Black Physician Assistants Matter: A "JEDI" discussion.

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Podcast host and NYC Physician Assistant Klarisse Mathis welcomes two colleagues and mentors. Infectious disease specialist Sondra Middleton, MHS, PA-C, is Assistant Professor at the Touro School of Health Sciences, and Associate Director of Physician Assistant Manhattan. Daytheon Sturges, MPAS, PA-C, CAHIMS, CHES, Associate Program Director, Assistant Professor, Justice, Equity, Diversity, & Inclusion (JEDI) Chair at University of Washington – School of Medicine – MEDEX Northwest PA Program. Together they explore the role of advanced practitioners in general, and the importance of a diverse workforce specifically, and the disparate impact of COVID-19. All views expressed are the participants own.

Klarisse Mathis: Hello everyone and welcome to this week's Healthcare Disparities Podcast, a program of the Movement is Life Caucus. My name is Klarisse Mathis, and I am a physician assistant in orthopedics based in New York City and also a member of the Movement is Life Steering Committee. This week, it's my pleasure to be co-hosting the podcast with my good friend and podcaster extraordinaire, producer, Rolf Taylor.

Rolf Taylor: Thank you, Klarisse and welcome back to the podcast. You know the last time you were on here was as a guest talking about your profession and career as a physician assistant in the great New York City. You gave a really good interview, so congratulations on taking the lead now. I just want to mention that all our participants on the podcast today are representing their own personal views, thoughts and communications not representing views or positions of their respective

organizations. So, Klarisse, you titled this podcast, "*Black Physician Assistants Matter"*, why this specific title?

Klarisse Mathis: Well, I feel like this is definitely an area that should be touched upon. You know being a black PA it's so far and few of us, you know we are not very represented in the field. And I think that you know, especially with the climate that we're in right now, I think this is even more of a targeted area that we need to start expanding on, especially since you know a lot of people are, one still not even familiar with what the physician assistant role is. So, one, we need to highlight that. Two, we need to definitely start targeting and just exposing ourselves as being a black PA and how we are very helpful in the field as far as, you know, reducing healthcare disparities, also just exposing and discussing some of the healthcare disparities that are affected by black people. And we need that black representation in medicine in general, and as a PA how we can kind of combine that, so we can start to kind of combat the situation that we have.

Rolf Taylor: That is what the Health Disparities Podcast is all about. So, it's going to be a great discussion. Let's welcome the first of our two guests today. Hello to Sondra Middleton, MHS, PAC. Sondra is associate director at Physician Assistant Manhattan, and I believe you have a specialization in infectious diseases. Welcome to the Health Disparities Podcast.

Sondra Middleton: Thank you and thank you for inviting me to be here today. I am very excited to talk about this. I'm a little passionate about this topic and Klarisse and I have known each other for a while. So, she knows some of my views on this and we had had some offline discussions. So, I'm absolutely looking forward to this discussion.

Klarisse Mathis: Thank you Sondra for definitely being here. Can I just add a tip point? This is my mentor, this has been my mentor since PA school. She was my PA school advisor. So, I have known her since 2008, and she has gone from adviser, mentor, still mentor to colleague, but she's still my mentor. And I just definitely appreciate her being here because I know she is one, very passionate and she definitely will keep everything very real. That is what everybody loves about her and that's why she is the assistant program director, because everybody loves her. So, thank you, thank you, thank you once again for joining me.

And I would definitely like to introduce our other guests. His name is Daytheon Sturges. He is a Family Medicine PA with a focus on chronic disease. He is also the Assistant Professor and Associate Program Director of Regional Affairs, Justice, Equity, Diversity, and Inclusion at MEDEX Northwest University of Washington. And he also has a lot of multiple degrees going on. I definitely want him to introduce the things that he's working on. Not only is he a Master's in Physician Assistant Studies, but he also has other accolades. I definitely want him to touch upon as well.

Daytheon Sturges: Well, thank you. Thank you for that warm welcome, Klarisse. So, I call it the alphabet soup.

Klarisse Mathis: Yes.

Daytheon Sturges: I have a certification in Healthcare Informatics, as well as I'm a Certified Health Education Specialist. I got the certifications along my path to get my PhD, which I hope, fingers crossed, to be done with in May of 2021, and that is a dual focus on health promotion/health education with the focal area on higher ed. So thank you.

Klarisse Mathis: Of course, this is also a person that I recently met maybe a couple of years ago at APA and it was kind of like we had our own little black caucus meetup there and ever since then, I've kept Daytheon right by my side. He's definitely somebody that I look up to because he is just taking charge as far as being a black PA, the representation, his multiple degrees and just making an impact on his community and where he's working. So, I definitely appreciate you coming along and joining me on this podcast as well.

Daytheon Sturges: Thank you. I appreciate being here.

Rolf Taylor: Before we focus more on the black PA aspects, who would like to give us a quick history of the PA profession for our listeners, who maybe

aren't familiar with the distinction between, say a PA or a nurse or a PA and a general practitioner, for example.

Sondra Middleton: So Daytheon, because I'm old okay, I figured I would take this one.

Daytheon Sturges: Yes, yes go ahead.

Sondra Middleton: Well, okay mature, whatever you want to call it. I've been a PA for a long time. And as someone who's been a PA for over 30 years.

Daytheon Sturges: Oh yes, you take it.

Sondra Middleton: I'm always very interested in teaching people about the history of my profession. I am incredibly honored to be a PA ad I'm therefore also incredibly protective of my profession and what it is and what we do and who we are. So, who are or what is a PA? Sort of the general definition is a PA is a person who is specially trained to perform many of the functions that you would associate with a traditional physician. A PA can take a medical history, can do a physical examination, can diagnose and treat patients pretty much in any particular specialty. We also are known for our work in primary care and being able to take care of patients throughout the lifespan. This is a profession that's fairly new. It's been around almost as long as I have, so about 55 years or so. And we started out of the dearth of medical professionals available

to provide general healthcare for people in rural areas, especially in places like North Carolina down in sort of the Southeast. So, the PA profession, it was brought up that way in working with the community, in working in primary care and being able to take care of people throughout the lifespan. And I'm always working with my current students to make sure that they understand that and understand what the history is and what they need to take forward into the profession into the future.

Rolf Taylor: That's really helpful. Daytheon, would you like to add anything to that?

Daytheon Sturges: I want to add a tidbit, since we are talking about black PAs, I want to talk about Richard Smith, who was the founder of MEDEX. So, in the spirit of black excellence, I do want to highlight one of our early pioneers, Dr. Richard Smith, who was a graduate of Howard University, which is an HBCU in Washington, DC. He had the wherewithal to what he called the mantra of multiplying his hands, where he, as a Peace Corps volunteer, saw that there was a need for healthcare extenders in other countries abroad and he brought that same model back into the United States and simultaneously started the MEDEX program along with Dr. Stead who founded the PA program at Duke University.

