Addressing the legacy of racism in education and health care

There's a long history of racism in both education and health care. But some health equity advocates — including Michellene Davis, President and CEO at National Medical Fellowships — are holding onto hope that real change is possible.

"The only reason why I like the name, the title 'social determinants of health,' is because anything that has been socially constructed can be socially deconstructed," Davis said. "Health disparities do not naturally occur in nature, they have been manmade, right? So now it's time for us to unmake them."

In this week's episode, host Dr. Tamara Huff speaks with Davis, along with Jennifer Holmes, Senior Counsel with the Legal Defense Fund, who works on cases that advance racial justice in the areas of educational equity, economic justice, and voting rights.

The transcript from today's episode has been lightly edited for clarity.

Jennifer Holmes: When you have more diversity in the medical profession -- when you have a doctor who might look like the patient or has been trained in an environment where they are exposed to a diverse amount of other professionals, other students, other patients -- they promote better health outcomes. They promote trust among patients, they have better decision making than a homogenous group. And so, you know, this is not just a nice to have thing, you know, diversity as a buzzword. It's really a health imperative.

Tamara Huff: You're 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 Dr Tamara Huff, I am an Orthopedic Surgeon based in Columbus, Georgia, and a board member for Movement is Life.

Joining me for this episode are our panelist from the session "Unearthing the Roots of Health Inequity: Addressing the Legacy of Racism in Education and Healthcare," - Jennifer Holmes, JD, who is Senior Counsel with the Legal Defense Fund or LDF, and Michellene Davis, Esq., President and CEO, at National Medical Fellowships.

Ms. Holmes works on cases that advance racial justice in the areas of educational equity, economic justice, and voting rights. Jennifer was trial counsel on behalf of a coalition of Harvard student and alumni groups in SFFA v. Harvard, an ongoing lawsuit in which LDF is fighting to preserve the ability of colleges and universities to use race-conscious admissions to diversify their student bodies.

A native of Washington, D.C., Jennifer received her J.D. from Stanford Law School and her B.A. from Yale University with distinction in Political Science. She is a member of the Bars of the District of Columbia, New York state, and the U.S. Supreme Court. Welcome Jennifer Holmes.

Holmes: Thank you so much. I'm happy to be here.

Huff: And Michellene Davis is the National Medical Fellowships, Inc. (NMF) President and Chief Executive Officer. She is among Modern Healthcare magazine's Top 25 Most Influential Minority Leaders in Healthcare, Becker's Hospital Black Healthcare Leaders to Know in 2023 and 2022, and Becker's Hospital Review's Great Leaders in Healthcare in 2022 and 2023. The National Association of Health Services Executives awarded her their 2021 Senior Health Care Executive Award.

She co-authored Changing Missions, Changing Lives: How a Change Agent Can Turn the Ship and Create Impact, published by Forbes Books in 2020, which provides a blueprint for those committed to leading systems change within organizations. Welcome Michellene Davis.

Michellene Davis: Thank you so much for having me.

Huff: I'm so excited to have you all here. Because I have two lawyers next to me. That is amazing. And as a medical professional, sometimes we get a little nervous when we have our friends from law next to us.

But I think this is really an important perspective to have, especially in the things facing us in the health equity space right now. So our listeners may or may be asking, or our audience may be thinking, Why in the world do I have somebody from the Legal Defense

Fund, and from the National Medical Foundation here to address health equity? Could you share a little bit each of you all how your particular organizations address health equity, like what your roles are? How you see your organization's role in health equity?

