Vital Voices, a podcast from the Josiah Macy Jr. Foundation
Episode 3 Transcript

Holly Humphrey:

Welcome back to Vital Voices, a podcast from the Josiah Macy Jr. Foundation. I am Dr. Holly Humphrey, president of the Macy Foundation. On today's episode, continuing in our discussion of addressing harmful bias and illuminating discrimination clinical learning environments, we are going to address contemporary issues and solutions to addressing bias and discrimination, particularly anti-black racism in health professions education. To help us with this discussion. I am joined by Dr. Valerie Montgomery Rice, the president of the Morehouse School of Medicine. Valerie has experience at the highest levels of patient care and medical research, as well as organizational management and public health policy. Valerie uses her position at the Morehouse School of Medicine to enhance opportunities for academically diverse learners, diversify the physician and scientific workforce, and fosters equity in healthcare access and health outcomes. Valerie is also a familiar face to the Josiah Macy Jr. Foundation, as she is a member of our board of directors.

As always, this conversation is a follow-up to our webinar series discussing the Macy conference recommendations. If you haven't already done so, I encourage you to watch the recording of the webinar featuring Dr. Valerie Montgomery Rice, as well as our other webinars in the series. You can find all of the webinars, the conference recommendations, and other resources on our website macyfoundation.org. And now here is my conversation with Valerie Montgomery Rice.

Valerie, thank you so much for being with us today on our Vital Voices podcast. To begin, I'm wondering if you could help us set the scene, as over the past year, there has been an increasing national conversation about systemic racism, equity, and diversity. In this current context, I know that our audience would love to hear from you about the most pressing issues that you see for health professions education.

Valerie Montgomery Rice:

Holly, thank you for having me and thank you to the Josiah Macy Jr. Foundation for putting this information out there for so many to hear. You are correct – the past year really did pull down the curtain on health inequities in this country, and most importantly, the many ways systemic racism and the lack of diversity manifests itself in our healthcare system. What we know is that for health professions education, we have to educate culturally competent persons, and that will lead to a diverse workforce. Lots of times, people think that we're only talking about race and ethnicity or gender, but when we talk about diversity in the workforce, we're also talking about people who've had different life experiences, because we know that it is the richness of those experiences that's going to add to how we solve these complex problems.

When we think about our health profession schools, we can't talk about who we admit. We have to talk about the learning environment in which they're going to be educated. However, if I start at the admissions process, we have to think about what it really takes to recruit a diverse student body. How do they look at innovative ways to bring in diverse students? I think it starts with the admissions process and moves them through once they matriculate.

Holly Humphrey:

That's a perfect segue to my next question! One of the topics that came up on the webinar was your personal advocacy for getting more black students and black faculty into academic medicine. In your role as president of the Morehouse School of Medicine, you have been very successful in recruiting black men into medicine. S I'm wondering if there are lessons that other schools can learn from the experience that you have had in this very successful recruitment of black men.

Valerie Montgomery Rice:

You are correct. We are very proud of what we have been able to do at Morehouse School of Medicine, but we are one out of 158. We clearly need other institutions that are dedicated to diversifying this healthcare workforce and looking at it from a lens of where there is the largest gap. And you are right, it is

with black males. When we look at black males and medicine, we see that if we look at the 2019-2020 stats, there were about 21,863 first year medical students. That only included 1,626 black medical students, and the majority of those were women, 62%. If we look at the total [*physician*] population, black men are only representing about 2.8%. If you're talking about cultural competence and you're talking about having congruency between the provider and the patient, it does begin sometimes with gender and race. We know that's one way to start, and then adding those life experiences.

When we think about what we should be doing, it's not just about having a pipeline; we're actually trying to create a pathway for success. The first thing you have to say is, "Okay, what are the barriers on that pathway that prevent people from getting into medical school?" And we know that the MCAT has been the gatekeeper, not just for black males, but underrepresented minorities in general. And if we know if we were to delve deep down as to what the MCAT score tells us, we know that it has not been shown to significantly predict whether students will successfully progress in their medical education.

The AAMC put out a report that more than 90% of the students with MCAT scores in the 502 to 505 range, and that represents the 60 to 70% [*percentile*], they progress to year three on time. Whereas a lot of schools are like, "Okay, I'm not going to even interview somebody if they don't have above a 510." They may be missing some of those bright spots, because those students with those MCAT scores of 502 to 503 may have life experiences that are going to add to the richness of your school body, of your learning environment, and really contribute to how you educate and train culturally diverse providers.

