How med schools can better equip doctors to help eliminate health disparities

Many people who go into medicine come from well-off families and don't know what it's like to live in poverty. So when they graduate and become physicians, they can struggle to understand why their therapeutic interventions aren't improving the lives of their patients.

This, according to Dr. Pedro José Greer Jr., is because med schools have not done a great job helping their students understand the social determinants of health — the many nonmedical factors that influence health outcomes.

"It's not for the student physician to be able to resolve the social determinants, it's for them to really understand what they are," Greer said. "Without understanding all these other things, we're not going to make [the] right therapeutic calls.

"The health outcomes in this country are embarrassingly bad," he added. "So we have to be driven to improve those disparities."

Greer is an American physician of Cuban descent and founding dean of the Roseman University of Health Sciences College of Medicine. He spoke with Health Disparities podcast host Claudia Zamora about how to improve medical education, why diversity matters, and why it's critical that med schools train doctors to show compassion and empathy for their patients.

The conversation was recorded in person at the 2023 Movement Is Life annual Health Equity Summit.

The following transcript of this podcast episode has been lightly edited for clarity.

Claudia Zamora: You are listening to the Health Disparities Podcast, a program of Movement is Life, being recorded live and in person at Movement is Life's annual health equity summit. Our theme this year is "Bridging the Health Equity Gap in Vulnerable Communities," and as always we are convening with a wonderful community of participants, workshop leaders and speakers.

I'm Claudia Zamora, your host for today's episode of the podcast. I'm a health education consultant and health equity advocate, and I serve on the Board of Directors for the National Hispanic Medical Association and the Board of Directors for Movement is Life.

Dr. Pedro José Greer Jr. is an American physician of Cuban descent. He joined the Roseman University of Health Sciences in 2020 as Founding Dean, with the goal of establishing an innovative mid-21st Century, Las Vegas-based medical school that will align students, educators, and community in designing and delivering an inclusive and collaborative environment for learning, health care and research.

Better known as “Joe,” Dr. Greer has been an advocate for health equity by engaging communities to create effective health and social policies and accessible health care systems. Dr. Greer is here to speak about the lack of equity in the medical profession, and the real need for social and public policy changes and how to get there.

Welcome Dr. Joe Greer.

Dr. Joe Greer: Well, thank you. And thank you for those kind words. Once again, my mother wrote them.

CZ: Well, Dr. Greer, before we dive into your presentation at the summit, I wanted to ask you some questions on your path to becoming a physician and a health care advocate. You were the founder of Camillus Health Concern, as we mentioned, an agency that to this day provides medical care and social services to thousands of homeless patients a year in Miami-Dade County. This was in addition to your regular job as a medical doctor, practicing with your father. How did you find the time to establish his charity and what inspired you to do?

JG: Actually, I started off when I was an intern. So I had even less time. But what inspired me to start the clinic was, unfortunately, my little sister wanted to spend her 18th birthday with me and she was driving down from college. And she was killed in a car accident. So you can imagine being a young, the only boy in an immigrant family and taking care of your sisters and your little sister passes away. I had to take care of all the arrangements and one of the things I did was I never wanted to see people die or suffer alone.

So during my internship, one of the my rotations was in the intensive care unit and we had a patient who will school what's called miliary tuberculosis, which is metastatic TB. And he had a wristband that said no address meant he was homeless. Well, pursuant on the on the promise I had made, I went out to try and find his family. There were only two shelters: the rescue mission and Camellus and I couldn't find his family. He unfortunately passed away. He was a Korean War veteran.

And that, what I saw, the realities of poverty out on the street, now remember, this was the 1980s, we were in a recession. The crack epidemic was hitting, AIDS, everything was converging at once. And so I went there to say, you know, I want to open a clinic, I'm free on Tuesday nights. I can do this on Tuesday nights and Brother Paul Johnson there told me, Well, why don't you try serving food first or hanging out clothing?

