



Residents In a Room
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(SOUNDBITE OF MUSIC)

VOICE OVER:

This is Residents in a Room, an official podcast of the American Society of Anesthesiologists, where we go behind the scenes to explore the world from the point of view of anesthesiology residents.

I refer to residency as the great equalizer because only in residency are you really working closely with other folks, and, and collaborating.

The opportunities that we have all the time as anesthesiologists to try to influence the lives of young people and I think we should seize upon that opportunity to do so.

He grabs him by his shirt and, and, and tie, he pushes him against the wall and gets his face right up in the other.

DR. COURTNI SALINAS:

Hello, I'm Dr. Courtni Salinas current CA3 at University of Washington. Welcome to Residents in a Room, ASA's podcast for residents by residents. Today, we're going to eavesdrop on a conversation recorded for our sister podcast, Central Line. Dr. William McDade, Chief Diversity Equity and Inclusion Officer for the Accreditation Council for Graduate Medical Education talked to Dr. Adam Striker, the host of Central Line about standardized tests, what diversity means to ACGME, and the true value and necessity of diversifying the healthcare workforce. As someone who's personally passionate about diversity in medicine and working towards health equity for our patients, I learned so much from this conversation. I think it's worth sharing with you, my fellow residents. So let's listen in:

DR. ADAM STRIKER:

Typically, we use the words diversity, equity, and inclusion quite a bit. And I wonder if you can disentangle those words, for all of us actually, and what each of those truly means.

DR. WILLIAM MCDADE:

Well, diversity is an interesting concept because it's really more from other things. I mean, when I started in the Dean's Office the University of Chicago, I was the Dean for Multicultural Affairs because people recognize that people of different ethnicities and backgrounds had different histories that came into the, the situation that we're in right now. It was based in culture. And then that morphed to other areas as well so that you could have ability, or you could have gender, or you could have, you know, any sort of other sort of parameter that people could all describe themselves. Because everybody has a culture, everybody has an identity, and, and so the idea of diversity really has now morphed into a, a much larger sort of comprehensive goal.

But let me focus with what we were trying to do at ACGME. Our, our goal is to improve health care and population health. And one of the biggest problems that I think we face in our society here in the US is health disparities, uh, racial and ethnic health disparities. That is the uh, premature death and the, the excess burden of disease that occurs in some communities on the basis of race and ethnicity. And this really was pointed out to us in 2002 when the Institute of Medicine then now, the National Academy of Medicine published the book called Unequal Treatment. This is about 600 pages and it detailed a broad expanse of disease categories in which minority people in general were, were outstripping the majority population with respect to disease burden.

And it really impacted almost every entity in healthcare from hospitals, to clinical situations to all over. Uh, and it with respect to the, the diseases, uh, that, uh, minority people face. If you'd like to, try to think of the disease burden being carried by minority people as the disparity. Um, when we think about diversity at ACGME, we're thinking about building a workforce that's more likely to help us to eliminate those health disparities. That was really the goal of Healthy People 2010, then started Health People 2020 now, and, and one of foci of, of that was to try to create a workforce that's going to be more likely to serve to reduce those disparities. Well, you ask yourself, well, what, what group is that? And, and, so it turns out that there's a disproportionate rate of, uh, minority physicians who see minority patients, and if you look across disciplines, you'll see that if you're an African American physician, you're about 23 times more likely to see an African American patient than as a white physician. If you're a Latin-X doctor, you're about 19 times, um, more likely to see a Latin-X patient than a white doctor. If you're an Asian physician, you're about 26 more times likely to see an Asian patient than a white physician. And if you speak only Spanish in your home, you're about 18 times more likely to see a Latin-X physician than if you are white physician.

And why would this be? Well, William Julius Wilson the, the sociologist at Harvard would argue that it's because in fact we live in hyper-segregated communities in United

States, and that the tendency to see a physician of your same race is that strong, that powerful. In, in primary care, a, a group studied this and saw that the tendency to see, to see a Black primary care physician if you're Black is about 40 times greater than a primary care physician who's white seeing a Black patient. And, and because of the way that we live, and the barriers that exist between communities, even if there aren't fences there, uh, it stops people from being able to, to see that physician, uh, who is different from them because of other things like trust or the ability to communicate or the ability to, to follow through on medical advice in racially discongruent relationships, discordant relationships.

And so, the diversity we are seeking is to try to figure out who's going to more likely serve that community and is going to help us to improve healthcare? And, and the answer to that, to some extent, is, is people who bear that great burden of disease and who share the same sort of backgrounds as those individuals who are suffering from those, those diseases. So I'm looking primarily at racial and ethnic disparities, but that doesn't mean that's the entire panoply of diversity. We, we have field in medicine, say orthopedic surgeon, where only 14% of orthopedic surgery surgeons are women. And, and so if you look at all of the specialties, there's an axis of diversity I think that pertains to everyone. Um, if we collected data on LGBTQ, I am confident we would find that there are disparities that might be improved. And, and if we had a workforce that was more likely to serve LGBTQ communities. Uh, people with disabilities, or differently abled people, certainly have, uh, an impact on healthcare and considerations around healthcare that could be improved by enriching the workforce in those individuals.