Holmes: Absolutely. And you're not the only one who's nervous. I'm a little bit nervous as a lawyer to be talking to a bunch of medical professionals about what they should do in medicine. Since it's certainly not my area of expertise, but the Legal Defense Fund, we work to advance racial justice across many sectors and that includes the endemic problems with racism discrimination in the health care arena. And one way in which our work has intersected with that very recently is the case that you mentioned in the introduction -- students for fair admissions versus Harvard, which was the case in which unfortunately, the Supreme Court ruled that Harvard as well as the University of North Carolina's affirmative action programs were unconstitutional. And so that, although that outcome was somewhat anticipated, has thrown colleges, universities, and, important for our discussion today, medical schools, sort of for loop about how they're going to try to continue to advance diversity, and educational equity in their admissions on their campuses, so that they can make sure that they are training a diverse array of doctors. Because we know, and the studies and the science have shown us, that when you have more diversity in the medical profession, when you have a doctor who might look like the patient, or has been trained in an environment where they are exposed to a diverse amount of other professionals, other students, other patients, that they promote better health outcomes. They promote trust among patients, they have better decision making than a homogenous group. And so, you know, this is not just a nice to have thing, you know, diversity as a buzzword. It's really a health imperative. And so our work in the SFFA versus Harvard case in which we were representing student and alumni groups fighting to save affirmative action intersects directly with the imperative that we need to advance, retain and advance diversity in the medical profession.

Huff: One key thing that you just said that I just want to bring home, is the concept that diversity equals better outcomes. So often, people think of the concept of increasing diversity of medicine or increasing diversity at any standpoint, it's just a feel good. This is not a feel good thing. This actually has measurable benefits to communities, of having a diverse population serving that community that mirrors that particular community. So thank you so much for bringing that home and saying it so eloquently. Please go ahead.

Davis: Thank you, I'm so excited to be able to talk about this in real time. So National Medical Fellowships has actually been the sole private organization in this nation that has been advancing health equity at the intersection of the health - wealth gap for the last 77 years, founded in 1946, by Dr. Frank McLean, who was not of color, NMF was literally created at a time when both hospitals and specialty training were still very segregated. As a result of the acknowledgement of the fact that black and brown communities were going to need more than just primary care physicians, NMF was born. So what I will say to that is the fact that we have over the last 77 years given out well over $45 million in scholarships, to well over 35,000 alumni. And our alumni are those who are literally shaping the landscape in medicine. And so I when I say that I mean every single one of them because I am so incredibly proud. But also, every US Surgeon General who has been black or brown has been an NMF alum. Right. And so we are giving back to this country in particular, not just medical professionals, but medical professionals who assume leadership roles, like our alum, Dr. Valerie Montgomery Rice, who is leading Morehouse School of Medicine, and Dr. Helene Gayle, who is right now leading Spelman College, literally making certain that the lived experience is also an element of not just the practice of medicine, but quite frankly, health care leadership.

In your introduction, you mentioned the fact that I came to NMF from large scale academic medical center system. In fact, I did after a serious level of commitment to that institution. And I came to NMF, and not just to create more black and brown physicians as worthy as it is, I came to NMF in order to create more black and brown physician leaders. Because as the Great Awakening was occurring in 2020, after the lynching of brother Floyd, one of the

interesting aspects was the fact that we were finally talking about, in the mainstream discussions, the element of addressing the systems and structures that have led us to where we are today. The issue is that we need to ensure that there are diverse physician leaders who wae there in order to lead these new systems and structures which we are willing to erect or quite frankly, that we were willing to erect given the fact that we're now in the midst of the backlash, which I've been talking about for some time. So what I will tell you is I'm delighted to be there, not just because of the fact that NMF has been advancing health equity in the scholarships, but also because of the unique opportunities that we also provide for service learning, in order to really encourage our scholars to also remain in primary care, as well as to go into specialty training, but also what we're doing right now around our diversity in clinical research program, which indicates that we literally have opportunities for additional education for our scholars, not just when they are in medical school, but quite frankly, after they have graduated, after they have begun to practice as physicians, we then bring them back in order to ensure that they have the experience of becoming emerging investigators so that we are actually addressing medical efficacy.