So, he had a model that was MEDEX International, where he actually had this textbook and this program set up where he taught non-physician extenders to provide care to where there was a gap in the

access. So, I want to highlight him, and his program is still going strong is where I work right now 50 years later. So, I just wanted to make sure that highlight one of our first pioneers, who was actually a black man. But a funny story is that his son, so he moved to Hawaii after he left Washington and his son went to school with President Obama and before he died, President Obama came to his house and honored him. They have pictures together and while he was there, they realized that we were classmates in school. So, I think one of the ultimate things was being honored by President Obama before he passed away, but he passed away probably about two or three years ago.

Klarisse Mathis: Thank you Daytheon and Saundra. So, let's just start with some of the healthcare disparities that you guys are currently seeing or what are some of the chronic healthcare disparities that you're witnessing, whether it's in your practice or what you're currently focused on teaching and the ones that you are most concerned about as well.

Sondra Middleton: So, as well as being an educator, I also do clinical practice. I currently do clinical practice and clinical trials, infectious disease clinical trials. So, that's something that I think we're going to talk about a little bit later when we talk about COVID-19. So, before I worked in clinical trials, I worked in primary care HIV, and I did that for about 15 years and that was probably toward the end of the eighties until into the early 2000s. Healthcare disparities, it was for me it was really very interesting and the time when I went to PA school many, many years

ago, we really didn't talk about healthcare disparities, but I noticed it in my practice and a lot of what I saw was health literacy. People not really understanding what the interaction in a medical setting should be. Not understanding necessarily how their body actually works. I spent a lot of time in the beginning of my career making sure to educate my patients so that they would be able to advocate for themselves if I wasn't there. So, if they went to the hospital, for instance, they would be able to advocate for themselves. They would be able to tell people even if they couldn't say the names of the pills, well this is the pill that I take for this okay or this is why I do this particular practice as part of my own healthcare. Health literacy was really the big thing that I saw as a health disparity in my patients. And then, there were some of the more common chronic things that you would oftentimes see with patients, which would be not having access to particularly healthy foods. Some of my patients living in areas that were not very safe, that causing stress, just life stress, as well as impeding their ability to be able to be healthy.

Rolf Taylor: How about you, Daytheon?

Daytheon Sturges: First just the health disparity is really just a gap. It represents a gap, it can be among populations within populations, and they manifest in a lot of different ways. Like Sondra said, a lot of things that she mentioned really were what we call social determinants of health that really affect the bottom line when it comes to morbidity and mortality in

populations. So, speaking, in general, when we talk about health disparities, with my background has been more in chronic disease management and family medicine with a heavy emphasis on diabetes. Education and health literacy is a vital piece of the puzzle. You know, we mentioned self-direction, but we have to teach that self-direction and give them the tools that how to navigate the health system, which is a disparity of its own, a social determinant of its own, because it's very hard to navigate health systems. Some of the biggest things that contribute to disparities are transportation issues. You know, we set appointments for 9:00 in the morning, but we're not aware that maybe our patient takes the bus, and there's three different stops to get there. So, they're late and we end up canceling their appointment so, or it could be food insecurity. A lot of things we don't ask about when it comes to food insecurity, we will give mandates to eat a low sodium diet or a low fat, low cholesterol diet but what if our patient is homeless and the only access the food is a hot dog on white bread every day. So, it starts with us to recognize what are some of the contributors to our patient outcomes and not blame the patients. When we talk about institutional and systemic issues, those are systemic issues. And a lot of times they are not able, to work those things because there's systemic oppression, institutional oppression, which manifests in the social determinants. For example, when we talk about housing, you know, minority communities have most likely been relegated to areas what we call red line districts, where there are not many jobs. So, they're not many taxes that fund schools or fund different community

outreach. They're food deserts where there aren't any fresh foods, but there's a McDonald's on every corner, things like that. So, we have to really do our due diligence as providers to learn about our patients, especially our underrepresented patients, in order to achieve better health outcomes. So, when it comes to disparities, it is a kind of a vicious loop until we peel back the onion and try to address each issue, which is not an easy thing, but if we have at least one person doing that and advocating for patients in the clinic or even in the classroom, that's one or two or three, which turns to hundreds of more patients that have been touched by your goodness and your wherewithal, and we can achieve some better health outcomes.

Rolf Taylor: Yes absolutely. And we hope that, you know, this podcast can be a small part of that, creating a platform for that. I think it's interesting talking about redlining because redlining happened decades ago, yet the ramifications of that are clearly still happening.

Sondra Middleton: Yes, absolutely. I mean that's something that, it started decades ago, but is continues right until this day in many areas of the United States of America. And thank you so much for saying that Daytheon and bringing forward, paying forward Dr. Smith's original mission and his vision for the PA profession. So, that was wonderful, thank you.

Rolf Taylor: Klarisse, how about Manhattan and New York City, I think you work in both. What are the disparities that you're seeing there?

Klarisse Mathis: I guess it's a little biased because I work in the Upper East Side. So, that demographic is mainly Caucasian, people have money, cause we're getting patients from the Upper East side, the Upper West Side. I mean people are very affluent, so I'm not really seeing too many patients that will necessarily not have the insurance or they're coming late for appointments and things of that nature. Our population is pretty straightforward, especially since I work in orthopedics, everything's elective. So, these are people that, hey, you know I want to, I need to get a total hip, total knee replacement and pretty much have the funds or at least the insurance to get it. The only time I will see the person that probably will need some help or things of that nature, we'll occasionally get the homeless person that fell in the train station. Now, it's just like, okay we're a hospital, we're always going to treat everybody, but now it's a social factor, now. Where's this patient going to go? This patient doesn't have a home, they come from a shelter. You have a cast on your leg. How are they going to maintain that cast? Are they really going to come back to a follow-up appointment? And it's kind of the fact that we just fixed you, but at the same time, how are we going to maintain what we just did, and then, it's a good chance we might see you right back at Lenox Hill, right back at the hospital. But I do have a per diem job as well, which kind of balances me a bit. I work in pediatrics and these are people, these are pretty much all of the kids that are crossing the border and they're coming into our center. And basically, as a PA and some of the MPs that are working there, we're

kind of first-line medical that they're seeing. So, even if they weren't seen back in Central America, which is where most of the kids are coming from. We're just pretty much, you know, doing their history, physical exams, we're doing their vaccinations and we're doing sick call. They also have a school system kind of built for them there as well, just to kind of transition them from wherever they came from because most of them are either going into foster care or we're trying to connect them back with their parents that are here in the US. But we have to make sure all of their paperwork and vaccinations and things of that nature are up to date. So, it's kind of a different reality check there because one, none of these patients speak English. And once I do find out the stories, a lot of these patients are crossing the border and coming to the US because one, they were separated from their parents. They're coming over here by what they call coyotes. One patient I had, she basically was maybe like 13, 14 years old. They crossed with no shoes, they have all this foot fungus, they have lice, they have all these scars. Some of them are pregnant at 14, so not only am I vaccinating the mother, but I'm also vaccinating their two month old baby. And a lot of them are running away from gang violence, kids were raped. So, they're going through a lot of trauma, not only just physically, but they have a lot of psychological trauma that we have to deal with too. So, for me, that's kind of like my counterbalances, these are people that definitely need a lot more of my help versus my elective patients. And these are people that I feel like I

can have an impact on because I feel like I'm at least helping them in some sort of way and giving them the aid that they need, as well.