And so the way that we're interpreting this is ACGME is that diversity is defined locally by the hospital, or the academic medical center, or the sponsor institution that's around it. And whatever that institution sees in their community as a need to try to increase diversity to address a healthcare disparity, that's the group, I think, that we need to focus on. So it's a little different. In instead of thinking about the identity around what we'd like to describe ourselves, or like, what we'd like to call ourselves, we're thinking about the functionality of the physician that's produced that will really eliminate an issue in, in disparity. And that's how I'd like to really think about diversity.

Now, let's go on to equity. So equity, really is best envisioned. So imagine there's a baseball game and everyone wants to look over a wooden fence in order to see it. But you got three people of differing heights. You got someone who's very, very small, someone who's kind of intermediate size, but still can't see over the fence, and then you have someone who can really see over the fence very well. Imagine if you gave each one a box that they could stand on. So you give the shortest person a box she can stand on, an, an intermediate person a box, and the tallest person a box. That would be referred to as equality. Everybody gets the same box, but the little one still can't see

over the fence. The intermediate one now can just get his head over the fence and see the game. The tall person didn't need the box in the first place but still stands on the box because it's all equal.

Equity means giving people what they need to be successful. So the tall person didn't really even need a box in the first place, don't give him a box. The intermediate person needed just one box in order to, to see over the fence, but the shorter person needed two boxes. And now with two boxes, she can see the game, the intermediate person can see the game, and now the tall person can see the game, and everybody benefits.

Now, let's imagine instead of having a wooden fence, we had a chain link fence that everybody can see the game from where they stood to begin with and that's what we refer to as liberation. You remove the barrier, you've taken it completely away so that you don't need a box in order to see the game. So that's what I think of in the term equality, equity and, and liberation. They all are a spectrum of what one needs to be successful.

And the last thing is inclusion. Inclusion in, in my way of thinking is really just a way to make sure the diversity works. That if you bring people into an environment that's not inclusive, they're not going to be successful. If you have to figure out ways of ordered, in order to make people feel welcome and belonging in an environment, then that's what inclusion is there for. So what do you have to do? You have to mitigate the biases, the, the thoughts that that really work against an individual and discrimination, the acts that actually works against an individual. You have to remove micro-aggressions, or those elements that really are toxic to the environment of somebody who is different than other people in the organization. You have to figure out how to remove stereotype threat which is a way in which society has said that this person should be viewed and that person actually internalizes it and believes it themselves. Camara Jones would actually refer to that that as internalized racism.

The, the individualized racism that exists in society, is, is really the racism that everyone thinks about. It's the acts of bad people and we're not really so much focused on that. We're focused on really the acts that are just built into the system as norms. They're part of the normal structure and, and that we don't really see them because they're woven into the fabric of society. Getting rid of structural racism is really the most important thing that we can do. When we find that things disparately affect one group as opposed to another and advantage one group, the dominant group, as opposed to marginalize groups, that's something that we have to work on as a society to remove. And that makes our environment more inclusive when we take down those, those unspoken rules, or those barriers that persist that keep people down, the headwinds that marginalized people face. And, and so when were thinking about diversity, equity,

and inclusion, it's about finding, you know, the, the broadest group of people with whatever they bring to the equation that's going to improve healthcare. We're, we're thinking about equity to make sure that they get what they need in order to be successful, and if they don't need so much, then, then, then don't give him as much as they otherwise could be given but those people who need more you give more to. And then inclusion, make the environment welcoming so that they feel a sense of belonging so they can be the most successful they can be in achieving their goals.

DR. STRIKER:

There's a couple things I want to get to. Here, uh, the first question I have related to diversity, or disparity in healthcare, do you think that that is a major hurdle for the medical community to understand? That this is about approaching it from the patient's perspective, and getting everyone the access to healthcare that they would otherwise not have without the diversity in the workforce. I, I get the sense, and maybe this is wrong, that perhaps a large percentage of the medical community feels that this is simply about making everything look the same and that we're just doing it because we want to make sure we're representing every group, but not really approaching it from the patient's perspective.

DR. MCDADE:

No, not, that, that's not it at all. Um, so, one of the that things I, I did, um, to, to, look at this problem was, um, I looked at the American Medical Association Health Workforce Mapper, which is a tool, a geotool, that allows you to put a dot where every physician practices in the United States as a function of zip code.