Huff: That was a whole word. I absolutely love that because it addresses things, so many different stages. So many times with medical education, when we think of doctors, we just think of the training, they get at one stage, we don't think about that next step. Both of you all really hit on something that I feel very passionate about is the concept of advocacy. And in our current situation in ensuring health equity, I think advocacy has really taken on a big role in medicine. And traditionally, physicians have been a little hesitant, medical students, this new class of medical students are amazing, they are definitely advocates. But prior to that we were a little hesitant to be advocates. Do you all, could each one of you all share a little bit about how you could see our audience, especially given that this audience is going to be physicians, some specialty physicians, a lot of specialty physicians, actually medical students, or even people that are just in the health care system, as providers, as mid levels or as physical therapists -- How can we be part of that advocacy, even on a local or state level?

Davis: I actually think that doing it on the local state level is, quite frankly, the almost the easiest way to immediately see the impact. I think that the focus around civic engagement is incredibly important. Whenever I'm asked what is the most important decision or thing that a person can do for their health? I always say vote. Right? And so you're absolutely correct about this new generation of medical students, they are looking not just to change the face of medicine, they are looking to change the the entire system of health care delivery in order to make it more equitable for all. Listen, when I was at that large scale academic center system, I oversaw Policy and Government Affairs as well as healthy living, community wellness, engagement, and of course, founding social impact. One of the things that I consistently say to folks is that there is such a need to ensure that the efforts of your Government Affairs Department, the efforts of that policy development arm within these large scale institutions, is fully aware of your expertise, the way in which you could serve as an expert to state local municipal officials is incredibly important, right? And so there's so much of an opportunity to really impact and effectuate change just by lending your voice. If we add to that, in addition to medical training, the lived experience of so many of our scholars, well now we actually have the double whammy, right? I usually give people extra credit saying yes, you get me as a Juris Doctor, but you also get me with a PhD and being a black female. And as a result of that, you know, there's an important element of what that lived experience brings to the practice of medicine, you are absolutely accurate, that my new friend here Jennifer, talked about the fact that it is undoubtedly been proven that more BIPOC clinicians actually better for BIPOC patients that racial concordance is is solid, right? research evidence is that black babies live longer when they have black doctors, etc. There's a new study that just came out of Florida, about mothers as well, right, everything that Miss Mamie in a church and abuela in a neighborhood always knew, but now we've actually write the research has been catching up to the community.

And when we take a look at that, if we literally are not leaving that expertise on the shelf, and invoking that expertise, when we talk about reviewing legislation, resolutions, etc, that literally impact our local communities, as well as our state and federal landscape, you know, now we actually stand a chance at actually effectuating change. I will say that I think

that it's incredibly important that as physicians are looking to do that, that they do also include the agenda of their institutions, I don't want to get anybody in trouble, that they're having that dialogue with folks that they're making them aware of what their expertise is. But anybody can can submit a public letter, right? There are bill comments, comments for rules and regulations all the time.

Huff: Here in our conference, we actually have workshops, and one of the big workshops we just had yesterday, was talking about the importance and power of advocacy and getting your voice heard. And I love that you brought up that anyone can be an influencer, anyone can actually write that letter and step up. So thank you so much for bringing that out.

Holmes: And I'll just add that, you know, my expertise is mostly litigation, so suing people, getting into court, writing briefs, that's my bag, but there's plenty of ways in which we need experts to plug into that process. People sometimes think oh, the courts that's the lawyers arena and policy that's also kind of lawyers and politicians arena. No, it's everyone's arena. We need people with medical expertise to, as Michellene was saying, submit comments on bills to testify before Congress before local legislatures and other jurisdictions that are considering health policies. Just to give some concrete examples, in the affirmative action case, we had the Association of American Medical Colleges submit a very powerful amicus brief or friend of the court brief that went into tremendous detail, all the all the racial disparities along all these health indices that are still present still pervade our society. And that voice has a lot more gravitas and expertise than just the lawyer saying this is true. And so that information was very powerful. And I think some of it wound up in Justice Jackson's dissent in which she really, you really have to read it, because she went through on all these sectors of society and showed how we are still living with the legacy of slavery, and Jim Crow, and discrimination, because it's baked into all of our systems. And she has a lot of information about health inequities, and things like that. And that information needs to be provided by the experts. So there's plenty of ways

in which people in the medical field can plug into these realms that some may wrongly think are only reserved for the lawyers or the politicians.