I did that for a month, which allowed me to understand what was going on. And then we opened a clinic on a Tuesday night, it was a free clinic, got my buddies to volunteer. And off we went. And I remember my brother, my ex-brother-in-law, who was an attorney, saying, do you have malpractice for that? I said, Brian, what can they take from me? I'm married, I have a mother-in-law, and I have loans. They can have them both. But we never were sued. And I was just there the other day, by the way. They've done a remarkable job of all the services that they're giving and all that.

CZ: I'm sure it was very thrilling for you to see what you started.

JG: It was thrilling to see these young providers so enthusiastic in what they were doing, and that was going to just make it better.

CZ: Now you have been recognized by Presidents Clinton, Bush Sr. and Carter for your work with Miami's impoverished communities, you were awarded the Presidential Medal of Freedom by President Obama. And I may note that other recipients die here included physicist Stephen Hawkins, and Bishop Desmond Tutu. What was it like to be recognized for your leadership in this way? And does this recognition help you to do more?

JG: I remember what my mother said. First of all, my kids didn't believe it. They thought it was a joke. And she said, listen, even if you don't deserve it, don't return it. It's opened a lot of doors. But like with all things, you know, if if you're given this gift, I was given the gift of these great parents that made sure I got done with my education. If I'm given the gift of something like this, it's to benefit others. And how do I use that to open doors to make sure that people understand that this is a true plight that we need to address in this country if we want to be a nation that's a great nation.

CZ: So now moving on to present day. Tell us what took you to Las Vegas to become the inaugural dean of the Roseman University of Health Sciences College of Medicine. And what are you hoping to accomplish?

JG: What got me out to Las Vegas was, number one, finding a place where we, when I say we, because we're team, could start a new medical school with a new curriculum to really improve the health of this nation.

Now, it was not just a new medical school, but it was looking at what we had done wrong and correcting it. We had, as we discussed at the conference, were a racist, sexist, homophobic and elitist profession. Well, why don't I put together a senior team, that is not that, that represents diversity, where the overwhelming majority are women, who by the way, tend to be better physicians. And African Americans, 50%, three out of six are Hispanic, or the two males, one's Hispanic, one's African American. The African American just so happens that he's got a bachelor's, a masters, a PhD, and he did his postdocs at the University of London. And this guy's brilliant, he worked with John Lewis, Luther Brewster.

And the idea was to put together a collective group of brilliant minds, but who had the passion to make a change, and had the foresight to say, let's try something different that's going to make a difference. What are we doing wrong? Well, the medical school shouldn't be isolated. Medical school should be an integral part of the community.

As a matter of fact, what I say is, we're not a community engaged medical school, I'm a community-dependent medical school. I depend on the community to educate our students, I

depend on the community to be there, for us to go and integrate with them, to become partners to the point where if a community member that is teaching our students, whether they have a high school degree or not, or a college degree or a medical degree, if they're teaching our students, they will be offered a faculty appointment.

CZ: So going back to your previous work at FIU, can you give our listeners a sense of the Neighborhood Health Program?

JG: The Neighborhood Health Program actually was created, Lu and myself, David Brown were sitting around, the question was, how do we get to the poorest, sickest patient before they show up to the clinic? Now, why say that? Well, traditionally American medicine I could send them to the clinic and they have students would train in disease, and that would be great. But that doesn't benefit the patient. Why? Well, if you're an hourly worker, and you don't have benefits, when you choose to go to the doctor, you're going to make 20% less that week, in an economy that's hard-pressed, in a community like Miami, where the disparities in income are unbelievable. So you're gonna wait till you're really really sick before you show up. Because if you show up to that clinic, that means your family suffers, whether it's rent, food, medicines, whatever it is.

So what we decided to do was do a thing where we had trusted partners. So we had about 150 trusted partners. These were NGOs, faith-based organizations, mom and pop shops, schools, government agencies, whether it was a police department, public health, whoever. And we would have them because we knew that they were the first ones to see when somebody didn't show up to work. They would call us, we would go do a household visit, do a rapid assessment to see if the emergency was social or medical, and then send our team there. And household-centered care is a system of teaching students through interdisciplinary teams that would go to the household to address the social determinants, but at the same time, mitigate social determinants.