And so if you look at your Chicago, for instance, you'll see a nice cluster of cardiologists and blue dots around the University of Chicago, and you'll see another cluster around Northwestern and you'll see across the North Shore line, uh, of Lake Michigan on Chicago, a number of cardiology practices. And then you'll seem some sprinkled through the North side of Chicago. Um, but when you look at the South side of Chicago, not so much. And so the idea is, in, in a community like Englewood, which is just West on the other side of I-94, uh, from the University of Chicago, people don't actually go from Englewood East to the University of Chicago for their care. And you say, well, why?

Well, it gets back to the idea of trust, of having a physician who cares about your community and wants to work in your community, and, and it's about access in general that will the insurance that I have be accepted by the physicians who were just on the other side of I-94? No one has a cardiology practice in Englewood. And if you look at

the life expectancy of the people who live in Englewood as in the New York Times article back in September, you'll see the life expectancy is 60 years old in Englewood, compared to Streeterville uh, the community that's just around where Northwestern is on the, the near North Side of Chicago, where it's 90 years old. So a 30-year mortality gap exists between two communities that are a short train ride apart. And it's because of the access that people have and it's because of the willingness to see physicians who are different than you or the willingness of physicians to actually see patients from those communities in part.

So here's the problem. I can teach everybody who goes to medical school about cultural competence or cultural humility or all the things that we think are necessary to eliminate healthcare disparities in their practices, which are things that ACGME wants you to do. But the problem is that if you don't co-locate in a place where people who have these marginal life expectancies live, then you won't have much of an impact on the health care disparities that exist in, in our society. So what you have to do is find individuals who are more likely to practice in these underserved areas in order to make a dent.

And so if you ask first-year medical students as the double AMC does in their matriculating, uh student questionnaire, whether they're going to practice in a community that's underserved when they graduate, 60% of African American medical students will say that. 50% of Native American indigenous medical students will say that. Around 44% of Latin-X physicians will say, physicians in training will say that in their first year of medical school. Then you ask them again at the Medical School Graduation questionnaire, whether you plan a practice in an underserved area. Native Americans still at 50%, African Americans down around 45%, Latin-X down around 32% Whites and, and Asians around in the teens.

And so when people graduate, where do they practice? Well, they practice in areas that have a, a large number of people who look like them and because of the hyper segregation we talked about, it's, it's really easy to, to, to put yourself in those communities if you're an African American or Latin-X or an Indigenous physician. It sometimes is harder despite the fact that the numbers are larger to find white and Asian physicians who want to practice in those areas. So, the answer is, can you fix the health disparities that exist in our country simply by teaching everybody about the things that you should do right when caring for people who are different than you, and, and the answer is no. That you still need to make people who are more likely to practice in those areas, areas and serve those people on a regular basis in order to make the dent that we need to make. And so the author and activist Bryan Stevenson who wrote the book *Just Mercy* and runs the Equal Justice Initiative down in Alabama, he spoke at the double AMC annual Learn, Serve, Lead conference last fall and what he suggested is that there is an empathy gap in our society, that we allow health disparities to persist

because of the separation that we have between communities in the United States. That because we live in, in, in, enclaves of people who are much like us, uh, in this hyper segregated environment, we don't see the people who are really carrying the greatest burden of disease, and so they don't exist to the reality that we would otherwise know if we experienced them directly on a regular basis. And because we aren't proximate to the suffering, uh, Brian would actually say that we don't really appreciate the urgency that we have to put behind getting rid of these disparities.

And, and that's the problem. Vaclav Havel actually said the same thing. Sometimes we have to be willing to, to, to get into those, those difficult situations to be proximate to the suffering of individuals to really want to change it. And I think we're now seeing it to a large degree. This past summer with the racial unrest that took place after the murders of George Floyd, uh, Brianna Taylor and Ahmaud Arbery. Now, it's coming in to our view that we see that people are being treated differently on the basis of race.

And then we see COVID, that overlaps with this, that shows us that COVID has had a disproportionate impact on people who have underlying health disparities and because of those two synergistic relationships we are now seeing even more clearly that the disparities that we have existed with in health for such a long time, have a greater impact than we, uh, otherwise would have thought, because now we see people who are dying in disproportion. In Chicago of the first hundred people who died of COVID, seventy of them were African American. So, it, to me, it's right here for us to see and, and we have to really be intentionally ignoring it in order not to see it.

DR. STRIKER:

But do you feel that the current medical community understands all this, or is that a hurdle that needs to be overcome? It's, it's noble and necessary, but are the current physicians understanding of that?

DR. MCDADE:

Well, I will tell you after the George Floyd situation in Minnesota this summer, um, a number of healthcare organizations had people who came out en masse, uh, holding signs that, that said they were in support. Uh, a, a number of organizations wrote statements that, that really decry the current system and demanded equal justice in terms of healthcare access and in the ability to, to eliminate health disparities through whatever means that we can marshal in order to do that.