Huff: Oh, love how you brought in the social context of all this. Because I think a lot of times we live in isolation, and there's just so much right now, we're experiencing a lot of backlash from what happened with George Floyd. And just frankly, and just some of the different policies that were that were implemented to try to correct those wrongs. We're seeing it in the courts with some of the cases that you're litigating directly, Jennifer, as well, as we're seeing in policies in higher education. I guess one of the questions I have for you kind of following up on what both of you guys are saying with the idea of facing backlash from people that may not automatically see their connection to people of color or see their connection to oppress people. How do we bring this to the larger population of the U.S. or to the majority Caucasian or the majority population of the U.S. who may not see themselves, like why is diversity important, important, and supporting these policies important for everyone, no matter where you are, whether you're in South Georgia, or whether you're in the mountains of Tennessee? Why is that important to people that might not see themselves reflected in this discussion?

Holmes: Well, I think in the healthcare space, it's actually a area of society where there's very, very strong evidence based information to show why diversity is so important. But it's really kind of a life or death issue. Because you have all this science, you have all these studies that show the benefits to patient outcomes. When you have a doctor who has the same race or a doctor who has been trained in a diverse environment, you have studies that show that diverse doctors are more likely to go into underserved or underinsured areas. And that includes rural areas where a lot of white folks live. So there's a lot of studies and science here.

I would guess, maybe more so than some other areas that show the tangible life or death benefits of diversity in the health care arena. And so I think sharing that information is just really important.

Davis: I'd love to add to that. So yes, and, right? Yes. And, you know, as we were talking about this, I want to make certain that folks understand that having diversity in medicine is not just good for black and brown communities, it is good for every community. And I say that because of... the business case for diversity has already been found. We know that when there are more women on a board that the bottom line in a Fortune 500 company that that revenue is actually higher, we know that the scrutiny that's applied through different and diverse manners of thinking actually benefits businesses, the same is true in health care, and health care delivery. So, you know, I want to make certain that we understand that it's not just that, you know, black doctors can bet black people write, quite frankly, it's so incredibly important that we understand how that diversity literally is across the board better for everyone. What we have seen is the fact that when you have more diversity in medicine, that we literally see patients who respond better patients who are more likely to accept a diagnosis, we see that actually the amount of time that is spent in the patient physician setting is actually longer, we find that there's actually more discussion that occurs that is both culturally competent and culturally humble. And that that's not just with black and brown patients, that that is actually across the board.

And so I just want to make certain that we do identify that I love what my fellow guest also mentioned, in reference to, you know, just what we are seeing about the research and evidence that's out there, this case has already been made. This is so clear. And I think COVID showed us more than anything else. We live in communities of contagion. We do not live in an isolated vacuum. It is a global village. And if in fact, you believe that, well, it's okay. And they have something over there in that inner city. So long as I'm over here on Rodeo Drive, let me tell you something, sweetheart, let the wind blow strong. And I guarantee you that you will catch that too, right. And so it's really important that we harken back to what we've just been through understanding that if in fact, the most vulnerable are not taken good care of, then not only will you not get your groceries but quite frankly, you too will be living in a community of contagion. Because who do you think stands up your community, right? And so it's really keenly important that we make

certain that we peel back the onion layers that would permit people to think that it's a us/them opportunity, because it is not.

Huff: Everything you all said, I just want to echo again, because I brought that question, because so often people think we're so siloed in our thoughts in our in our communities, in just like you said with COVID, it broke down all those barriers. But we're so quick to forget, we're so quick to forget the fact that it's all of us living together and taking ownership of one another that we can get through this. And there are systems that actually benefit from the division that's been historically here. So kind of transitioning with that, some of those systems that have, as we said in our actual title of this, that are like the root causes of these problems are things like structural racism, that directly affect our overall health because of the social and political determinants to determinants of health. So I would like to have you MIchellene, talk just briefly about that concept, because people always hear about the social determinants of health. And they'll hear things like redlining. But where does that kind of, you talked a good bit about political determinants of health? Where does that all intersect when we think about health equity?