Rolf Taylor: Together you've described disparities in terms of health literacy. You've described disparities in terms of diabetes and also disparities in terms of trauma in terms of levels of trauma. And I would imagine that those patterns are replicated right across the country to different degrees in different areas. But as black PAs, how do you see your role in terms of addressing health disparities specifically? And was that part of your motivation to become a PA, to have the opportunity to perhaps tackle some of the root causes of health disparities?

Daytheon Sturges: The bottom line of why to become a PA was just that to help my community, but not only my community, but underrepresented communities. But I feel it's very important for this representation as a black PA, because there are some cultural things that we get and that we understand, and are able to teach our colleagues, too, as regarding our patients. For example, you know, I always go back to my diabetes days, but I had a patient that came in once and their documentation said that, oh, she's doing very well on her diet. She eats greens all the time, but her A1C was like 12 and they were like, but we don't understand it. So, when I saw this patient, I said, “Okay, you eat greens. How do you cook those greens?” “Oh, I use fat and I use ham hocks and I use this. I was like that's the problem, you know, and I add sugar. I add sugar to my greens, too, but just to give them a little bit of

more flavor. So, a lot of times, it's learning the nuances of culture. I'll remind you that race is more of a social construct. So, if we're going to be talking about race or trying to do race-based medicine, which is problematic, we have to remember it’s social, which means that's culture and that's different other elements that inform a people. So, I feel like it's very important for the black representation in the PA field. A lot of times, too, it's disarming to our patients, they're able to let their guard down and trust a little bit more. But also, along the way, like I said, we can help our colleagues and create allyship, though it’s not all on our backs to do that. I want to make sure I put that out there. But if we're willing to do that, we can help create allies and a more collective understanding of our patients. And again, like I said, it all boils back down to the health disparities and social determinants of health. I'm going to probably say that plenty of times throughout this podcast but understanding those things will help you understand your patients. I didn't always know those things. I just knew what I knew from my lived experience, but lived experience is one thing, but then also learning and putting yourself out there to get the information to put in your toolkit is very important. So, I would say that I love being a black PA, I know I'm needed. I know my patients are elated to see me. I get it from all the time, and you know it's just a really good feeling when you have someone, you know back pre COVID when they could touch your shoulder or give you a hug and say, “You know what? I'm so proud of you.” And you know exactly what they mean and so I, that's why I think we're doing this. We’re encouraging people to increase this

representation and also, we're doing it on the levels of education too, because it starts in the school. If we're not opening the gates to let people in, then we're not going to change the demographics of this profession.

Rolf Taylor: Thank you so much for sharing that Daytheon. And it's obvious that comes straight from the heart. So, how are you going to follow that, Sondra?

Sondra Middleton: Oh boy, I don't really know. I was like this is an audio broadcast, but you Daytheon can see me shaking my head at everything that he's saying. Yes, so what brought me to being a PA? So, the first thing that brought me to being a PA and not being a physician for instance, is the fact that I really resonated with the fact that PAs are primary care providers. I wanted to be able to give my patients everything, not just the little thing that they came to see me for. And I wanted to be able to do that and that was something that you oftentimes cannot do because you can't practice outside your scope as a physician. So, that was my idea originally was to be a physician. I was lucky enough to have a family member who was a physician. So, the idea of a black medical provider wasn't foreign to me and actually many members of my family are in various and sundry roles in medicine. My family are either all teachers or they're in the medical profession. But, it wasn't, although from my own personal experience, I hadn't had an experience with a black provider. I knew that they existed because they were in my

family, but when it came time for me to decide what I wanted to do, that's what called me to the PA profession, was the fact that I would be able to help people in my community, I grew up in a predominantly black and Hispanic community. My ultimate goal actually when I went to college and then eventually going on to PA school, was to come back and to work at the neighborhood community center where I got my care as a child. And I felt that I was taken so well care of that's what I really wanted to do. It unfortunately did not work out that way, I literally, when I graduated from PA school, the first thing that actually, before I graduated, the first thing I did was like went back to the center and I was like, can you hire me? And they were like, we don't have any money to hire you. I was like but I went to school essentially just work here. And I had said that to my doctor when I was still in high school, before I left for college. And she was like, “Oh, okay,” and I was like, “No, seriously, I'm going to come back in a few years, and I want a job.” And, unfortunately, they weren't able to hire me, so I ended up getting a job at a different hospital. But even with that, I wanted to make sure that I was working with underrepresented populations, which is one of the reasons why I went into HIV. Just the idea you know, as Daytheon said to be there, to be a physical, visual reminder that this can be you, too. I enjoy any time I get an opportunity to speak at a school because I want them to see the doctor can look like you, right. You know because little kids, especially their doctor, they say doctor, they don't really understand the whole PA concept, but, you know, the doctor can look like you, that person in the white coat, that person can look like you. I

was never so excited to see Doc McStuffins on TV and to see this little black girl who was being a doctor, being a veterinarian, working with our stuffed animals. And it was just these types of representations are so important and people don't sometimes realize that at the time and how they will change the lives of people who are in your sphere when they can see you in that position.

Rolf Taylor: So, it really sounds as if part of the attraction of the PA profession is that you get to have a broader remit and to take that remit as broad as possible, it means you're almost approaching kind of a more holistic approach and then the holistic approach, when it includes the cultural elements and the fact that you're a walking example of your doctor can look like you, that's about as holistic as you can get. That's really terrific insight, thank you for that. And how about you Klarisse?

Klarisse Mathis: For me? I knew I always wanted to do something in the medical field. And I just knew that I didn't want to be a doctor and I didn't want to be a nurse. So, for me it was more of a technical decision, at first. Once I went to college, one of my colleagues was actually applying to PA school and she was the person that actually introduced me to the profession. I was just like, hey this sounds like a pretty good fit. You know I like the fact that one, we have a lot of autonomy, especially on, depending on where you work. Like I work in the OR, so depending on the surgeon, I'm first assisting, I'm making incisions, I'm drilling, I'm sawing, I'm closing wounds by myself. And I like the fact that as long as

you're with someone that's willing to teach you, they're willing to let you fly basically. I also liked the fact that we have a lot of flexibility. So, like I said, I work in mainly orthopedics, but then I have a side gig in pediatrics. So in the PA profession, we don't necessarily have to go back to school and do residency like a doctor would, if they wanted to change their specialty, we're pretty much trained in all areas. So, for me it's just kind of getting retrained on the job, so we can always bounce back from different things. So, I like the flexibility of it and also lifestyle. I think that's very, very, very important. We have, I feel like PAs, we have a very good work-life balance. You're able to work a full-time gig, you can work two part-time gigs, you can work a per diem gig if you want to as well, so you have a lot of choices, a lot of autonomy. And it's like, I like those underdog positions. It's still a profession that a lot of people don't know about, so I love to educate people. They always think I'm the doctor when I come in or maybe a physical therapist, I don't know why. But you know when I tell them I'm a PA and a lot of people again, still don't know what we do, they're like, “Oh, okay, basically so you're like a doctor.” And sometimes you just got to, especially with my elderly population, I'm like, okay, you know what. They'll still come into the room, even though you say you're a PA, they'll still call you doctor. So, it is what it is, but at least I'm expressing to them exactly what I do. And they feel a little bit more comfortable knowing that I work along, side-by-side, with the doctor, so, I'm pretty much their righthand man, their right wing, that sort of thing. The money's pretty good, too. So that's also a plus.