Are there people who have lagged? Yes, and we have to work with them to help to bring them along. But the ACGME has started to really move in that direction. For the last 10

years, we've been looking at ways to reduce health disparities through educating the C-Suite on the necessity to do that, and we're seeing some movement there. And then a year ago, we started program requirements that, and joined residents and partnerships with their sponsoring institutions to engage the mission-driven ongoing systematic approach to increase recruitment and retention of a diverse work force and provide inclusive learning environments. And that diverse workforce included residents and fellows, faculty, other GME staff and other academic folks who might be involved in the GME effort.

Now, every program has that as a requirement, and so my hope is that medicine will learn, uh, along the way that these are important things to it to strive for and that the people who educate in graduate medical education programs, and the ACGME now is the sole accreditor of all the residencies, and most of the fellowships in the country. So, everyone's going to come through a program where this was required of it. We hope to be able to move the needle on this in ways that we never could before when this didn't exist in graduate medical education. So you could come through a, a domestic medical school in the, and the LCME has a similar requirement, but you know, you recognize 25% of the physicians who train in America didn't come from LCME accredited schools. And so now, everybody is going to have this as a, as a goal in their training programs and hopefully they'll carry it with them long into their practice.

DR. STRIKER:

Is there anything that's holding you back from making any further progress?

DR. MCDADE:

Well, obviously with structural racism in an existing society is a barrier. Because structural racism is one of those things that unseen it's, it's racism without racists. It, it really looks it outcomes, it looks at processes as opposed to acts of individuals. You know, things that have become normative, things have become the usual, the standard the, the way that we interpret things. The myth of meritocracy, that's all built in to, to, structurally racist sort of concepts that have been built up that have really caused the differential, uh, that exists between education between the wealth gap that exists between blacks and whites in society here and, and a number the barriers in healthcare that prevent good health. I mean, obviously, the social determinants of health are all predicated in structural entities that are historical and are, per, persistent because of the way that our society works. Those are the targets of the things that we have to try to change in order to really advance healthcare equity. And that's really the goal is to try to, to make sure that everybody has what they need in order to achieve good health.

DR. STRIKER:

And what would you say to people that might say, okay, well, I understand what you're saying, but ultimately, you know, we're talking about physicians and physicians need to be able to do the job and be competent and to have aptitudes in math and science, and I, I get what you're trying to do, but I want to make sure that, uh, we have people that actually can do the work of, of being a physician. Have you gotten that question before, and what would you say to that?

DR. MCDADE:

Well, you know, there was an unfortunate article that was published in the Journal of the American Heart Association that it has since been retracted, and what is alleged is that by lowering standards, quote unquote, by looking at other parameters other than the standardized exams, um, that have been historically used to say that there's a, a person who, uh, did well on the exam, was of of higher quality than the person who didn't do so well. Um, the, the problem with thinking like that, is that the tests actually measure the competence in the, the, the outcomes of physicians who have those sorts of, of scores?

So, David Asch, performed an important series of experiments, or of studies back in 2009 published in the Journal of the American Medical Association. And what he looked at was the practice outcomes of OB-GYN doctors with respect to their complication rates. And he looked to see whether or not their USMLE score for the MCAT score or their passage on the ABMS certification exam, um, varied with respect to their care for patients in practice. And what he found is that the thing that actually made the most difference in what the quality was or what the complication rate was of an, a practicing obstetrician-gynecologist for the next 17 years of their, their practice, was where they trained. If they trained in an institution that had a low complication rate, they maintained a low complication rate relative to their peers for the next 17 years. If they trained in a place that a high complication rate, what they found is that they practice with a high complication rate, for the next 17 years. The idea that individual qualities on, on aptitude tests or on, uh, placement exams or on standardized exams actually tells you how good a physician you're going to be, how low your complication rates going to be in practice, didn't correlate it all. And, and so if you're trying to produce physicians who are going to give the best care to patients, who are going to be the lowest complication rates, who are going to serve people who aren't served right now, I think we may be looking at the wrong sorts of things, in that we measure the things that we can measure because they're easy for us to measure, that to have an exam that allows us to say that somebody does better on a, on a, on a quantitative exam or than somebody else means that they've had more time to practice. They had more access to practice. They've taken more practice tests. They paid, they paid the \$5- or \$7,000 that you need to have in

order to, to do review courses that many people can't afford who come from more disadvantaged backgrounds.

Uh, Jordy Cohen in an article also in JAMA on the premature abandonment of affirmative action in medicine showed a graph that I thought was very telling, that for underrepresented minority students income matters the most for your MCAT performance, in that the lower your parental income the lower your MCAT score, the higher your parental income the higher your MCAT score, and that the difference was greater for African American, Latin-X and Native Americans, then it was for uh, whites and Asians.