Davis: Yeah, thank you so much for the question. So and I want to be clear, so I've been utilizing the moniker of political determinants of health long before my dear friend Daniel Daws wrote his book, but please, by all means, everybody should read it. I think that the really important element here is really understanding how none of this is episodic, how all of this is in the aggregate, and it's all been cumulative. Right? If we take a look back to, you know, quite frankly, structural racism in education, and I want to say this, when I talk about racism, yes, I talk about structural, yes, I talk about systemic, but I don't leave individual out. And the reason why I say that is because it has been the racism of the individuals who have been setting up the systems and structures that have literally given us the system that we have today, right? So I want to make certain that we address that to what I will tell you is that they push back the tide of achieving actual health equity, right? Of achieving health and wellbeing for all -- that is what these structural barriers do, right? And so when I'm talking about them, yes, you talked about redlining. Absolutely, but remember

what happened to our educational system too, right? Remember that it was literally outlawed, not just for for both free and enslaved black people to learn how to read, right. But then when schools began to be developed by black people, for black children, because they could not go to the other schools, they were destroyed as a result of white supremacy. 630 schools were burned absolutely in the south. And then in the north, we had restrictive anti black bias laws that kept the disinvestment, and the marginalization going. So when we look at that today, what do we know? We know that there is a concordance between, a correlation between both education and health, we know about it between socioeconomic status and health. So if we are literally looking at this in the fullness, and we're having a holistic view, then what we can easily see is the way in which these issues happen. Now, I could keep talking to you about those policy stats, or I could tell you a little ditty.

So when people read my background, thank you very much for the beautiful introduction, I love to be able to say listen, that's just proof positive of praying parents. What I will tell you is I grew up with a little brown girl in the city of Camden, New Jersey. Camden, New Jersey is regarded as, when I was growing up, the most dangerous city in America. It is one of the poorest cities in the 14th wealthiest state. I mentioned it because of the fact that you do not have that equation without intentionality. Why is it that that environment -- talk about redlining, we'll talk about zoning -- why is it that that community was the location for the county incinerator? The tire factory? The cement entity? I remember children coming home and having layers of cement dust on their skin and saying to them, Oh, my God, what is that doing to your lungs? Right? So I just want to give you that scenario. And I distinctly recall my friend who was 12 years old, Tammy who died of severe asthma. Right? You think that that was an isolated incident? So we talk about, so what is the impact on health equity?

The only reason why I liked the name, the title, social determinants of health is because anything that has been socially constructed can be socially deconstructed. Health

disparities do not naturally occur in nature, they have been manmade. Right? So now it's time for us to unmake them.

Huff: So powerful. And I think I love the fact that you went back, and really, this is a human issue. This is not just stats and things, this is something that affects us every single day. And, I love how you tied back into education. Because a lot of people when we start talking about the legal challenges that we're facing right now, that whole term of merit keeps coming back up. And what is merit, whenever you hear some of the naysayers pushback on, do we really need these methods of advocating for diversity in anything? They're like, well, we should, this isn't the meritocracy. Jennifer, could you talk a little bit about that whole concept of what is really married, and how that plays in that false dichotomy really plays into health equities or inequities in anything?