I would say the first thing we need to do is to really look at our data. And that's the first thing we did at Morehouse School of Medicine, we looked at our data, and, yes, we had pipeline programs, but did it lead to a pathway for people to be considered for medical school? And then once they got there, did we have the resources around them for them to be successful? I would say to anyone who's out there listening, "look at your data and ask yourself when you did take a chance on someone who was on the lower end of the bell curve, how did they

perform?" And what you probably will find is that they perform well if you put resources around them that allowed them to feel included.

Holly Humphrey:

Wow, that's a very powerful message and I think a terrific way to begin, which is look at your own data as an institution, and then the structural barriers that you may have in place that you may not even be aware of. But the other thing that you said, Valerie, which I really want to underline, and you and I have had a chance to discuss this in the past, but it's being committed, not just to the admission of black men into your medical school, but to nurturing the lifelong pathway to their careers as physicians. Is there anything more that we can learn from your experience about nurturing that pathway specifically? I'm thinking into graduate medical education and then to their careers after residency.

Valerie Montgomery Rice:

Holly, people talk about diversity and equity, and I think that the most important part of that three letter thing that people talk about, "DEI," is the inclusion. So how is it that you ensure the inclusion of those diverse learners in that environment? How do you really stress to them that we really want you to bring your authentic self to the learning environment, and where there are gaps, which we all have. None of us went to medical school knowing everything. Some of us went knowing nothing. Yet, we were in an environment that poured into us the resources such that we could learn. The first thing that people had was expectations of your success, and that feeling of expectations of your success allowed you to have some relief to say, "Okay, they actually want me here." That's the first part of inclusion.

And then they were very intentional about hearing my voice. I think about in medical school, even if I didn't want to speak up, there were activities involved that were developed, like the learning communities, et cetera, that started out in small groups so that you could then use your voice, and it would be heard. You then put a support mechanism or support network around the students. Once you did that, you presume, first of all, that they could be successful. You created small support networks. You then needed to do assessments on where there may

be gaps. And that's what we do all the time in our testing, et cetera. And when people don't score as high as they want it to, or as you wanted to, you don't lose that confidence in them. You have resources in the institution because one of the things that we know now is pretty much how to predict students' outcomes based on some of their performance metrics. And every school should be looking at that. You then have to build resources.

At Morehouse School of Medicine we have student learning platforms that are not just for students who are having challenges, but that all students have access to. And one of the most successful is peer tutoring. Instead of having other professors come and tutor the students, or for students to go to other professors when they have gaps or challenges, they go to their peers because they can sometimes translate information in a way that allows it to stick sometimes better than from the professors. It is an opportunity to first recognize the potential of the student, show them that you want them there, put resources around them that show them that you want them there, and then continue to nurture that all along the way.

Holly Humphrey:

Oh boy. Thank you, Valerie. That was a rich and wonderful description of very specific ways to create that inclusive community. Let me pivot to a different topic, a topic that actually came up during our webinar, and many in the audience actually were interested to know how to teach about healthcare disparities and the impact that harmful bias and discrimination can have when you have a really diverse class of students, some of whom, on one end of spectrum, may be completely unaware of issues related to disparities and to bias and discrimination, and others who actually may be retraumatized by having the discussion. I think that's a really challenging question, and I'd love to hear your thoughts about it.

Valerie Montgomery Rice:

Holly, you are correct, and even at what we describe ourselves as, a historically black college or university and a medical school, we still have to be very sensitive to how we talk about some of the legacy of discrimination and inequities that have been experienced by underrepresented minorities. The first thing that I

would advise, though, is that students have to experience the results of racial biases and discrimination and inequities, and the best way for them to experience that is to be involved in the community.

At the Morehouse School of Medicine, we have a longitudinal community health course that every medical student takes, and it starts in their third week of medical school, and it's throughout. They are assigned to what we call an NPU, a neighborhood planning unit or some other controlled environment in the community, and they have two preceptors who go with them every week to that community and in their didactic sessions that occur in school. And we teach them in a pedagogical way about community-based participatory research, community-engaged research, and cultural competence, and they get to engage with the community on identifying a concern that bubbles up through the community and address how they would solve that problem.

Their partners in identifying what the problem is and framing that solution are the community leaders and the community participants. And many times, they get to see how the social determinants influence people's access to care and the quality of care. But when you talk about the root of that, they then get to see what 400 years of enslavement did to African-Americans, they get to see what under employment does, they get to see what not having access to fruits and vegetables, et cetera. They get to see it in real time.

But the really good news story is they get to bring solutions to whatever this problem is, being informed by what the community desires the outcome to be. They don't get to just throw onto the community some solution that they think will work. They have to listen to the community to develop that solution together. That's how I believe you break down this barrier, and you also ease people into the conversation. You're raising awareness, you're educating them, but they're not just hearing it from a textbook. They're hearing it from people's lived experiences.