Rolf Taylor: That's the trifecta. It's well-paid, it's flexible, you can change around specializations. I mean really does sound as if you find the profession extremely rewarding.

Klarisse Mathis: Definitely, and just being able to work with different people. You know definitely like I want to touch on what Daytheon said, I definitely will go into a certain patient's room, especially like a black patient and they'll give you that I'm so proud of you. You're like a doctor I'm like, yes and they're just like, I can't believe it. Like it's nice to see someone that looks like me again, like someone that they can relate to, someone that they can talk to and just feel a little bit more comfortable. Not saying it's intimidating when you're with somebody else, but again, it's that comfort level. And when you're in a hospital that's already uncomfortable as it is because you're likely in there for something that possibly has gone wrong. For me, you broke something, so no one's happy about that. So, you want to make sure our people one, you want to make sure that they at least like you because if they like you, then they'll definitely trust you and they'll feel a lot more comfortable working around you.

Rolf Taylor: Klarisse, I'm going to hand back to you because I know you've got a couple of questions you'd like to ask, a couple of specifics that you'd like to cover.

Klarisse Mathis: Sure. So, let's just talk about some of the things that are going on currently. COVID-19, that's definitely a big factor in all of our lives right now. So, just want to start touching upon in terms of like access, treatment, vaccinations, clinical trials, things like that. What exactly are you seeing going on with COVID-19, and what are exactly some of your concerns with what's been going on with this pandemic? And then just to piggyback on that, how do you feel the PA profession has been contributing to this pandemic? I'm going to start with Sondra first.

Sondra Middleton: Yes, COVID-19. So, because I work in clinical trials and infectious disease clinical trials specifically, we have been, or I have been very involved with COVID-19 since the beginning. In terms of clinical trials, and I have to say, this is another thing about being able to look like your provider. So, one of the things about my particular office, is that the office and myself specifically make a point of making sure that any clinical trials we have are being offered to everyone. Sometimes in medicine, there are conscious and unconscious bias regarding clinical trials. People will say, well we're not going to offer it to a person of color, because we don't think that they're going to be accepting of clinical trials, because people of color don't like to be in clinical trials. My mother taught me that somebody saying no to me won't hurt me okay, it's just a word. So, I made it a point to ask everyone, okay. My thing is that I don't make the decision about who should be in a clinical trial, I let you know the patient make the decision about whether or not they want to be in a clinical trial. So, one of the

things about our group is that we turned out to have one of the highest percentage of people of color and women in the early COVID 19 trials, that we're running for things like Remdesivir, which is one of the drugs that was approved to treat. And some of the antibody therapies that have been approved to treat COVID-19. So, when they went back and looked at the data, they came back to us and they said you guys were unbelievable who you were able to get. And I was like it's not that who we were able to get into trials, we know that people of color are disproportionately affected and disproportionately affected severely and disproportionately die of COVID-19. So, how can you have a trial that does not contain these people, when they're the ones that were in the hospital? It was very confusing to me.

They came back to us, the companies came back, and they were like, how did you do this? And my response was we asked everyone. It didn't matter who you are. Our hospital at one point was 100% COVID-19. So, we asked every single patient, we would just literally go from room to room and say, you might be eligible for this trial. Is it okay if we talk to you about it for a minute? Are you interested? So, we had everyone in our trials. We, for the convalescent plasma trial, we had to have the consent form in so many different languages, the people who were running the trial were like, are you kidding me? We had consent forms in Hindi, in Russian, in Chinese, I mean because we approached every single patient. So, that was something that I did and brought the other people in the team around to that way of thinking, as well. You

know, I explained to them that as far as I'm concerned, everyone is a clinical trials candidate, let them say no, no never hurt you. And I mean this is data that we need, and I would say this to patients. I was like listen, this is an important new disease, emerging disease that we know is affecting these different groups of people. We need to know, do these drugs work. You know, we can't extrapolate from other people's work. And so many people were like I never thought about it that way. And they were like listen, if there's nothing else that that's available, I am very happy to try this. So, it worked out really, well. We had, I mean we had about 150 people on various and sundry trials between March and probably about July, so a lot of people.

In terms of what I saw in my hospital which was wonderful. We have a very strong PA team as part of the hospitalists in my hospital. So most, especially when we got probably I'd say around June, most of the care that patients were receiving in my hospital came from PAs and from physicians in training. So, residents, a few interns, but mostly residents. And so, it was so wonderful just to see how the PAs were working with the different patients. You know sure, were they afraid? Yes. But were they afraid in the way that it would make them not take care of people? No, okay. They took their time, they wore their PPE, they worked just fantastically within the hospital. I was really very proud of my profession in jumping in and making that commitment to be able to help people during such an incredibly stressful time. I mean, nobody ever thought they'd be in a pandemic, right? This is something that we

teach our students in class about the influenza pandemic of 1918. And we teach them a little bit about the influenza pandemic of 2008, 2009. But it wasn't, it was really more of an epidemic than a pandemic, but we never thought that we would live through anything like this, and PA's have really been on the forefront I think of providing care to people.

Klarisse Mathis: That's great. I'm glad that you're definitely taking charge with clinical trials. I'm just going to hope he's listening. Dr. Fauci, I think you should have Sondra working by your side during this pandemic. You know it'd be great if we had a PA on his infectious disease team. I don't know if he doesn't, but let's put it out there. Let's put it in the atmosphere. And how about you Daytheon?