What did that teach the doctor to be? That they're not always going to be the queen or king, that they have to be part of a team, that health care is not the most important thing for people when they can't eat, or they can't pay their rent.

Remember, the students come from very well-off families, they have no understanding of what's going on there. However, as a country, when you graduate from med school, they become responsible for the health of a nation. And there's a lot of other issues that go along with that, that we're not fulfilling. But it's teaching them not only that, but why their therapeutic interventions might not be working. What are the things that are inhibiting it with the social determinants of health?

It's not for the student physician to be able to resolve the social determinants, it's for them to really understand what they are, because our role is the medical role. But without understanding all these other things, we're not going to make right therapeutic calls. And the other amazing thing was, they did a study, and they showed that our students had the highest rates of

empathy, after the third year of any medical school in the country. Why is that? Well, we took them out of the ivory tower. All of a sudden, now, if you're going to somebody's house, you get rid of that power differential. So you learn what's actually going on.

CZ: Now, did you see from, let's say, day one, your interdisciplinary team, going to the household. By the time the medical student graduated four years later, did you guys track the outcomes of the family?

JG: Yes, we did. And then it became very important to do that. And the reason was, number one, we became one of the few if not the only medical school in the country that had four years of longitudinal care of a family. That's how life is, unless you're an ER doc, you know, you follow patients for months for years, etc, etc. But medical school rotations are generally six to eight weeks, and then you go into another specialty. So you stop following that patient.

So they got to see the growth of a family, the complexities of what goes on, to prepare them to be true physicians. Do we follow that? Yes, because especially after the student had graduated, if you have a two year old, and you go through four classes, there's kids now getting out of high school. And you see whether they're successful or not.

Because the other intervention we started with our household care was, we started targeting instead of, you know, when somebody would send us patients we started targeting with schools, who started to call us, because they would miss class were because of asthma or diabetes, or obesity. So they had to go to the ED. By going to the ED, they had to call one of their parents to go take care of. Now what happens, a kid loses a day of school, or more, the parent loses a day of work. So we decided to address those by looking at that.

And then we interestingly, very much found that because we were out by what was Little Haiti, and we didn't realize this, there's a big gang problem there. So there was that issue at school. So we had to work with anti-gang and gang members to be able to incorporate the whole thing, because the idea was we're measuring not just how much weight they lost, or hemoglobin A1C, how many days of school did you miss? How are your grades? How many days of work did your parents miss? Because you got to make the family whole.

CZ: Exactly. Now, do you think, I mean, it sounds like it did have an impact. What percentage of the medical students by the time they graduated medical school, decided to do primary care because of the work they did in the house?

JG: It's a tough call because we had the majority go into primary care but that doesn't mean that they didn't specialize afterwards. You can go into pediatrics and then become a pediatric gastroenterologist. You can go to primary care internal medicine and then do all the subspecialties. You can do family medicine, and end up doing, you know, women's health, sports medicine. So there's, from graduation, we had over 50%.

CZ: That's a very impressive number. Now, moving on, can you give us an overview of your presentation here at the summit: How medicine and medical education needs to change to achieve true health equity. What were the highlights?

JG: The highlights very simply were: what kind of hubris do we have as academic physicians to talk about health equity, and we don't have equity in our own profession. So as we strive for health equity for the most vulnerable populations, we have to have equity within our profession, and especially medical education.

As it turns out, when you look at the statistics and the numbers, we are racist, we are sexist, we are xenophobic, and we are elitist, based upon the income of families of medical students, based upon the number of African American, Hispanic, the salary that women or the position that they get, because women are, in the diversity space, doing well. But in the equity and inclusion space in health care, they're not. And that's represented not just in the student population, but in the faces of the faculty.

We know that one African American physician in a community that has African Americans, the health outcomes improve. From that simple perspective is: If we know that diversity improves the health of a population, and that population is a diverse population in this country, why are we not producing physicians that represent these populations, and also makes the population more willing to go see somebody that maybe has the same accent, maybe speaks the same language, can understand?