Holmes: Absolutely. We need to rethink this idea of so-called merit. That merit is a concept that, like everything else in our society, has the racism baked in, the discrimination baked in. People think, oh, merit, its objective. And so it's, quote unquote, fair, but when people think of frameworks for, you know, admission to school, or various programs that are 'merit-based,' you know, and I'm using that in quotes, they think of things like standardized tests or grades, but those types of metrics have all sorts of disparities baked into them. Standardized tests were created and normed around middle class white students. When the LSAT was created, it was normed around middle class white students, and what tested the knowledge that they knew, their ability to score high on certain questions, didn't take into account whether other racial populations have scored higher on different questions, the questions that black and brown students would score higher on were not considered the hard questions. So these standardized tests have been normed around white students when they were created. Also, even in their modern day iterations, they test things like socioeconomic status, the access you have to test prep, parents' occupations, moreso than someone's ability to be an effective student and effective physician effective in whatever position they're going into. And so when you use these types of tools, as merit as things that you use to make the decision, you are reifying, something that has these problems

already baked into it. So we need to rethink, what we're really testing for when we say we're using tools that measure merit.

Often they measure things like elitism, money, access to resources, and not really success, potential success or potential talent. And so often, the word merit has been used to undermine and push back on things that would expand opportunities for students of color, and to things that would identify talent everywhere that it lives. And so we really need to rethink the idea of merit, and not get so tied up in you know, the scores and the numbers and see what other skills what other talents can we measure for that really are more tied to, can this person succeed, can this person contribute, and can this person share their talents?

Huff: That's such a great point, because marriage is such a loaded phrase or a loaded word. It reminds me of something one of your colleagues at the Legal Defense Fund to actually shared with me, this statistic, and I didn't even think about this. We always talk about brown and black students don't go into STEM, and don't really go into medicine at the same rates as other groups. However, she shared this just amazing stat, and I'm going to destroy the stat but the concept is that most of these many of these kids are coming out of schools where they're not even offered event AP calculus. So you're not even able to take the prerequisites to get into the pre medical programs to be able to apply for medical school. So yes, you're gonna have to do a postback program or something to even get into the state institutions that will allow you to move forward. So I thought that really brought home to me is your tax dollars, your dollars to support property tax for your local schools, your children aren't even getting the opportunity to take the necessary courses that would allow them to go on to an institution, a state institution, which again, our tax dollars are funding, your child may not may have great grades, but they don't, that high school doesn't even offer the course that that child would need to be able to be a part of that. So I really appreciate you saying that, because so often we think of the great equalizer is education. But what if you don't even have that access? But that's the whole crux of having public education is so everyone has access. But what does that really mean?

Holmes: Absolutely. Can I add one one other thing? One other point on the merit question. So I've read a study recently about the MCAT. And it looked at MCAT scores for recent classes and kind of divided them up into three sections, the lower third, the middle third, and the highest third of scores, and then saw how those students did went performed when they went to to, I almost said law school when they went to med school. And there was almost no difference between the highest third of scores and the mid range third of scores, even though tons of medical schools are trying to pick from the highest highest MCAT scores. But the difference was, you know, they were those two cohorts, the mid range and the top range, they were achieving their degrees at almost the same rate, the high 90 percentiles, I think, 98%, and 95%. But the major difference was difference was the middle third of MCAT scores, they are more diverse, more likely to go into underserved communities, and more likely to go into underserved specialties. So you are losing out on those successful physicians who can still hack it just as well as the top scorers, when you focus too much on 'merit,' on quote, unquote, merit.

Davis: And if I may, if we add to that, you know, Dr. Joe Greer gave a fantastic presentation yesterday, I am a big, I said I had a brain crush on him. I'm a big fan. And one of the things that he talked about is, you know, he asked the audience, quite frankly, you know, as a physician, you know, are we racist, and then gave the stats on, quite frankly, how underrepresented in medicine, individuals are in certain categories. But he also asked the question, are we elitist? And when he asked that question, I loved it because of the fact that he evidenced the data that showed that the majority of the attendance at in medical school right now, based on a study done by Holly Humphrey in 2020, at the Josiah Macy Foundation, literally evidence, the fact that the household income of most of these of medical students was $140,000. The household income of an NMF scholar is between $35,000 and $45,000.