So what we're saying, is that the, the historical wealth gap that's generated because of slavery and in subsequent oppression, that really causes this difference in wealth, is really responsible at the core for the difference in performance on standardized exams. Yet, the communities that are suffering from greatest health disparities are also the ones where the people who are the victims of, of this oppression need to go back and practice in order to help to eliminate um, health disparities.

So that's the, the dichotomy that we're really looking at in this it is that there are other things that matter other than the performance on a standardized exam and that you can actually be a really good doctor, but maybe you don't score so well on standardized exam. There's a phenomenon that the psychologist Claude Steele referred to as stereotype threat. It's reinforced in environments that really are, are not inclusive where people are made to doubt that they belong in the environment, something that we refer to as imposter syndrome. And stereotype threat is really one of those things that, that generates the performance that you see people have on standardized exams. What is, best is shown by is by women who are in their sophomore year of college and asked to take the math portion of the SAT. You can take half the group of women and tell them that women typically under-perform on these math exams compared to men and then you can say absolutely nothing to the other group and you'll find that consistently the women who were given the message before the exam that women don't perform as well as men, underperform on the exam. You can reverse that phenomenon by telling the women at the beginning of the exam that women typically outperform men on these types of exams. Women show no difference in performance in the women were told absolutely nothing.

If you try to do this with a cognitive exam and race where you have a, a marginalized group, African American say, and you tell them that African Americans typically outperform non African Americans on a cognitive exam, they don't believe you. It's internalized with those individuals so much by everything that's seen in society that just by giving the mere suggestion that their thoughts about this will be different, doesn't

affirm them. It doesn't help them. So what happens during the course of a test for somebody who's the victim of stereotype threat? Well, you engage in something called rumination, which is you start thinking about all of those parameters that are involved with your not doing well on that exam potentially, and what would happen. So you're thinking, if I don't do as well on this exam as my, as they expect me to, they're not going to give me another chance. They're not going to let another person in this program who looks like me. I know, I don't, I'm not supposed to be here cuz I'm the only African American my program, I'm the first African American this program. You know, if I don't do well on this exam, my whole family is going to be, be out of money because I'm going to be the person who everyone looks to for money. Now, you're thinking all of this while you're doing question one. Meanwhile everybody else has moved on to question four and so in a (Sic) exam, those people who engage in rumination don't perform as well as those who don't have stereotype threat, and who aren't engaged in rumination and who are just objectively answering the questions.

So nobody thinks about this as why people underperform on an exams unless you really understand what stereotype threat's all about. And that's why I include this is so important. You can reduce those sorts of barriers and what I find in residencies, and I refer to resume to the great equalizer because only in residency, are you really working closely with other folks in, in collaborative learning environments. In medical school people are excluded, marginalized from study groups. Pre-med it certainly happens, but once you get to residency programs the cohorts are so small and people work together so well because you're exchanging information. You're, you're, you're handing off the people who are caring for your same patients that you have to develop in Esprit de corps. And, and what happens with that, if you learn something that is really important. And that is that the internalized racism that, that said that whites and Asians are, are superior intellectual to you as an African American isn't true. They present and you think of things that they could have said better. You understand a little bit more about the clinical problem than they did. They have the same questions that you have. And so what you see is by working closely with people, shoulder-to-shoulder over the course of a residency, you dispel the notion of racial superiority. You teach as a senior resident junior residents who are of a different race than you. That dispels myths that they may have about white superiority that may dispel myths that you have as the fact because you now teach people who look up to you, um, and that's, that's where the thing is, is something that many African Americans never get a chance to experience. And by having this, this, this dynamic broken, you can actually perform on, on standardized exams much better than you could before when you were ruminating and dealing with stereotype threat.

So, so it's really an important concept to understand that performance isn't just about, you know, knowledge and, and quality and all the rest of that. There are factors that

transcend that. And the importance of what those individuals will do once they graduate and commit to a career in medicine, I think, far out, exceeds with marginal differences that may exist on standardized exams.

DR. STRIKER:

Well, are medical schools getting that? Those are compelling arguments. Are the medical schools getting that messaging? Are they able to actually take that messaging and, and operationalize that in some fashion?

DR. MCDADE:

I think that many medical schools are moving to holistic admissions and situational judgment test that are trying to tease out these things. The MCAT uh, 2015 is now putting in social science questions and, and questions at that, that really test the ability of individuals to think about things more broadly than just the biology, chemistry, physics, and, and organic chemistry. The, the idea that other things matter, that the psychological sciences, and, and that biostatistics makes a difference. I looked at the breakdown of individuals as a function of race and which residency programs that they are dominating and African Americans and Latin-X individuals are over-represented in by their numbers in the primary care fields, as you might expect, especially in the areas greatly under represented. But one of the things that shocked me about African Americans is that they represent 12.5% of all the people who are in preventive medicine programs. That means that those are people who are thinking about public health issues, and occupational health issues, and, and areas that really transcend just the practice of medicine per se, but are thinking about the larger social context of medicine. Those things that, the disparities in care, that are related to social factors play a role in are the things that, that people understand when you come from a source of communities are, are important.