Holly Humphrey:

That's a powerful example of programming, Valerie, and one that is just so authentic. And as I listen to you, it reminds me of my own experience caring for a

large group of patients on Chicago's south side, and it was really through my patients' lived experience that I came to see the structural barriers that they were trying to get access to healthy food and access to transportation and education and all those things. Let me build on that just a little bit more because sometimes to put together programs such as the one that you just described, we end up unintentionally overburdening our colleagues from groups who are historically underrepresented in medicine. Are there some ways that we can think about developing programming and curricula that doesn't put an even greater burden on our faculty and junior resident colleagues from historically underrepresented groups, that minority tax that we've talked about before?

Valerie Montgomery Rice:

First of all, this is a required course and is taught out of the community health and preventive medicine department. Everybody in that department teaches some component of this course. Everybody. No discussion. When you join the community health and preventive medicine department, even if you are joining just as a researcher, you are going to teach in that longitudinal community course. And we ensure that our preceptors are not just underrepresented faculty. Now we have an advantage in Morehouse School of Medicine that we have significantly more underrepresented minority faculty than most people. But our majority faculty who would be underrepresented at the Morehouse School of Medicine, they have to teach in these courses too, and they do a great job at it.

First of all, I think leadership has to require that everybody is engaged. Because again, remember, we want persons who are majority to bring their lived experiences, because what they're going to share when the students are trying to figure out why is this structural barrier there, and they may want to point the finger at their Caucasian faculty member or colleague, that person gets to give their perspective from their lens. Again, when we are having the community in the room while we're trying to solve these problems, maybe that is a dimension to the solution that would not have been thought of if we didn't have that different person in the room.

I think it is really important that the leadership understands that you cannot just burden the underrepresented minority faculty with dealing with social

determinants of health in a community-based research, that our majority colleagues also can contribute to our understanding of how to remove these structural barriers and how to have these different and difficult conversations and to educate all of our students. Because remember, the majority of students in medical school are not black students, or Hispanic students, or underrepresented. They are majority students, so they need to hear from persons of all races about how they can help to contribute to the elimination of racism in medicine.

Holly Humphrey:

That's a very rich description of, I think, true inclusion, where everyone feels that they belong. That's beautiful, Valerie. Thank you. We're getting to the end of our time together, so I'd like to conclude today by inviting you to help us think about something that I think everyone can work to improve, and that is our own self-awareness so that we can better understand our own implicit biases so that we can work to eliminate the harmful ways in which our implicit bias can come out. Do you have any thoughts for us?

Valerie Montgomery Rice:

First of all, and this is always so hard when you take that first implicit bias test, and everybody should take one, and you will have a rude awakening of the areas where you are biased and you thought that you were the most open-minded person in the world. Then you will have to say, "Okay, who am I missing on my personal board of advisors who can enlighten me on my blind spots?" I have always had the benefit of having a diverse group of people who have served as my mentors and my sponsors who have helped me to see some of my blind spots. And I try to do the same. I serve as a mentor to several people who are not women, who are not African American, and the reason for that is that if we build trust in our relationship, then I can give them some perspectives that help them to advance in eliminating or do increasing some of their conscious biases.

And then in order for us to continue to raise awareness about our unconscious biases, I think we have to read more, we have to do more research, we have to ask those uncomfortable questions of ourselves and of others. And when people answer, we have to listen with an open mind. That is the only way that we are

going to be able to appreciate the rich diversity that everyone brings to the table. We have to step out our comfort zones. And if we can continue to do that, which many of us, not just with the pandemic, not just with the racial inequities that we've seen this year, they have really forced us to step out of our comfort zones. Now we are having to, because of this pandemic, see what it means sometimes to walk a mile in other people's shoes. And when you do that, you can only be more humble. And if you are humble, you will care more, and if you care more, you will behave differently.

Holly Humphrey:

Oh, Valerie, that is just a beautiful note on which to end today's podcast. We can all do better, and that cultural and personal humility that you speak about in such a moving way I think will make this world a better place and our health professions learning environments inclusive in the beautiful way that you described for all of us. Valerie, thank you very much, and we look forward to continuing the conversation.

Valerie Montgomery Rice:

Thank you so much, Holly.

Holly Humphrey:

Thank you to Dr. Valerie Montgomery Rice for taking the time to walk us through this important issue and the steps that we can take to address bias and discrimination in our clinical learning environments. For more on this discussion, I encourage you to watch the webinar featuring Dr. Montgomery Rice, and to read the Macy conference recommendations and related resources. You can find all of these materials on the Macy foundation website macyfoundation.org. Thank you for listening, and we hope you'll share this conversation with others. Be sure to subscribe wherever you get your podcast, so that you'll be notified when the next episode drops. And make sure you're signed up to receive email updates from the Macy Foundation.