Holly J. Humphrey, MD, MACP (HJH): Welcome to Season Two of Vital Voices, a podcast from the Josiah Macy Jr. Foundation. I am Dr. Holly Humphrey, the President of the foundation. Our second series of Vital Voices is focusing on the remarkable careers and accomplishments of the individuals and institutions who have received the Josiah Macy Jr. Foundation Awards for Excellence in Social Mission. Social Mission in Health Professions Education includes activities or initiatives that teach, model or improve community engagement, reduce healthcare disparities, and address the social determinants of health. Social mission means making health professions education not only better, but fairer. These awards are supported by the Josiah Macy Jr. Foundation, and their selection is made through the Social Mission Alliance. This alliance was formally known as the Beyond Flexner Alliance, and this national organization focuses on health equity and training health professionals as agents of more equitable healthcare. The alliance is based at the Fitzhugh Mullan Institute for Health Workforce Equity in the Milken School of Public Health.

Today's interview is with Dr. Robert Rock, who received the Fitzhugh Mullan Rising Star Award in 2021 for his many accomplishments in incorporating social justice in medical education. Dr. Rock attended the Yale School of Medicine where he co-developed *US Health Justice*, an elective course for medical, nursing and physician associate students dedicated to social medicine, health equity, and health advocacy. As part of this course, Robert co-developed a workshop called *Making the Invisible Visible* that has subsequently been incorporated into the mandatory curriculum for all Yale medical students. This workshop uses art observation to explore topics of bias, identity, and hierarchies of power in patient provider interactions. In 2018, the Yale School of Medicine introduced an annual award for student activism that honors Dr. Rock and his colleague Dr. Tehreem Rehman, who was his partner in this work. Dr. Rock recently completed his Family Medicine training in the residency program for social medicine at Montefiore Medical Center in 2021 and is currently a post-doctoral fellow in the National Clinician Scholars Program at Yale University.

You can find all of the episodes of season two of Vital Voices on the Macy Foundation's website. And now, here is my conversation with Dr. Robert Rock.

HJH: Dr. Rock, thank you so much for being with us today. I'd love to learn a little bit more about your pathway into medicine. I was interested to learn that your initial professional aspirations were in art and that you actually studied art history at New York University. What led you to change your path to medicine?

Robert Rock, MD (RR): The trajectory is a little complicated. You have to start earlier than art history in undergrad to understand it. I have always loved the arts. As a child, I was drawing all the time and always making things. When writing, I remember drawing pictures to replace words I did not know how to spell. In high school, I took studio art classes and made clothes in my spare time. My mother is a seamstress and taught me how to sew. So early on I thought I was going to be a fashion designer or a graphic designer, but in my junior year of high school, my great aunt became ill. She was a strong woman, the matriarch of the family. One of the first to come to the United States from Haiti who helped subsequent family members onto their feet when they arrived. She did not trust western medicine and was not one to share her problems with anyone.

So when she came forward about her abdominal pain, the family took it seriously despite not knowing what to do. It took a lot of time for her to get plugged into care, but she was ultimately diagnosed with late stage uterine cancer. She had so many appointments, tests, and treatments, but the process felt extremely impersonal to her. Between the language barriers and lack of explanation, it was as if she was taking a backseat to her own health. I remember vividly her being so frustrated by all of this, until one day she decided to forego care. She stayed home and died the summer after my junior year of high school. That is when I decided medicine was what I wanted to do with my life, not for the science or the challenge, but for the people. I wanted to play that role better for others than it was played in my family's life.

By the time I got to college, med school was the goal, but I had no idea what I was going to major in. Art history is a bit of serendipity. During an orientation lecture, there was an anthropology professor who told students that college was our last chance to study something just for the love of it. He advised us to major in what your mind wanders to when you are not paying attention. The funny thing is I was half paying attention at that point because I was doodling on my notebook. That is when I chose art. I thought I was going to go into studio art, but you can't major in studio art in the College of Arts and Science at New York University. You have to major in art history and then minor in studio art. That is what I did. Even though all of my pre-health courses took up all of the space to add studio art. I stuck with the art history major and it worked for me.