So I will just say, that medical schools are getting it. And, what you see now is really unfortunate, and one of the things I think is important about understanding standardized testing is that when you look at MCAT performance, African American mean score of MCAT's in the lowest 13% of everybody who takes the MCAT. Right? If you imagine that once those people are, are seen and reviewed by admissions committees, they're not going to get in to medical school if they're in the lowest 13%. What we see is that the, the tail of that distribution may go all the way to the top. That's a really thin tail. The majority of people are down by that mean score. And then if you look at the people who get admitted to medical school, and this is data out of UC Riverside that I just saw not too long ago, that the mean African American scores in the lowest 0.7 percentile of individuals were admitted to medical school. So I think people in medical school get it.

But the problem is that if you say we're going to wave parameters on admissions tests to get you into medical school, but we're not going to waive those sorts of parameters when you get to residency, you can then see how people who don't have very many opportunities to test, and, and don't have the resources to provide you with the background of will help you to supplement your performance on these exams, may suffer. And that's exactly what we see and it will see that USMLE Step One scores are much lower for African Americans than they are for a majority students. And if program directors use those scores as a measure of quality, uh, keeping people out of programs that, or types of programs, on the basis of having a threshold because they can be more selective about performance on a standardized exam, then you're going to be underrepresented in those fields. And so we have to look very carefully at that.

One of the things I was very pleased to see is that USMLE, um, the committee, said that they're now going to remove the 3 digit scoring and look at a pass-fail score for USMLE Step 1. Many program directions would say, well, let's to our detriment because we don't have the ability to go through applications and, and figure out these sorts of, of differences that that might be nuanced without a three-digit score that allows us to, to do what's easy in order to sort. And what I would argue is that, maybe it's not supposed to be easy. Maybe you're supposed to have to read some of these essays and really look at the applications and, and try to figure out ways in which you can actually change the way that the field has functioned in the past so that we can try to eliminate these health disparities that we've been so unsuccessful in remedying over the last several generations.

DR. STRIKER:

That actually brings me to another question. Are there other barriers that the medical schools have identified with regard to, uh, sorting out all their applicants? You already answered the point about, uh, having a numerical test score versus pass-fail. Are there other logistical barriers that they are citing?

DR. MCDADE:

Well I will tell you that um, of the people going back to African American's again, of the African Americans that take the MCAT, half do not actually apply to medical school. And you say, well why is that? In part it's because it's the counseling that people get before they get into medical school, when they're in the application process. There are countless stories of individuals who've been discouraged by college counselors to apply to medical school based on an MCAT score or a grade in organic chemistry. And yet, we've seen examples of individuals who still went ahead and applied, who've been extraordinarily successful subsequently, for all the reasons I talked about before.

Anthony Abraham Jack published a wonderful book called *The Privileged Poor*, which really talks about the plight of underrepresented minority students who come from what he refers to as doubly disadvantaged communities as opposed to similar individuals who are given access to elite, pre-college opportunities, and then compared those people from upper income levels who, who are very familiar with the things that occur on elite campuses. And medical schools still draw many of their students from these elite campuses so it was very important to look at this. And so what he showed is that if you don't understand how to navigate the college pathway, um, understanding what office hours mean, understanding that you may have to work but there're certain jobs that you can work that actually pay you but you don't have to be disengaged from academics at the same time that you're doing those sorts of jobs. Those are the sorts of things that it takes someone who understands the college process coming into it, who's had a parent, or has a sib, or has had exposure to it in the environment to understand how to best navigate it. And the doubly disadvantaged people who didn't go to an elite pre-college high school don't understand it and perform less well. And so we lose those individuals in the first couple of years of college and they're, they're discouraged from applying

One of the things that I think would be essential to do that has not yet happened is in the medical school admissions requirements book, now websites, that talk about the parameters of medical schools, we often look at the data there and, and say well I would never fit in that medical school. Because the data that shows up in the MSAR is really the average MCAT score or the average GPA of a medical school student. But as I just told you, on the MCAT score, African Americans are in the lowest 0.7 percentile. So it's the range that's really important in making decisions about whether you should apply to medical school or not. And unfortunately, that data is not made available to us. I think it should be, because it would help people to think about not counseling themselves out of a career in medicine when the otherwise could.