When I talk about the fact that we're advancing health equity at the intersection of the health-wealth gap, it is because of the fact that while so many other foundations do not provide scholarships, we do, in recognition of the historical wealth gap in this country. And

the way in which so often, so many have been prohibited from actually not just attaining wealth initially, but in building generational wealth, generational wealth and passing it down, right? So as a result of that they are graduating from medical school with upwards of $600,000 in debt, because you are a first generation medical school, first generation college, some first generation high school graduation, some first generation American, right? So where's that support system supposed to come from, that's supposed to be able to help them to pay off that medical education, right? So when talking about this, and we talked about the elitism, so imagine the school system in a community where the average household income is $35,000 in this incredibly wealthy country.

Huff: Just when you stop to think about that, it makes me want to really pause to look back, how are we even judging people to get into medical school? Like how, what are some solutions? When you think of, we're being elitist, that is obvious in the comments that you just shared with us Michellene. I mean, again, we ourselves as medical professionals, even though we don't necessarily think we are, we're perpetuating a lot of those stereotypes. Dr. Greer just did a beautiful job of just talking about yesterday, all of the biases that we hold, and that we really do need to facilitate having these difficult conversations with our trainees so we can make sure that we're bringing in the next generation. But how do we even get those people? We know that the MCAT isn't necessarily the best way to look at students. When we look at the new data that's coming out for this USMLE, with it being pass and fail, there's a lot of angst about,how are we going to judge people now? And that's talking more about graduate medical education. But do you all have any suggestions as we close out about how, other things that we can use as a surrogate to merit when we're thinking of choosing students or helping students get into higher education, especially in the light of the fact that we can't use traditional race-based policies?

Holmes: Yeah, I think there's, there's a lot of strategies out there. I can think of kind of four buckets. One is just a reminder, I know a lot of schools and universities are focused on the end of affirmative action and what they can and can't do under the law. Now, they also

have obligations under state and federal antidiscrimination statutes, they also have to pay attention to ways in which they are discriminating against black and brown applicants, and that should not be forgotten. So pay attention to those obligations under your state and federal antidiscrimination statutes. You have obligations there. And if they fall short in that way, they can get sued, including by organizations like LDF. And so that's sort of bucket number one, make sure that you are at least not violating the law when it comes to how you're treating your black and brown applicants.

Second, we really need to reimagine the admissions process to be more individualized and focus on the context of the individual. I'm not saying there's no place, especially in med school admissions for consideration of grades or scores in some way, but you need the context there. You need to know what high schools and colleges these students are coming from, what other background circumstances they have, what hardships and adversities they have, they have overcome what goals they have in terms of who they'd like to serve, how they would like to use their degree. I think interviews are a really important piece of the puzzle. And you also have to look at who's making the decision? Who's in the admissions office? Are there people of color? Are there recent students who have input who are maybe closer to the applicant, you're going to have? Are there alumni, alumni of color, who's actually in the room making those decisions as an important question. And also looking to schools that have been dealing with schools in states that have banned affirmative action before the Supreme Court lawsuit, there were nine states that banned it, including California, Florida, Michigan, I think Washington State, there's a couple others. So those schools have been toiling under the, quote unquote, new regime for a long time. So you can look to those peer or institutions to see what they've done, what worked in the past. And then I think quickly, the other two buckets are outreach and recruitment, building those bridges and relationships with HBCUs and other minority serving institutions, bridge programs to even high school students in underserved communities and black communities, students who have an interest in STEM, you want to build that up, making sure they can get the prerequisites they need, and they know where

to get the resources. And, and community colleges as well, we have to remove the stigma of admitting applicants from community college.

And then finally, you got to support the students once they're there. If you admit them, but set them up to fail, then there's no point in all the work you did on the front end. You have to do the work on the back end as well and support students when they are actually at school, especially in the first year. And maybe that's having more academic support. Maybe that's supporting cultural institutions and affinity groups, doing climate surveys to make sure then addressing the issues that come up, to really have a handle on how your students are feeling, especially when there are high profile incidents. I know, at Harvard, there was a Doxxing incident of the black students. And that didn't wasn't addressed very well by the institution. You know, you need to make sure that these students feel like they belong and they're supported or else admitting them is just doesn't make any sense. So those are sort of the four areas that I would touch on.