HJH: What a wonderful story with so many important themes, the most important of which is the real heartbreaking story of your great aunt and everything that she and you and your family went through, and I'm so sorry that that is a part of this narrative. But what a wonderful way in which you are honoring her memory and the serendipity of art history as a way to enrich your own life, as well as the lives around you. It is a beautiful, beautiful story, and in fact, it likely influences where you go next, and that is to medical school. And I understand that when you got to medical school, you felt that the curriculum ignored some important issues related to health equity and health justice, and together with your classmates, you set out to rectify the situation. Can you please tell us a little bit about what you observed and then what you did about it?

RR: So it started with Tehreem Rehman, my sister from another mister. Honestly, she was my best friend in med school. We started together. I spent so many afternoons sharing my frustrations with her about the lack of curricular content on issues of health justice. Towards the end of the semester, we started meeting with lots of upperclassmen, asking if the content shows up in the later years. They mentioned some public health courses in our second year, but told us, not to hold our breath about it. It was more epidemiological methods and learning how to read papers then actually talking about domestic health inequalities or social determinants of health. Our original idea was to revamp an optional orientation

program that the school offered at the time. It was called *Service Around Yale* and consisted of volunteering around New Haven for two weeks before classes started. We wanted to add sessions to that experience that would contextualize the issues that were happening in the city and orient students to what was going on.

I am not sure why, but we shifted from trying to tweak that orientation activity to wanting to make our own elective course. We knew that so much was missing and knew that it would not show up in the later years. So that functioned as our needs' assessment. Then Tehreem Rehman and I started reading voraciously and meeting with lots of people from across the university in the city. We did a literature review to learn about best practices around teaching health professional students about domestic health inequalities and health justice, and we reached out to faculty with a demonstrated interest in health equity. We eventually were connected with faculty from the Robert Wood Johnson Clinical Scholars Program at Yale, who had been doing a lot of community-based participatory research up to that point. They introduced us to so many of the community partners that really brought the course to life and shared a number of papers that interviewed New Haven residents about what they think are the most pressing health issues in the city.

We chose the course topics according to the priorities listed in those papers and the hospital's community health needs assessment. From there, we started drafting up course goals and objectives, session descriptions, and identifying discussion facilitators for each session. Given our growing list of contacts, we gathered a number of them to serve as a curriculum development committee. We sent our curriculum drafts to them and they tore them apart essentially. Tehreem and I learned a lot that summer. It was a lot of work, but we were ready to pilot the course in the fall. We called it *US Health Justice* or *USHJ* for short and opened it to students from the medical school, nursing school, and physician associate program. The course was dedicated to understanding health inequalities as a manifestation of societal oppression and giving health professional trainees the tools to be agents who change wherever they decide to practice in the future.

Sessions were taught by clinicians, lawyers, professors from other schools in the University, patient advocates and community activists. We went on two tours led by community partners as well. We recruited 20 students for the course, and by the end of the semester, there were rave reviews. Students loved *USHJ*. They were telling their peers and faculty about it. They did not want it to stop. The issue is that Tehreem and I were going into our clerkships immediately after that, but thankfully, a group of students in the first cohort agreed to take it over for the next year. They are the ones who created the year-round, all-inclusive affinity group called the US Health Justice Collaborative. Since then, successive groups of students have led the course, revamping it each time. I think the fall is going to be the ninth year that the course is run.

HJH: That is an amazing story, entirely student-developed and sustained over time. Do the faculty have a point of view about this course? What is their sense of this course?

RR: I think that the faculty who prioritize health equity have always been a part of helping develop it, helping shape it, mentoring us in the process, but really letting the students be the leaders in terms of deciding what eventually ends up in the course. Every year, we have had a faculty course director. It kind of changes maybe every three years, depending on people's bandwidth, but there's a solid group of faculty mentors who really bend over backwards to help students with the course and help those students after they are done with it.

HJH: That is just a fantastic story of co-creation, where it was really the students taking the lead, doing the work, and very importantly, sustaining it after nine years. So congratulations to you! What an accomplishment! Now, I also understand that you had a pretty integral role in creating a workshop that drew on your earlier interests, experiences, and to some extent a real expertise in art. Can you tell us about that?

RR: As part of the *US Health Justice* course, there is a session called *Making the Invisible Visible: Art Identities and Hierarchies of Power*, and Tehreem was actually the one who challenged me to make it happen. Arts education already existed within the medical school through a program funded by the Dermatology Department that teaches students to be more descriptive in their evaluation of skin pathology. As first years, Tehreem and I were taken to the Center for British Art at Yale to practice being more descriptive when relaying our observations. The session seemed fine on the surface, but I had studied abroad in college and had taken a lot of British art classes in England. I knew that some of the paintings we were practicing our descriptive abilities with were Orientalist, which is a genre of painting where European artists from France, Britain, and other western European countries paint images of scenes of the Near East.