The Association of American Medical Colleges put together a website several years ago, over a decade ago now, called aspiringdocs.org. And it really talks about some of those other barriers that cause people to self select out. That is the idea of generating \$200,000 in debt when your family may be a rental family because you can't afford a house. Only 40% of African Americans actually own houses in the United States because of the wealth gap I spoke of before. So how could you possibly think about going the \$200,000 of debt if you're from a family that doesn't have a house, or family that has a house that maybe only costs fifty or sixty thousand dollars? So that's the sort of mentality that has to be overcome in order to get people in the door to consider careers in medicine.

Now once you get them in to a pre-medical program or a college program, you've got to think about the things that they need in order to be successful, this idea of giving someone what they need to be successful. Equity, um, is something that doesn't happen on very many colleges. And so what medical schools look for are individuals who have had those sorts of, of privileges, I suppose. Those, those things that are able to allow those students to compete. And there a lot of them out there, and we got to get more of them into the practice of medicine. And, so that's another one of the parameters.

The other thing that I think we have to go back to is to think about the humanistic level that individuals show when we're thinking about who belongs in medicine. If you tell me, and I've interviewed thousand of medical school students because I was on the admissions committee at University of Chicago for 17 years, I used to chair it. You ask people why they want to be a doctor, what is it they want to do with their careers, who is it they want to serve? Those answers have to make a difference to you as an admissions committee. If someone tells you that they want to come into medical school because they want to serve the underserved, they want to make a difference in health disparities, they wanted helping communities thrive, that to me, there's a lot of weight. If you tell me you want to do research on, on a disease, or on a complex that impacts a community that doesn't have very many people studying that, that particular phenomenon. I'm going to say that's, that's the person we need medicine. Because we need to have somebody who's going to be thinking about those sorts of things as research projects when they get into medical school and beyond.

So, so those are the sorts of parameters we can look at in the holistic view of an individual, people with leadership who will drive an agenda, people who can teach. One of my favorite questions when I used to interview medical students for medical school positions, you know, what's the Latin translation for the word doctor? It's teacher. So, go ahead and teach me something, because you're going to have to teach patients later on how to take care of themselves. So go ahead, teach me something you think I need to know. And people will get stuck at that position, trying to figure out what it is they're going to teach me, and how they're going to teach me. But then you'd see people who love that, and could go right into a description of something that you really had no idea about, and now, you know a lot about because they were able to communicate, they were able to reach you and understand. And, that's what we need doctors to do. And those are the sorts of things that we need to look at when we're admitting medical school classes.

DR. STRIKER:

Dr. McDade, is there any advice you'd like to give to residents specifically?

DR. MCDADE:

I think the biggest thing you can do to help people through residency program is to instill confidence, to stop forward feeding, to really mitigate the stereo... the micro-aggressions that you can think about it, maybe stop yourself before you do it. You know, the urge to say, well, you got a very complicated name, I'm just going to call you this. That little sort of thing is enough to cause people to think that I'm not with you, you're, you're not with me.

When I was Chief Academic Officer down at Ochsner, one of the foremost scientists at Ochsner, the best scientist in my opinion at Ochsner, when I first met her I said I'm going to make you a star, was a woman named Ebony Price Haywood. Ebony is a health services researcher of the highest quality. And she came to my office in tears one day because she was in the group meeting with a bunch of the folks who do health services work for the, the um, health care system. And she said, Dr. Carmouche was there, you know, Dr. Hart was there. They all called him Dr. Carmouche and Dr. Hart. I got called Ebony. And that little thing was enough to set, set her apart, ensure that she really wasn't respected in the same way that they were. Those little things are really quite amazing. Um, and in residency programs, we do them all the time, and we've got to be a lot more careful about how we treat people and the respect that we give people to make them feel that they're actually important and part of the, the organization, part of the fabric of the organization.

DR. STRIKER:

Can you flesh out why that matters?

DR. MCDADE:

It's a tiny thing, in our opinion, because we're men, we have privilege. You know you can call me Bill all day long. I got an MD and a Ph.D. It doesn't matter to me. But for Ebony it matters because she recognizes that women are marginalized and, and that, in fact, you are continuing to marginalize of the contributions that she makes by doing that.

DR. STRIKER:

You hear the word ally thrown about a lot. And I'm wondering if you could share with us advice on how to be a good ally.

DR. MCDADE:

I think that you really have to believe that the people who are coming in are just as good as you are. Um, you have to dispense with the unearned privilege that you have because you're a, a white man for instance and really try to put that aside when you start thinking about what people have overcome to get to where you are right now alongside you.

You know, I, I kind of chuckle to myself when, you know, people ask about what my experience was like on the faculty of University Chicago where I was the only African American probably over the last 15 years that I was there, in, in anesthesia. And, to me I work alongside these people. I trained a number of these people over the course of the years. But the problem is that the people who are minority just didn't want to stay in academic medicine or they didn't get hired. But in part it's because we don't see them as our replacements. Um, if you have a minority student, you think it will they're going to go out and serve their Community. They're, they're not going to want to stay here in the faculty. And the answer to that is, is, no. You've got to groom them the same way that you would other people. And as residents, you got to treat them the same way that you would treat other people with the same career aspirations that you have, with the same thoughts that what they're going to contribute are just going to be in the same importance of the stuff that you're going to contribute. And I think we don't do that enough. We, we don't make people feel welcome.