Davis: I love that and if I may, I'd love to add just a few 'Yes, ands' to the fantastic list that Jennifer just provided. One, when we talk about, you know, really making certain that we have relationships with HBCUs and minority serving institutions. I always pause for two reasons. One, yes, I think that HBCUs are fantastic. I'm always concerned about those students who are at PWIs, who quite frankly, had to take the initial scholarship in order to be there, right? And so we run the risk of permitting those whose families could afford to send them to HBCUs, and then widening the gap between the haves and have nots. So I want to make certain that we're sensitive to that, and that we're looking at that. Two, the holistic admissions approaches, which quite frankly, have already been implemented at so many HBCUs really are what every college and university should be utilizing across the board, right? Taking a look at the full student, not just the scores, making certain that they understand everything that they bring, to the circumstance and the situation, looking at it contextually, as well, I think is incredibly important. And also being really sensitive about retraumatizing these students. One of the things that I'm concerned about is the fact that they're like, Well, you can write about, you know, an issue that happened to you, and

literally having to revisit the trauma. You know, this isn't a, you know, just an adverse childhood experience when you are subjected to racism or discrimination when you're growing up. These are racial trauma incidents, as we weather racism, some of them are actually racial violence. And so we have to be really sensitive to the mental health and well being of the students in reference to what we have to put them through prove to me that you've been harmed. I can't walk through your neighborhood and see the impact of disenfranchisement, disinvestment, and marginalization, right?

Huff: Well, I really appreciate you bringing that up. And I'm gonna go into a little bit more about that for our audience, because a lot of people may not realize as part of the mitigating factors about the ruling is that yes, we may not be able to use race in admissions, but students can then talk about their experience, which might reveal the fact that they're of a certain race, and it can be very much retraumatizing. So so thank you so much for bringing that up. As we come to a close, is there any additional call to actions or anything that you'd like to share with our audience before we close out for today?

Holmes: I think one thing that I kind of left off my list is money, money, money, money, because of all the disparities, all the disadvantages, all the systemic racism in our society, obviously, there's a gigantic wealth gap, a wealth chasm. And so we need money to do a lot of these things. And these students need money. So you know, get your, your funders, your grant makers, your donors on board, to give us the money to make this happen.

Davis: I feel like that's a direct segue to me, Jennifer, because that is what we do at NMF. And we are in need of making certain that these students have what it is that they need to succeed. We cannot provide scholarships without investment. And so I look to those who are our listeners in order to make certain that they understand that this is a call to them in order to do so. The second thing I'd really like to say, is that they serve. And so for a moment, I want to speak to those who are physicians, clinicians, health care administrators, etc. about the incredible need for them to serve on these admissions committees. If it's not your alma mater, right, go back to something that's local. Everybody wants to have a doctor, right? They love the fact that you have this specialty area. And so

they love to have you especially if you are a member of Movement Is Life. And so as a result of that, so much of this is easier to impact and effect from within an internal organizational position. And so if in fact you are on their board or on their development committee or on their whatever it is, you have the ability to directly implement that requires you to serve, many institutions will grant you additional wellness points, right, in order to do so utilize them and serve.

Huff: Love that. We'll include in our show notes, your individual organizations' websites and information so we can continue that concept of giving, because that is just so powerful and so important. Well, that brings us to the end of another episode of the Health Disparities podcast. I absolutely enjoyed speaking with you all so much. And thank you for your candor. Thank you for your ideas. Thank you for your passion and your drive and everything that you're doing.

Holmes: Thank you for having me. This was a great discussion.

Davis: Thank you so much. This was fantastic. And I look forward to many more.

Huff: Great. Well, thank you again, and thanks to all of our listeners for joining us on America's leading health equity podcast. Until next time, be safe and be well.