Daytheon Sturges: So, you know me, I'm going to take it back to the social determinants of health. I'm going to talk about equity. So, you know, well, maybe some of you don't know, so the USA is dead last when it comes to healthcare outcomes among the developed nations in this world. But we're number one, rah! rah! rah! when it comes to healthcare spending, there's a mismatch. And most of that spending is not toward the social drivers or social determinants that actually affect our health. So, we were in for an expected, but for some unexpected treat when it came to COVID-19, because we have so many things that will negate us achieving good health. So, socioeconomic status is one of the biggest drivers when it comes to health outcomes, because let's

think about it, those people who are living urban areas or in public housing, they're closed in spaces, its tight spaces, there's lots of people on top of each other. Boom! There's more transmission, right? Some people might not have transportation and relying on public transit. Boom! There's another mode of transmission. Some people don't have the privilege to work from home and be on Zoom and they have to go out and work. Boom! There's another transmission. I could go on and on, but I won't. There's a good paper, I don't know how I do this, but I pulled it out my head, by Rollston and Galea called, "*COVID 19: The Social Determinants of Health*". Its recently published here in 2020, but it goes into more detail about all the different social drivers that have led to the increase in the disparities amongst black populations, as well as other populations of color. You know, I want to go back to what Sondra said about the implicit and explicit biases or conscious and unconscious biases. We have to dismantle that because that also leads to adverse consequences when it comes to especially the new novel disease like COVID-19. So, providing that more access is going to actually help all patients, especially, when you're in a pandemic, you want to make sure you're reaching everyone. So that means putting in an equitable practice, also dismantling that the notion of Black people are not going to participate in trials or vaccines. Yes, there is a lot of misinformation out there regarding this vaccine, right now. You know, I was listening to NPR this morning, they were saying that in the Jamaican community, they are saying that this is the mark of the beast. So, if you get injected and so people are believing that, so

it's our duty to kind of dispel some of that. But also acknowledging the history behind why people have mistrust and distrust. So, at the end of the day it's their call, but for us to be able to acknowledge the historical trauma and try to help someone work toward having a change of heart or change of mind, I think that's what we can do. We're not going to change everyone's minds, but I always say medicine is not finite. It is a sociology, it is medical anthropology, it is psychology, it's a history. History plays so much of a role in our place of decision-making, and I think that there was seen a lot with this COVID-19 that, there's a lot of misinformation. But it's easy to believe that because of the roots of which a lot of this distrust comes from.

Rolf Taylor: Yes I think it's significant when both of you, first of all, Sondra you're saying ask everyone. Ask universally and then Daytheon, you need to give some time to acknowledge and work through and hear people's concerns but at the end of that, you're going to get potential engagement and participation.

Sondra Middleton: Yes. So, for me, I mean I've been working in clinical trials now for a long time. And even when somebody comes in and says, “Nope, I really want to do this, I'm ready.” I always tell them, let's take some time. Let's go over this information again, then go home and think about it and I will call you the next day. Because sometimes people come to things with disinformation, as you were saying, Daytheon and they totally think something that's not really true. They think that this

experimental treatment is going to save them. So, I need to have them understand that we don't know that's why we're doing this. It's like, yes you may have heard something about this that said it was great, but understand that we don't know if that works for everyone. So, yes, having that education, coming back to my whole thing about health literacy, having that education, understanding what a clinical trial is, being able to get someone to understand pretty sophisticated concepts okay. And I always say that medicine is really not that hard okay. Pretty much anyone can really do this. I mean I hate to say it like that, but if you can break it down in a way that people understand, then they can make an informed choice and that's the most important thing to me, it's just making that informed choice.

Klarisse Mathis: I just wanted to touch on one thing very quickly, because I know you mentioned clinical trials and that just made me think of a time when I was working during COVID, because you know, it was just so new to everybody, we were literally one day when we would get our protocol on how to treat patients. The next day it's like, no, take off the vitamin C, we're not doing that anymore. But I noticed that in my ward where I was working, we, they kind of called it like the, it was like the segue. Most of these patients had already been on a telemetry floor, they've kind of gone through a lot with COVID and now they're pretty much waiting to either placement for a home or a placement for rehab. So, these patients were so-called stable, but they really weren't because by the time they got to us kind of between day seven to 10 of COVID,

that's when patients were starting to crap out on us. So, they might've started doing well with the steroids but between that time period, they weren't literally either start having PEEs or we'd have to send them back upstairs. But, during one of those times I had a patient, and he was a white Jewish male, and he was pretty young maybe in his forties and he seemed to be okay. Like he wasn't having a lot of bad symptoms, like a lot of other patients were, or maybe his neighbor but he told me that he was on a clinical trial. And I noticed that out of all my 20 patients, how did he manage to get in here on a clinical trial but like grandma next to him is on nothing, two doors down I have two people basically on palliative care there, unfortunately were dying on us and I was just wondering like, how did this happen? That's why I would constantly call you during COVID, Sondra and just say, how can I get the clinical trials in my hospital or is it in the hospital? Is because like, just where I'm working, I'm not up on the floors and the regional or ICU units. Like, I don't know what they're doing ID wise, I know we definitely don't have infectious disease PAs in my hospital. But I was just like, I was upset because I wanted to know how did he get access? How did the white Jewish guy get access, but most of the minority patients that I'm seeing have no access. You know, you can't even talk to your loved one, so you're definitely not going to just come out of the blue and ask for, can I be on a clinical trial? You let alone don't even know what's going on. So, I thought that was kind of interesting, and I wish that that's something that we could have more forefront, because again, like you said, a lot of people don't know. I didn't really know cause I'm just

like, I just want everybody to survive. I'm just trying to keep my patients alive but if there is something new or something that we can trial that can maybe make a difference in somebody getting better, getting off of five liters of oxygen versus my patients that are on morphine drips, then I definitely want it to be all for it. Daytheon, you definitely touched on a couple of things that I thought about too, is that you guys both mentioned about the biases, the unconscious biases that we have in the medical field and dismantling that and, it's funny, because I actually mentioned this before Rolf, when we were talking, last podcast of how when I was first a PA my first year. I'm green, I don't know anything, I'm just excited to be working, and one of the patients, the nurse called me from the PACU saying the patient is in a lot of pain, you have to come upstairs. You know they just had spine surgery. So, I run upstairs, see the patient and they're like, “Oh, they just have a case of the aye-yi-yi’s. And I'm like, “The whats?” And they're like, “The aye-yi-yis,” and I'm like, “What does that mean?” They're like, they're Spanish. So, they're crying in pain and they go, “Aye, yi, yi, yi.” And I was just like, “Well, let's just,” you know, this is the first stereotypical thing that I've learned about, Spanish, Latino patients. So, and I think that goes back to again, historic times as far as black people, how they don't recognize our pain because we don't have pain. But let alone this Latino patient, if I were to go with this bias, I could miss something. I had a patient who.

Daytheon Sturges: Yes.

Klarisse Mathis: Yes, may have been screaming aye yi, yi, but guess what? She was in pain, she did end up, they did end up having like a hematoma, because they just had spinal surgery. So, sometimes this pain is real, and we can't just go with these cultural, stereotypical biases of this is what this culture or this race does. This is how they react to pain, this is how they react in general, so we're going to brush it off. We'll miss something and next thing you know this patient's dead because we're going against what people think. So, I think just looking at a patient from the whole center of I'm a medical practitioner, I'm here to treat I'm here to diagnose and instead of like, oh, well let me look at the race or the culture of this patient and I know that a black person does this, or a Latino patient does that or Jewish people, yes they do come in, they want to leave by Friday before Shabbat, or it's just like, you have to respect these things. I think for me, that's one thing I'm learning especially being a black PA, I feel as though you kind of just have to jump into things and you have to learn everybody's culture. You just, you can't just sit there and just focus on you being black. I feel like that's also an advantage to us because we're kind of like looked upon as sometimes the underdog, but it's just like, yes, but I can relate to everybody. I'm understanding where everybody's coming from, so I'm not going to be that person that's just going to brush them off and not tend to their needs. I'm going to look at them as a whole person and not be, I don't even want to say racist, but be racist towards somebody or culturally biased against what they're going for.