And so that's, that's the all-time goal. But the first one is, you can't do that until you change the the color of the skin, the tone of the accent, and the gender and everything else in the face of medical education. Having said that, we also have to make a priority in medical education virtues, because without the proper, without humility, without empathy, without compassion, how are you going to make the world better? Are you gonna make the world better just so you get your name in the stars? No, you make the world better, because you took an oath. And that's what we're charged with.

CZ: You know, in your talk, you talked about the experiences and what led you to the work that you're doing today. Can you share with us a story about the homeless woman?

JG: Want me to read the story?

CZ: Yes please. Actually, both stores if you don't mind.

JG: Not at all. I have another one about the only football game we ever won in high school. Because we were so bad in high school that the priests wouldn't even pray for victory, just for no injuries.

By the way, just to preempt -- this is from a book I wrote called Waking Up in America, was published 25 years ago, but I'm a narrative writer.

It was a Tuesday night the clinic when a young woman in a tattered red dress came in. She was about 25 years old, but she seemed a lot older. The lines of her battle-weary face, beauty concealed between beneath a smudge of stale makeup, her soiled clothes, a swath of spandex. They told a story of her hard life on the street. Her eyes revealed her turmoil. Whatever her story, she deserved a bath and a rest.

That night I was working with third and fourth year medical students. I send Carlos, a third year student, into room two where she sat weeping. Within minutes he rushed out of the exam room. "Dr. Greer," he called to me in a hurry to tell me, "I can't get a history out of her. I don't know what to do."

"What's the problem?" I asked.

"I don't know what she's crying like a baby. I can't get her to talk to me."

I said, "What's your guess? Is it physical, emotional, drugs?" I insisted, giving him a signal follow me.

"I don't know," he repeated more urgently as we walked towards the exam room. The chart says she has been here once before, had some dermatologic problems. No history of psych problems noted. Ah," he says, "she does smoke crack. Must be the perks of prostitution."

Now that in itself is a teaching moment, when you take a student to the side and you talk to him about what is inappropriate and what is not. And that nobody wants to be an addict.

I stepped into the exam room and found a desperate woman. She was trembling. I extended my hand to greet her. "We're here to help you, do you hurt somewhere?" I asked, gently nudging her elbow to give her sense of stability. She was full of tears gasping for air.

"It hurts down here," she said between sobs, holding her lower abdomen and doubling over. "It feels like it's burning. It won't stop, please help me, please."

The nurse and I let her calmed down a bit before we laid her on the stretcher and I examined her and I palpated her tender belly and we examined further. I concluded that her symptoms and the exams suggested a mix of pelvic inflammatory disease and other sexually transmitted diseases.

"It will be okay," I told her, trying to offer a little reassurance. Slowly, she began to tell us why she really came to a homeless clinic, when she could have gone to the gynecologist or the public health unit. "I was raped, raped hard last night," as she said, as she doubled over again and she had tears and shame.

"And why didn't you go to the rape treatment center of Jackson?" I asked. After all, it was less than a mile away and a top-notch center.

"Doctor," she said with a look that suggested I should know the answer to my own question. "Look at me, she said, look at how I'm dressed."

She paused and then broke into sobs. I couldn't take the comments that people would make. She was right. We have this mammoth system of health care that can offer excellent medical care and all of the best technology.

But there's no system or edifice that can offer solace, empathy, or protection from prejudice. That's because there's a gaping error on the construction of any building. They can't build a heart. No matter how advanced a system like what that lady needed that day, compassion.

What lessons can we learn as a society from a quote-unquote, "homeless hooker"? Plenty. We can learn to listen. We can learn to ask the right questions.

And this was one one of the most invaluable lessons I had. And it was a woman living on the streets having the worst experiences in the world. And just because of her pointing these things out, how broken our system was. And the bottom line is that we as individuals become the heart. But we have to always remember that, because there's somebody suffering out there that we have to take care of.

And the other story that really influenced me was:

One afternoon around lunchtime, I walked into the clinic with a sandwich. I greeted the patients in the waiting room and walked over to the pediatric area, where I found a mother with three of her children.

This was a homeless clinic. They told me they had come in from the Salvation Army, her youngest child caught my eyes. He was six years old, a little boy with a sweet smile. Well, I'm Catholic, so you can't walk into a homeless shelter clinic with a sandwich and not feel guilty. And I'm a nonpurging bulemic to boot.

