr. Underwood: Awesome point. And that's sort of the Buffalo Center for Health Equity. That's what we're actually doing in Buffalo, and it's paying off, but I won't get into that. But you hit the nail on the head, from my perspective. We have a few minutes left, so I want go right ahead, please. Whoever wants to add to that.

Dr. McDade: Let me throw in a plug for a different population of individuals. So you can invest a lot of money early on to try to improve education or you could try to reclaim a number of people who have not had success in the initial forays of the college. There are a group of people who are in post-baccalaureate education now who are going to be the fastest way to get a large number of people who would have been fantastic physicians, were it not for the fact that they were not prepared sufficiently to be successful in their first two years of college. And this doesn't mean that they weren't academically bright enough to do it. That means that all those other things sociologically that went into that college experience were not optimized for their success when they went in and it undermines their ability to have been successful candidates for medical school because you take your basic science courses, typically, in the first two years of college, when they were just understanding how...
college worked.

And I recommend Anthony Abraham Jack's book, “The Privileged Poor,” as a case study, and what happens to folks who go to those feeder schools from medical school and then don't meet with success in those first years but they're so bright. They catch up by years three and four, but they've already done a reparable damage to their grade point average into their ability to perform well on the MCAT. And so we lose them. Those post-baccalaureate students and medical centers would invest in post-baccalaureate programs to allow them to reclaim those individuals who are strong scientists and very bright people who could be capable doctors. I think that's another way that we can actually increase our numbers quickly.

**Dr. Yancy:** And very quickly, I would pay attention to the work of John Rich, an African American scientist, a MacArthur genius award recipient who identified the pernicious influence of the adverse childhood experiences. By the age of six, you can identify which child is going to be successful, just based on the aggregate adverse childhood experiences, like poverty, like a broken home, like depression in the household, like substance abuse and household stuff. A small child can't control it's right there. I heard something recently that I thought was so profound. All of these things require different policy. We believe that we only own public policy but the truth of the matter is that all policy is health policy because everything comes home to rest in the health life and living circumstances of individuals.

**Dr. Underwood:** Correct. So I'm going somewhere, I want to say this. When you guys were saying this, the thing I was thinking of, “Oh, we have a Juco program for those athletes who go off to the division one schools and they can't make it. They go back, they get additional training, they allow it to come back in.” Right. That's the same sort of concept. We get that with athletics and we can do the same thing academically. Yes. Just because you fail. And I don't mean cause you fall early on. That shouldn't mean that you're dead. Right. You should be able to come back and be able to move forward.

Gentlemen. Great conversation. Thank you very much. I'm going to know I'm going to close with this story. I was a freshman in high school and the teachers told one of my classmate’s father that he should move him away from me. Why? Because I was a bad influence on him. When they asked why I was a bad influence. She said, “He's overly polite. He wears a shirt and tie every day and he raises his hand all the time when he asks questions and he actually does his work. He must be up to something.”

Yeah, I was up to be trying to become a doctor. God bless everyone. Thanks very much. Thanks everybody.

**Unger:** You just heard from doctors Willie Underwood, Frank Clark, Michael Knight, William McDade and Clyde Yancy on increasing diversity in medicine.
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