Rolf Taylor: I think what I'm hearing you say is that you're acutely aware of the damage that stereotyping can do.

Klarisse Mathis: Definitely.

Sondra Middleton: And Klarisse, you know, when you said before that even though you tell them I'm a PA and they call you doctor, you have to understand that the way that you treat people is why they call you doctor, because that's what they expect a doctor to do. So, when you treat everyone with respect, when you listen to everyone and don't brush them off, I found that out very early in my career that the people because I would say, “I'm not a doctor.” They're like, “Well, you're a doctor to me because that's what doctors should do.” And I was like, “Huh?” I never thought about it that way you know. And a patient told me this years ago, when I got out of PA school, I was barely 23, my patients were in their thirties and forties. Most of my patients were older than I was, and I'll never forget a gentleman said to me, he's like, but you listened to me. He's like the reason why I switched to you from the doctor was because the doctor never listened to anything I said. He said you listen to everything I say, and you asked me questions and we work on things and actually I feel better than I did before you got here. So, that's why you're always going to be a doctor to me.

Klarisse Mathis: A testaments to how PAs are, because a lot of times you meet patients and they'll say, “I didn't even see my doctor much.” Like they

might've saw them for five minutes for that visit, but most of the visit was basically being seen by the PA. And I think during this COVID-19 pandemic, I feel as a PA we've definitely gotten a lot more recognition, pretty much all of the COVID units were being run by ACPs or advanced clinical practitioners. So, they were pretty much being run by PAs and NPs in our hospital because we only have but a handful of internal medicine, doctors and residents and ICU PAs and doctors as well. Once they started running short, they had to start dipping into PAs from all the specialties and pretty much we were running the units alongside with the attendings. We would round with the attendings in the morning and then pretty much the PAs and NPs were running the floors, pretty much by ourselves for the shift. And we can always call and reach out to them whenever we needed help, but I feel as though during this pandemic, I hope people can finally recognize what a PA can do and that we are fully capable to run units, see patients run codes. One of my friends in ICU, I watched her run a code. The doctor wasn't even like they were on their way, but she literally ran the entire code on a COVID patient. So, it just shows you that we can definitely make a big impact. I definitely want to segue to Daytheon, so I know your role with all these accolades, your role includes being the Associate Program Director and also working with diversity at the University of Washington. Can you just tell us a bit about that? How did you get into that role? What inspired you to kind of take on that position and why is it so important even though it's obvious, but why is it so important to promote diversity?

Daytheon Sturges: I guess the phrase is, “See something, say something.” I am a black male PA, we're very underrepresented. I'm a black man in America. You know, all the challenges that come with that. So, sometimes if you go through things, you just want it to be better for others and so that is kind of how I fell into this role. You know obviously it was told in the past that this was low-hanging fruit and I'm like, apparently you don't have my lived experience because this is high yield fruit to me. But really starting more so with lived experience and then as I get into my PhD, too, looking at the different disparities, has really influenced the direction I wanted to go. So, I kind of started out first with Project Access, which Klarisse participates in, in New York City. Is where we go into underrepresented minority schools and different areas in which we introduce the PA profession, and kind of let them see that a PA's like you, like I'm just like you. We basically answer any questions that they have. And from there, I moved on to get on the Diversity and Inclusion Mission Advancement Commission for PAEA, where we are aligned with key strategies for our national organization and work along with the strategic plan, for which I currently chair that commission now. And then I'm also the Cultural Perspectives Editor, soon to be just the Equity, Diversity and Inclusion section of the Journal of Physician Assistant Education. So, it's really for me to amplify our voice and give others the leeway and the opportunity and space to also join in on that work and amplify voices and create sustainable actions by having people at the policy level, for

lack of better words, to help kind of create these avenues for more diversity, but I always pose the question, what is diversity without inclusion? A lot of people tout and like to have diversity, which has so many different definitions, but most people look at it like identity diversity, so race. But, okay so when you get more diversity now, what are your practices? How are you tackling this? And then again, too, we talk about fairness, but fairness isn't fair when you're talking about social justice. So you have to say, what is justice without equity? You know, so I am very blessed that when I joined at the University of Washington, the chair of Family Medicine, Dr. Paul James before I even got there, actually had me as the co-chair for the Justice, Equity, Diversity Inclusion Commission for the entire Department of Family Medicine.

So that is run by a researcher and a PA, so again, that's representation, right. And then my program director, Terry Scott, who was my mentor prioritized, we call it JEDI- Justice, Equity, Diversity Inclusion, and created an Associate Program Director position around that. So not only now, are you creating time and space for me to do this work, you're also paying me for this work. And I bring that up because a lot of times we are asked and tasked to do a lot of things regarding diverse and inclusion, without any kind of renumeration. It's just looks like people think that it is a duty of ours because we are black, or we are underrepresented to do this work. Now a lot of us love doing this work and will continue doing this work, but I also want to

recognize the disparity that exists there too. Is when other people come in and doing talks and things like that, they're getting paid and, but we're looked at like okay, it's a duty.

So, I say all those things, because these are things we bring to the table. And in my discussions, it gives me a platform in order to say these things and to have people to consider these things. And when we talk about diversity and inclusion, we have to talk about anti-racism, too and specifically anti-black racism, when it comes to admissions, when it comes to retention, when it comes to hiring practices. So, looking at things from more of a holistic standpoint, when we're looking at students, it's not always about grades, it's about their lived experiences, about what other attributes do they bring to the table. For example, someone who has a 3.1 GPA with how competitive PA school is, now, it's kind of hard remarkably, kind of hard for someone who has a good GPA, like a 3.1, 3.2 to get into PA school. But did that person have a Pell grant? Do they work 20 to 40 hours a week? You know what kind of community service are they doing? These are of things that we have to start discussing and bringing to the table too, because we're gatekeepers when it comes to the PA profession and the public trusts us. So, in order for us to make a big difference, we have to really change our ways of looking at things and the way we practice. And even in that work that I do too, it goes to faculty and staff as well at UW right now in MEDEX, we have a huge representation of URM faculty and staff, now and we have these frank discussions,