So I offered my bag lunch to the little boy, and he graciously accepted it. He took the sandwich out of the bag, split it in half, took two bites out of one half, slipped both parts back into the bag, and then he carefully folded the bag and put it in his pocket.

"Why do you do that?" I asked him. Here I am. I have three postdocs. I've gotten to college, to medical school. And there's a homeless child. And I'm trying to figure out what he's doing. He's hungry. He's there. I mean, to be clear, ever think about being a homeless child.

I mean, I remember one time in Christmas, we asked the homeless kids what they wanted for Christmas. You know what they told us? Socks and underwear. Everybody gives us toys and

clothes, but nobody gives us socks and underwear. And that always stuck with me, that you have to question your assumptions. We assume people have these things, because that's the life we come from. Or you know, you don't have family dinners, you have shelter dinners. How do you discus a bad day with mom? You all live in an 8x12 room. And so it's very difficult.

So I looked at him. I said, "Why do you do that?" And his reply stunned me.

"It's for my brothers," he said. He was hungry, but he knew his brothers were just as hungry.

God has allowed me to study medicine to explore the depths of disease and treatment. He has given me brilliant professors, and inspiring mentors, he has opened the tombs of healing, and placed in my hands the most precise instruments of modern technology.

And on any random afternoon, God has extended his most remarkable postgraduate opportunities. He's allowed me to find him in the gentle lull on the city of Miami under a bridge, in an emergency room, in the waiting room of a neighborhood clinic, in the wisdom and humanity of a homeless child.

The goodness of that child has stayed with me through the years. I have often asked myself, could the lesson of his generosity be multiplied by a community, by a government by an entire nation? Can such a spirit help a broken system? Could we look at a disheveled man or woman on the streets and withhold judgment?

Every day I pray that I can be that 6-year-old kid and not pass judgment on others, but actually realize that, what has their day been like? Did something happened to them, like happened to the lady? Do they have to worry about always that your brothers are hungry? And it was just a little 6-year-old kid doing what all of us are supposed to do every day. So that's my hero.

CZ: Thank you for those two powerful stories. I'm going back to transforming medical education. How easy is it to change medical education?

JG: Well, I was thinking of going out and trying to be an envoy and dealing with the Middle East problems because that appears easier. It's very difficult to change a system that is wealthy and powerful, and sees no reason to change, especially in the silo attitudes of medical education where they're not dealing with the realities that exist out there. They're dealing just with disease, how to identify it, and how to treat it.

And I think what we need to do is change how we measure medical education. It's no longer publications, it should be no longer patents, but: Have you improved the health outcomes of the community you live in? Have you developed something to improve the lives of this, of individuals in this country or the world? Not just that I have created the basis for this, but, you know, how do we apply it? How do we develop systems that take care of all populations? And it becomes really important.

And the other thing is medical schools have to become schools that, hey, I'm there to produce clinicians, not bench scientists. We have those schools. They're established legacy schools, and they do a spectacular job. Their research is unbelievable, but on the other hand, the health outcomes in this country are embarrassingly bad. So we have to be driven to improve those disparities.

CZ: And I know you mentioned about, one of the changes that you think should be done is the admissions process.

JG: Oh yeah, 100%. I think that we're too quantitative. Everything is your MCATs, your grades, where you went to school? Well, there's a lot of life experiences that you have to bring into there. And we showed that example, at FIU where 70% of our students only got into FIU. 30, 35% were first-generation but every graduating class we had had the highest Step One pass rates and scores in Step Two, that's the US LME, the United States medical licensing exam, to become a doctor as you finished medical school.

And what did that show? And by the way, we were the second most diverse medical school in the country, with over 55% being Hispanic and African American. But yet they scored the highest of the entire state of Florida med schools. What does that say? It says we throw away talent, says there's first generation kids out there that would make great physicians, and plus they come home.