The issue is that many of those artists have never actually been to the Near East, and their paintings are stereotypes. The bad part is that I knew that the way they depicted the Near East perpetuated stereotypes of declining societies that needed to be civilized via European conquest. Essentially, many of those paintings are visual propaganda used to justify European imperialism. Toward the end of the workshop, I was frustrated and talking Tehreem's ear off about it. In college, my final paper was actually about the Western consumption of pre-colonial African artifacts in the 19th century. So I would juxtapose the stories Europeans manufactured about these artifacts with the original intent as defined by ethnographic papers from those different tribes and areas and came to really discover that the European-manufactured identity was not at all related to the original intent for those artifacts. And so the question that my paper asked was what purpose do these fabricated narratives serve?

I think it is actually very similar to medicine. We know that clinicians and researchers have a lot of power over the story of record. I have seen how stories in the electronic medical record can be used to justify actions or inactions. There are plenty of studies of bias language in the electronic medical record and how that language can prime clinicians to expect certain things and distrust what patients say, ultimately obscuring or justifying injustice. I explained all of that to

Tehreem, and she loved the idea and was like, "It needs to be in the course!" So I got to work. I met an amazing museum educator at the Yale Center for British Art and a community psychologist at Yale. We worked together to design *Making the Invisible Visible*. It was really effective. I think it provoked some conversation and some introspection among the students that they really carried with them after the course. And so word spread, and I was approached by Yale faculty to incorporate the art tour into the main curriculum for med students.

HJH: And do you know, does that workshop continue to the present?

RR: Yes. I actually spent part of the summer training some of the new students who are going to be facilitating it.

HJH: What an impact, what a legacy you left at your alma mater, Yale Medical School. And very importantly, it is a powerful example of so many of the themes that you just emphasized, the stories we tell ourselves and the fictions that we create. I could continue to talk about that, but I do want to move on. I want to pivot to the fact that I believe you are a physician in Family Medicine, and I believe that Yale does not have a Family Medicine department or a Family Medicine residency program. So where did you come up with the idea to pursue a career as a family physician, if in fact that may not have been a part of your medical school experience?

RR: That is a really good question. Honestly, it was serendipity. I did not know Family Medicine existed before medical school. If I did, I may have chosen to go somewhere else. I learned about it within my first two weeks actually. I ran into an intern in emergency medicine who had graduated from the same program that I did at NYU. So, we were just chopping it up, meeting each other, honestly, for the first time. And I was telling him about why I went into medicine, how I wanted to pursue primary care to be of service to individuals and families, helping them better understand their own health and navigate the health system. After sharing my story, he is the one who asked if I had ever considered Family Medicine, and I

had never heard of it before. So he described it to me and I did not really think of it that much after that.

It was not until I was facilitating a tobacco prevention activity for elementary school students that I came across Family Medicine again. It is called Tar Wars, and it is actually a program that is supported by the American Academy of Family Physicians (AAFP). I was the community service liaison for the Yale's chapter of the Student National Medical Association and was told to go on the AAFP website to download the activity materials. That is when I remembered the conversation with the ER resident. So I explored the website, did not think much of it after that either. That year, a national conference was in Washington DC and the AAFP was doing some recruitment at the conference and invited us to an event being held at the AAFP's Robert Graham Center for Primary Care and Family Medicine Policy Research. So I went, got to meet a handful of Family Medicine doctors in the area, and I really liked it.

I wanted to learn more. I actually took Tehreem to the AAFP National Conference in Kansas City, and by the end of the conference, I knew Family Medicine was for me. Things got a little complicated when I got back to medical school in my second and third year, mentorship was lacking, and honestly, I was deterred from pursuing Family Medicine. I did not want to go away from the specialty though, so I took an extra year to explore my interest and do research. Basically, I wanted to get out of the Yale bubble and see Family Medicine on its own terms. I wanted to decide if I was doing it for me or to spite my institution. That year, I did some electives, spent a month at the Robert Graham Center actually, and met more Family Medicine doctors. By the end, I knew it was for me and no looking back since.