though they might not be comfortable all the time, these are conversations we have to have. We have people at the table who have a collective understanding of some of the nuances that comes with maybe something, someone said that has a racist undertone, that they didn't even recognize, recognize or has some type of bias, but it's being brought up and discussed. So, that's in a nutshell kind of what I do and, and it basically, it spans all the campuses. We have five different campuses. We have Kona, Hawaii. We have Spokane, Washington, Tacoma, Washington, Seattle, Washington, and Anchorage, Alaska as well. So, you see we have so many demographics and different types of people, how important it is to have someone that is focused on JEDI to actually create what we call One MEDEX and keep everyone aligned. One thing that I started doing, especially after this summer with the murder of George Floyd. You know the world was burning down around me, no one had reached out to say anything to me to check and see if I was okay. You know I had been in the house, we were quarantined, I'm crying I'm looking at the news. The trauma that's inside me has been awakened and I immediately thought about my students and I addressed a letter with Terry Scott and sent it to the students. And they appreciated it so much and that opened the door for more conversation. On the eve of the election, because of all the political divisiveness, I crafted a letter and opened again for conversation. And then most recently with this domestic terrorism and insurrection that occurred at the Capitol, I sent a letter and we met and opened the doors for people to talk. And a lot

of our black and Brown students, our Asian students talked about what it feels like looking at that happen on TV and what it feels like to be them in America, right now and to let other people just reflect and talk about that because we might exist in a bubble when it comes to education, but that bubble will easily burst and every few weeks our bubble is being burst. So, we actually tackle these issues, too. That's my main focus is to bring voice and to amplify voice around these issues, so that we can get a better understanding, but also create some sustainable change as well.

Klarisse Mathis: That was a handful there. You definitely touched on one thing that I kind of wanted to address to you and Sondra, being that I look up to both of you guys, and I liked the way you addressed that. You know I would consider both of you guys gatekeepers because you guys are both in positions and the programs. What do you think as far as yes, black PAs matter, but how can we get to matter if we don't have that representation? We don't have that representation because we are not in school, we are not either graduating, we're not being selected. We don't, let's take it back, you know we don't know about the profession. So, what do you think are some of the things that we can do, whether you're faculty program director, or a PA, what are some of the things that we can do to help bring up this representation because I feel like what the numbers may be like between three to 4% black PAs according to APA, I believe? So, how can we bring that up to at least

some sort of double digits, because this is pretty much a predominantly white female ran, profession? Sondra, if you have any thoughts.

Sondra Middleton: So exactly. So one of the things, gosh, Daytheon, everything you said it was just incredible. One of the things that I did here with my job, it's actually very interesting when you said you should be paid for that. I agree with you, that is a great point. When I took over the Associate Program Directorship here at this program, one of the things that I did was I made sure to get myself on the admissions committee because our admissions, I felt was not representative of a program that is located in Times Square in New York City. Now, understanding that the college that sponsors our program is a traditionally Jewish institution, it still was not representative of Midtown Manhattan in New York City. So, over the last several classes, I've been working very hard to try to make the program more representative and it has been difficult as Daytheon has described. What has happened is that with the growth of the PA profession, it's become incredibly popular and so, in trying to basically reduce or weed out the number of applications, grades have become a big thing. So, we've had many discussions, not just with this program or with the other campuses that are also in the same school about, looking at people in a much more holistic way. And we've decided to reevaluate our admissions process going forward for our Class of 2025 because we were finding, as I said that our classes were not truly representative of the areas in which our schools are located. So, we're definitely working on that. I love the fact that you

crafted a letter to your students, that in our setting came from the upper administration of the school itself. And no one, as far as I know, has even touched on what happened on Wednesday with our students.

We have meetings with them over Zoom all the time, we have town halls and different things but, I think our upper classmen, they had a meeting on Sunday, so they may have discussed it there. But our lower class, we haven't, they're actually coming in later on today. So, that's something I'm going to bring up to our program director and maybe we can talk with the class about that a little bit today. I feel like it's so important to be able to bring more black, indigenous and other peoples of color into this profession, because these are our patients. So, why shouldn't our patients see people who look like them? See people who understand that when somebody says greens, what they mean right.

Klarisse Mathis: Right.

Sondra Middleton: I went to school in North Carolina, so even though I was born and raised in New York, I know what greens are. So, as soon as you said that I was like, oh yeah, they didn't get that at all. Before you even said her hemoglobin A1C was so elevated, I was like, “Ooh yes, they're thinking something totally different.” So, being able to understand those type of cultural things, and one of the things we do in our program is we actually have a class, we call it Psychosocial Medicine but partly what it is, is to try to introduce our students to some of the different

cultures that they're going to encounter in their training here in New York City because many people, you know, we talk about America, but America is incredibly segregated. So, there are many people who've just never seen people who don't look like them. People who don't have their same socioeconomic status, people who are not the same color as they are. So, we try very hard to introduce our students to the idea that people are different, they have different cultures. Here are some indications of some different cultures and here is how we would like you to start thinking about approaching your patients, approaching everyone as human. Whatever your preconceived notions may be, go with human first and anything else after. You know that's what we've tried to do in our program. I hope that other programs are thinking the same way that you are, and I am, and being able to open this profession up because I think it's an incredible profession and something that is going to be so helpful going forward to help with health and wellness of everyone in this country.

Klarisse Mathis: Thank you for that. Speaking of, since we were talking about diversity, I just want to switch gears a little bit. I find that, you know, like as being a PA, we are definitely in very, I would say diverse specialties, even though our basis and history was primary care. Since you specialize in infectious diseases, could you tell us just more about just being, a day in a life briefly of being the IDPA? You know, what that entails and especially if someone who is an aspiring PA, how would they even look into getting into that specialty? Because like I said,

during this whole COVID pandemic, that would have been great to see the IDPA. But no, we might have like five ID doctors that are working in the entire hospital, and with 300 to 400 patients, they're going to be spread pretty thin, as well. So if you can just touch on that for me.

Sondra Middleton: Sure. Well, one of the things about this profession, like I said because it is such a young profession, 55, 56 years old, it does allow us a lot of latitude. So, anything that you like you can probably do okay. What happened with me is that I got into infectious diseases because when I came out of school, HIV was the new emerging new disease and getting excited about learning about that in school, I decided that that's what I wanted to do for my career. So, I basically, literally got a list of HIV clinics and started cold calling them to see who would take me and that's essentially how I got my job. I did a rotation there. I did it before I finished school, so I did a rotation at the clinic. And then, once the rotation was over, I was lucky enough to be offered a position and stayed there you know, for many years. Many people get their jobs that way, they do a rotation and the people who they're working with liked them so much that they offer them a position. After doing that, like I said, for many years, I decided to move into research. Once again, another place where there are not a lot of PAs. I finally, after like 10 years of working in research, I finally met another PA that worked in research. So, I do clinical research, I work with CDC, NIH and pharmaceutical companies, we work with them to get their new drugs approved in many cases. Sometimes it's drugs that are already

approved and we're working on looking to get the drug approved for a different indication. So, that's what I do now and it's a little bit unusual, but it's really incredible. It's a job that, oftentimes, is filled by nurses, so because of my scope of practice, I'm able to not only be what is called a research coordinator or research assistant, but I'm also, what's known as a sub investigator because of my scope of practice. I'm able to see the patients and evaluate them where oftentimes, depending on your scope of practice, you might be able to administer questionnaires and do things like that, but you wouldn't be able to take the patient's history, evaluate their response to the experimental medication, provide any treatment if treatment is needed, prescribe the medication, the experimental medication. So, I'm able to kind of do it all, which is really great. It really is very fulfilling to me to be able to sort of see things all the way through, to see a drug that we've used in research eventually become first approved and then a standard of care. So, it's really very exciting but it's a different type of practice because it is limiting in some ways, because you're really focused on potential side effects and effects of this experimental medication on a human person. So, it is a little different than primary care, but it's very, very interesting.