The other benefit too is we offer them the first time to become a, to gain generational wealth in their family. So what I've got done is I went to Nevada State University, we have a program with them, where I will take a first-generation college student after their third year of college, all they need is a 3.0 I'll put them in on one of our master's program for biomedical sciences. They could do a one or two years Master's. This prepares them for medical school, gives us the opportunity to spend, you know, a year or two actually interviewing the student, make sure they're emotionally prepared for medical school.

But the other most important thing is our University of Health Sciences, we have a dental school, pharmacy school and a nursing school and graduate nursing school. So guess what the students have options.

CZ: Fantastic. Actually talking about Roseman, and why you're planning on doing there? Can you tell us about the three programs, Aspire, Genesis,....

JG: And empowered. Before the students get there, it's important that we build our relationship with the community, and also fulfill what our mission is. One of our missions is we need to be socially accountable as medical educators and as physicians. And what are the biggest problems in the country right now? Mental health, substance abuse.

So we have the Empowered program, where we actually go and take opioid and stimulant use disorder pregnant women and recent mothers, and we put them in a two-year program. We take

care of them, the children and put them back onto the track of what they're supposed to do. Two or three of them have graduated, and gone on to become therapists with us, which is really, really interesting.

The other one we have is called Genesis. That's a household-centered care model, where we identify and mitigate social determinants at the household level. We have about 95 partners now in Vegas that refer to us. And we take either only uninsured or one person might have Medicaid and we take care of them in perpetuity.

CZ: Dr. Greer, how unique is what you're doing in Vegas and are people around the US watching what you're doing?

JG: They are, although one of the nice things about Vegas is to go to Vegas, nobody watches. But the, it's extremely unique. Fitting in within the criteria of the accreditation and the standards, but it's extremely unique and it's something that we want to expand upon. We are already having a conference next week with Kaiser Permanente on social determinants. How do we do this properly? How do we do something to prepare the workforce that's going to make America healthy? And the nice thing about Vegas is two things. Number one, it's I'm not weighed down by the anchors of tradition. And somebody asked me one time, Why did I pick Vegas? Because I was looking for a city more intellectual in Miami. (laughter)

CZ: Now, what do you think is the biggest challenge in changing medical education?

JG: Medical education itself. It's a mammoth. It's a battleship in a swimming pool. Nobody's building the swimming pool bigger. So we'll build our own swimming pool. And if we have great outcomes with that, hopefully we could replicate what we're doing.

CZ: Now why is it important to have diversity in medicine and in the health care workforce?

JG: Because it improves the health outcomes of this nation, period. That's why. This is not one of your, you know, well, it's this and that, it's important, I think, in an ethical perspective, but we have the data shows it improves health outcomes, God forbid, we should go in that direction. So.

CZ: So if it is mostly social and public policy, why should physicians and health care settings take the lead?

JG: Because the consequences are medical. So if the consequence is medical, it becomes something that we need to take care of. But if we can prevent it, if I can give you a vaccine and prevent a disease, why can't I do the same thing with social and public policy?

CZ: Now, what can medical educators do to tackle health equity and reduce disparities?

JG: Well, one of the things that we're doing is, every case that a student presents, they have to tell us what are the disparities of that disease within America? What are the social determinants that caused it? Or affect the intervention? And what are the ethical issues? Why is that?

Because they have to be ingrained that they, if they don't understand that, they're not going to understand how to treat the disease. Because you treat diabetes very differently with the CEO of an international corporation, then you deal with a homeless person. I mean, the CEO, what are you gonna do? You call a chef in -- this is how you have to prepare the meals. What are you gonna tell a homeless individual, let me go to a shelter? You're lucky we can get food for them at all. So it's not just a disease state. It's all the complexities that go around.

CZ: Hence, tackling the social determinants of health.

JG: Exactly.

CZ: Well, that brings us to the end of another episode of the health disparities podcast. Thank you, Dr. Greer, for your insights, and for being a longtime advocate for health equity.

JG: Claudia, thank you for having me. And thank you for inviting me to this conference. And remember one thing, I took an oath, I have to do this. You didn't. But you do. So thank you.

CZ: Thank you. And thanks to all our listeners for joining us on America's leading health equity podcast. Until next time, be safe and be well.