HJH: It sounds to me like you were naturally wise long before one generally acquires that kind of wisdom. So congratulations to you and good bonus to the field of Family Medicine. Now, not surprisingly, given your track record in the examples that you've shared with us today, I understand you also had a transformative impact in your residency program by revamping the social

medicine immersion month that was part of the Family Medicine curriculum. Can you tell us about that?

RR: That was kind of like the story of *US Health Justice* all over again, but with much less time because I was an intern. I went to the Montefiore Family Medicine Residency in Bronx. They have a Department of Family and Social Medicine. A major draw for me was the residency's emphasis on social medicine. They even dedicated four weeks to teaching it during the intern year and another four in the third year. I was excited to take the course, but felt it needed a significant overhaul by the time I was halfway through; the content felt dated. There were new theoretical frameworks like structural competency, public health critical race practice, and intersectionality that better lent themselves to organizing the course. I also felt the community voice could have been stronger as well. We were taken on community tours by local activists, but aside from walking and describing what we saw, we did not get a chance to really sit down and have a discussion with them about how it all fits together in their minds.

Also, the course was very MD dominant and *USHJ* taught me how valuable it is to approach issues of health inequities through the eyes of multiple disciplines. Finally, the course also felt like it prioritized the perspectives of white physicians over communities of color, even though the topic was describing the realities of health inequalities in a majority minority borough. Thankfully, I was not the only one who felt this way and was not the only one interested in doing something about it. There were three other residents, Vanessa Ferrell, Luis Gonzalez Coro and Chanel Diaz, residents in the primary care social medicine residency that was like a separate track within Montefiore. We were lucky in that we were sharing our frustrations at a time of active transition in the leadership for that social medicine orientation course. We found a faculty champion who was willing to volunteer as course director and oversee us in updating the curriculum. We got the green light in April and went hard until October when the revised course was piloted. It was really successful.

We really leaned on our own contacts with community activists, researchers, public defenders, and patient advocates in the city and in the borough. It was a more involved version of *USHJ* that similarly we created the tradition of passing on leadership to successive classes of residents, and to my knowledge, it is still what is happening today.

HJH: Given that description, it is very hard for me to imagine how you possibly did that at the same time that you were an intern. So That is an amazing accomplishment.

RR: Lots of sleepless nights, unfortunately.

HJH: But what a great set of revisions to that course and to that experience for the residents and for the faculty, and very importantly, for the community and for the patients. One of your mentors described you as a natural leader in social justice medicine, and listening to the stories you've shared with us makes me firmly believe that your mentor is absolutely right. What are your long-term goals for your own career in shaping medical education for future learners?

RR: The dream is to make health professional training and health systems overall more attuned to what is going on in the communities that they occupy, and more accountable to the marginalized people in those communities who too often are ignored. I think every health professional school should require service learning curriculum as directly controlled and influenced by community needs and accountable to community critique. A curriculum that does not shy away from contextualization, from speaking on the history of political decisions and power imbalances that inform the resource deprivation that manifests as social determinants of health, and curricula that are unafraid to name racism, sexism, homophobia, and capitalism that create those power imbalances. And finally, educational institutions that are brave enough to acknowledge that those same drivers of power imbalance in the society permeate the healthcare professions and inform the injustices they perpetrate against the press community.

HJH: Well, you are definitely going to be busy for a lifetime taking on that vision. So what is it that you are actually doing today? Tell us a little bit about that.

RR: Right now, I am entering my second year of health services fellowship at the National Clinician Scholars Program at Yale -- an outgrowth of the Robert Wood Johnson Clinical Scholars Program that really mentored me as a student in med school. A lot of the faculty members who were so pivotal in terms of mentoring me, guiding me, showing me what else there was, aside from what I was receiving in my classes, are the ones who I am working with now. I am doing a lot of health services research and the focus of my research is figuring out how to operationalize community accountability, particularly between tax-exempt hospital systems and the communities that they serve, and then also trying to operationalize accountability within health professions training as well.

HJH: That sounds like a perfect fit for you. I want to extend my deep congratulations to you for everything that you've achieved so far and let you know how inspired I am. I am sure our audience is going to feel inspired by the big picture vision you have for the future. And of course, I want to thank you for talking with me today and wish you the very best of luck with all the work that you are doing.

RR: Thank you so much for having me. It is been a pleasure.

HJH: Thank you for listening, and we hope you'll share this conversation with others. Be sure to subscribe wherever you get your podcasts so you'll be notified when the next episode drops, and make sure you are signed up to receive email updates from the Macy Foundation. Thank you.