Rolf Taylor: That's a really, really wonderful summary. I think some of our listeners will be getting an insight into, first of all, being a PA. What is a PA? What is an IDPA? What is a PA in an academic setting? So, really, we've covered a lot of ground today and we're running a little bit out of time. So, as a final segment, I wanted to ask you, if you could just

focus on calls to action. It's a new year, it's 2021 new year, new administration. Hopefully, we're seeing the light at the end of the tunnel with COVID. So, as change-makers, what actions are on your checklist for 2021?

Daytheon Sturges: On my checklist is to continue seeing the elevator down. My cousin always says, once you take the elevator to the top, always push the button and send it back down to keep, so that we can increase our representation, especially when it comes to black PAs. I will continue mentorship, which is a big piece of my existence. I mentor mostly black men across the nation, actually. And it's been much easier now with Zoom, but I even would fly to their graduations and things like that and see them from the beginning to the end. I want to encourage all of our listeners, black PAs and beyond to mentor, to identify someone who is interested in becoming a PA and groom that person or give them resources to where the door was once closed, open that door to someone. Sometimes, even if you crack the door, they can kick it open. So, I just want to make sure that we continue to mentor and don't forget that we are in a position of privilege, now. The privilege of education, the privilege of a higher socioeconomic bracket and the privilege of providing healthcare, quality healthcare to our patients. So, I want us to use that privilege in order to help someone else come up in the ranks. And I guess another thing for 2021 that I want to make sure that we keep going forward is speaking truth to power and always putting forth the message of equity and not minimizing people's experiences,

especially our students, as they sometimes get a lot of abuse in the classroom and on rotations. Believe people, create a brave space for them to report such transgressions and follow up on that. So, I just want to make sure that we protect our students and in regard to our URM populations, make sure we have some equitable inclusive practices.

Sondra Middleton: Absolutely, I agree with all of that. Mentorship is so incredibly important. I, oftentimes, tease my students and tease people who are interested in becoming Pas, I tell them, thank you very much, because I'd like to retire one day, and I can't retire until I know I have someone who's going to be able to take care of my patients the way that I do. So, I absolutely agree mentorship is definitely number one, two and three on my list. I would hope, too, as I said, start to create, continue to create classes at my program, that more closely represent the area in which I am. We just started a diversity and inclusion committee here at the school, and I'm part of that. And I hope to continue to make that bigger and better with every meeting that we have. Get more students involved, do things, after the murder of George Floyd, that's how the committee came about. We've already had a virtual 5k fundraiser and we've raised along with a generous grant from our Dean, we have $25,000 for scholarship money for our underrepresented minority students to attend any of the school of health sciences programs. I want to continue to keep that going. I would love to be able at one time to be able to hire other people of color to be in this program. I am

currently one of two. Yes, two faculty of color throughout our entire program, which consists of four different programs at this point. So, I would love to have that that's definitely a big plus for me. And I keep telling Klarisse that she needs to start teaching, she's laughing at me because she knows I always tell her this. I'd love to bring her on board, I think she would be fantastic. And I'm here, I can mentor you. I'm not going anywhere, anyway, but I had to throw that in there.

But yes, and speaking truth to power that is so, so important to be able to advocate for ourselves as medical practitioners. To be able to advocate for our patients and for us as educators to be able to advocate for our students as well. And these things are all so important to make sure that going forward in 2021 and 2022, that things just continue to get better and better and better. Like I said, in the beginning, I'm incredibly protective of this profession. I only want to see it get better. So, that's, that's my wish going forward.

Klarisse Mathis: You definitely touched on a couple of things that I was going to wish for us, but you know my call to action but definitely one is a program that Daytheon mentioned earlier, Project Access. I'm just so disappointed that I actually started to get momentum with that program, I did my first program in New York. One of my friends is a bio teacher, but she's considered kind of like the Mrs. Clark from Lean on Me of that school, everybody listens to her, everybody loves her. So, I did Project Access, you know it was great to see the representation of Black PAs

on the screen. And then, of course, I throw in my orthopedic spin and we did a splinting session with music in the background, a competition, everybody loved it. They even walked around with the splints later on. I was like, I am not liable for that, I told you to remove it, but they just loved it so much. So, I was ready to take that program to every school that I can possibly get my hands on. And then, you know COVID, and everything happened. So, that is definitely one thing that when everything settles and it's safe to be in schools, that's definitely a one thing that I definitely want to keep pursuing and keep moving on with. And hopefully I can get other black PAs to join me as well. Teaching is also on my list of to dos. I've been saying that for a while, and I know Sondra has been trying to get me on board, so, I definitely want to at least be a part of this diversity committee, but I definitely want to get into teaching because I have been told that I have a good bedside manner and my students love me. So, they think that I'd be a great person to try to share the knowledge with, so that was just something I'm just going to have to take the fear out and just go forward with. And also, mentorship, something that you guys both mentioned which is something I think is extremely important. There are so many, and Sondra can attest to it, so many people that I've come across this past year that are black and want to become PAs. And they're either in the process or applications and between Sondra and I, I'm shooting them to her for like interview questions, reviewing transcripts and pointers. And they're calling me for moral support. I even had one pre-PA come to my house. She had dinner, she was in town literally for one day to

come in for interviews. So, even just providing them with that sort of support of hey, I'm in town, this is a familiar face, or at least someone in your network that you can come to and just chill, get ready for your interview and then fly out of town. You know, that was also something great and she's currently in PA school right now.

So, it's definitely good to see that process of pre-PA to PA and just knowing that you might have had some sort of impact on them. So, and just even looking up to you guys, you know I definitely, again, want to be faculty, a part of a program, Touro is probably going to be my in, at this point. And Daytheon, you know the alphabet soup, I keep telling you, every time I speak to you, I want to be like you when I grow up. I just want to definitely have that social impact, I definitely want to walk in you guys footsteps, but I definitely want to thank both of you guys for joining me for this Health Disparities Podcast episode. It's definitely been a pleasure to host and to have this platform for these important discussions. I definitely look forward to joining you in future episodes.

Daytheon Sturges: Thank you.

Sondra Middleton: Thank you.

Klarisse Mathis: Also, if this is your first time that you've tuned in, then please do subscribe to the podcast on iTunes, Spotify, or Stitcher. And if you go to the Movement is Life Caucus website, you can also sign up updates

and access transcripts on the podcast page. So, for now, everyone be safe during this pandemic. Stay healthy and talk to you guys, next time.

(End of recording)