When I was a resident, there was a group of residents who used to play basketball at the Charlestown Navy Shipyards every Saturday morning. And you know everyone was enthusiastic about me coming to play basketball on Saturday morning with them, but were they also is enthusiastic about have me study with them when they were preparing for their exams? You know, but those are the sort of things that you got to ask yourself, whether you're seeing a difference in the way you're being treated for one reason versus another reason. Um, and you got to, you got to ask yourself, you know, what can I do to make things different? And I think we have to challenge ourselves, ask questions about things that we just think are just normal, and then say could racism be operating here? And let's see if we can get rid of that, that unearned privileged that we have, unasked for privilege that we receive, the benefit of the doubt that other people don't get, and, and see whether we can further the like.

Being, being an ally, you know just having the language, when you see something disturbing happen to step up and say that's just not right. What do you mean by that? You know, I, I, I differ with you on that opinion. Giving people the language to respond as an ally, what we now refer to as up standard training, is important for every resident to experience.

And I think back to my intern year, so almost 30 years ago, um, I think about the situation where a third year medical students on service with me. I was an internal medicine intern that night. It was about 3 o'clock in the morning and we were writing our, our, I was writing my last note, say I'm going to going to crash for a while, but before I do, I want to buff you on your presentation tomorrow because I really want you to shine when you're doing your talk. And so he said, no I got this, it, it's down pat. This, it'll be no problem. I said, really, this is your first major presentation. You got to get it hard. You got to get it right. You got an attending who's going to ask a lot of tough questions. So he said, nope, I got it. Don't worry about it. So we go into the bedside, we present at the bedside, it's an oncology patient. The whole room is filled with the, with the teams. You got four interns on, on two different teams there. You got two junior residents, two senior residents, two fellows, the, the nutritionist, the, the social worker, and the attending. And this is the worst presentation I've ever heard in my entire life. Just absolutely abhorrent. So we walk through the, the laminar flow room, we go all the way out into the main hallway. And the student who presented, who was an African American male, um, about six one or so, is now confronted with the attending who's just incensed by this terrible presentation that was given at bedside. And he grabs him by a shirt and tie, and pushes him against the wall, he gets his face right up in the other—it's like the old Marine drill instructor—and he says, if you ever present a case that is that poorly constructed, I will see to that you never graduate from medical school. Now, the whole two teams are sitting there listening to this, anyone in the hallway who's walking by can see this, and he's doing it right in front of everybody. And who steps up and says something? Nobody. Including me. I'm the intern on the service. And I'm not even to stay at the hospital. I was going to, did my training for my preliminary year at one place and I'm going to go another residency. I didn't say anything. That's what the problem is. When you're not prepared, when something like that happens, you have to be prepared to step up to try to say, you know, it was my fault. I should have buffed him. It was not all his fault, and, and no one deserves to be treated like that. And that's really what the difference is. That, that fellow is still an attending physician. So, no one ever said anything to him about it.

DR. STRIKER:

Is there any more advice that you would like to give to our listeners?

DR. MCDADE:

Well, start where you are and, and do what you can. So, you can't do it all. If you can't build a program, you can't be a PI on a, on a RWJ Grant, you know, work where you are, work with what you have to try to make a difference yet. You don't have to change everybody. I often think of be the old starfish question, where the little girl's walking

along the beach and she's picking up starfish and she's throwing it back in the ocean. Somebody comes up to her and says, you know, you're not going to make a lot of difference by just throwing one starfish, there are starfish all over the beach. And she looked on them and she looked at the starfish and said, well, I'm going to make a difference for this one and she throws it back into the ocean. Well, that's what you can do. As an individual physician, if you can't run a large program, if you can't impact a lot of lives, impact one. And try to make a difference for that individual by really guiding them, and mentoring them, and letting them become the successes that they can be, that we need them to be in society in order to try to change the things that we see, that need to be changed to improve the health care and lives of all.

DR. STRIKER:

Well, Dr. McDade, uh, thank you so much for joining us today and for such an informative, informational, eye opening, and fascinating conversation. I really appreciate you taking the time.

DR. MCDADE:

All the best, Dr. Striker. It was a pleasure to be here and to, to talk to your audience.

DR. SALINAS:

That's a wrap for this episode. I hope you all found this conversation as enlightening as I did, and I hope that it inspires you to keep having these important conversations with one another because it really matters for our patients. Please join us for future episodes of Residents in a Room the podcast for residents by residents.

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