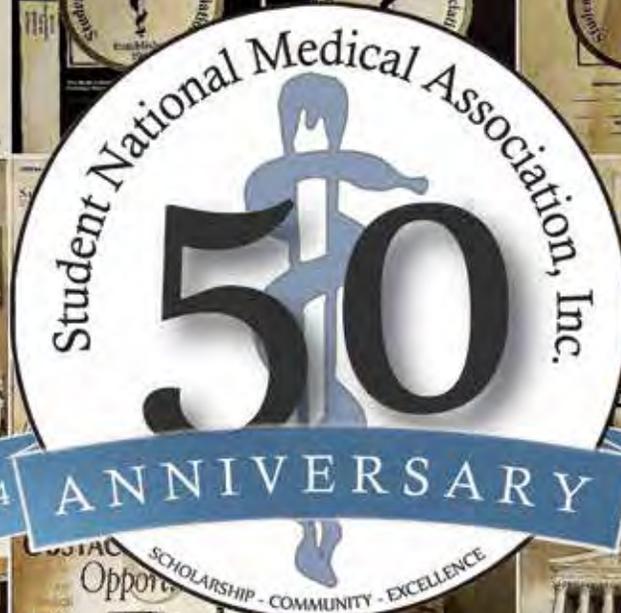


JSNMA

JOURNAL OF THE STUDENT NATIONAL MEDICAL ASSOCIATION



**Fifty Years, One Mission:
Diversifying the Face of
Medicine**

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- To Ms. Annette McClane, for providing so many resources to help us piece together SNMA's history, and allowing us all to keep focused on our individual and group tasks in order to get the project done.

Dear SNMA Family,



It is with great pride that I welcome you to the 50th Anniversary JSNMA. This special edition highlights the incredible history of the Student National Medical Association through contributions from current and past members. As we celebrate the 50th Anniversary of the SNMA, it is a timely moment to recognize the important role the JSNMA has played in conveying the message of our organization over the years.

For nearly 50 years, the JSNMA has stood as the written voice of the SNMA, its mission, and its members. Originally named "The Black Bag" publication, the goals of this regular journal has been to provide SNMA members an opportunity to share their thoughts and concerns on important topics such as health disparities and minorities in the medical field. In addition, this outlet has provided a chance to share knowledge about scientific advancements and academic support. Most importantly, through the JSNMA, our members have been able to tell the important story of the minority student, physician and our communities. These stories have been critical to increasing cultural understanding and greatly benefiting our members as well as our many medical colleagues of all cultural backgrounds. As we celebrate this jubilee year of the SNMA, I urge you to reflect on what the story of the SNMA should be for the next 50 years. Consider how your voice could help shape medicine into a more culturally inclusive and effective environment for our patients and communities.

Finally, I must thank those who have made this print version of the JSNMA possible. In years past, the JSNMA was provided to SNMA members in a print form. Due to restrictions in funding, the more recent forms of the journal have been distributed through its website, www.jsnma.org, and via PDF version. To commemorate the 50th Anniversary of the SNMA, we thought it fitting to return to our printed version and to provide this version to all attendees of the 50th Annual Medical Education Conference. We thank the Association of American Medical Colleges and the University of Wisconsin School of Medicine and Public Health for providing the funding needed to print this special JSNMA and for their continued support of the SNMA.

We hope you enjoy this edition and that you are inspired to share your stories in the next edition. Thank you to all current and past SNMA members who continue to use their voice to help "Diversify the Face of Medicine".

Yours in SNMA,

Courtney M. Johnson

Courtney M. Johnson
2013-2014 National President



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SNMA Founding History

By Oluwakemi Tomobi, SNMA Publications Co-Chair; Editor-In-Chief, Journal of the SNMA

“There were like 200 people in our class when we graduated and I would say there were 5 other minority students. We were extremely underrepresented, so to have upperclassmen, to have an organization, to have a national/regional support system was amazing,”

Dr. Matthew Walker stated as he reflected on his years in medical school and beyond.

Indeed, the founding leadership of the Student National Medical Association wanted an organization with a solid support system for minority medical students. The idea of such an organization was proposed by several past NMA leaders, including the late Dr. Emory Robinson in his NMA presidential address in 1946, followed by NMA leaders in the 1950s: Dr. Matthew Walker, and Dr. Stillson Smith. Then in 1961, Mrs. Alyce C. Gullattee, a medical student and class president at Howard University College of Medicine also expressed this need.

Social Consciousness in Medical Education



Alyce Gullattee

Gullattee wrote an editorial entitled, “The need for a student auxiliary to the N.M.A. (1).” Gullattee suggested that higher education, and specifically, medical education during the 1960s, did not adequately prepare one for the workforce. This era followed the

1954 *Brown vs. Board of Education* ruling that declared racial segregation of public schools as unconstitutional. The early years of school desegregation did little in the form of African and African-American history in the grade schools and in professional school. Gullattee indicated that while medical school provided trainees with the medical degrees and knowledge of the “art and science of medicine,” physicians of all races were not prepared to address the non-technical aspects of a career in medicine. Specifically, trainees were not trained with the social consciousness or the “knowledge of community relationships” needed for the healthcare workforce, the knowledge needed to

treat minority populations. The Negro physician was more likely to serve the underserved Negro population than physicians of other races. The Negro physician, in particular can not only develop this consciousness for themselves, they could share it with classmates to help all develop into culturally competent physicians (2).

Dr. Matthew Walker supported this idea, believing that since medical institutions tended to be homogenous, or “concentrate people from certain socioeconomic backgrounds and certain educational backgrounds,” he therefore suggested that “the more diversity and perspective we can add to medical school,” the better the medical profession can improve relations between healthcare professionals and between professionals and patients. What results may be “cultural competency.” However, the impact of cultural competency is not easily quantified or taught, but developed through being open-minded about “healthcare decision making and how people live their lives.”

This diversity was also necessary in the increasing number of females of all races entering the field of medicine. By 1945, the last of the all-male schools became co-ed and started admitting females to medical school. By the 1970’s, record numbers of females in all races enrolled in the field of medicine; with women at 9% of total US medical school enrollment in 1969 and at 20% of U.S medical school enrollees in 1976. This effect was especially noticeable in ethnic minority groups. The minority female professional dilemma sprung into view, such that in addition to dealing with the problem of race, there was also the problem of sex, as medicine was



House of Delegates, 1976

still predominantly white and male (3). Therefore, racial equality and to gender equality represented two major objectives to fulfill, considering the overwhelmingly large percentage of white males in medicine.

Communication and Rapport-building with Medical Students

In addition to a raised awareness of social consciousness, there was a need for an “ongoing program” to allow medical students the opportunity to learn about the NMA’s purpose and to develop more solid relationships with NMA members. A simple welcome letter and complimentary issue of the Journal of the NMA was not enough to improve communications and strengthen rapport. NMA leaders and medical students understood the value of “good communication.”

Therefore, the SNMA had a need to meet, serve, and “remove a giant roadblock in the path of general professional and educational development.” There was a need for a forum for the students to express themselves and to “inspire creative thinking.” The Journal of the NMA fulfilled this role, and in addition, the Journal was also to become a “vehicle for the publication of significant student research.” A section for students was added to the Journal.

It was through networking of Howard University students in Washington, DC, and students at Meharry Medical College in Nashville, TN, and the positive impressions of Alyce Gullattee and Lloyd Thompson at the 1963 NMA convention that the Student National Medical Association was born, on October 4, 1964.

Involvement in SNMA Provides Real World Skills

In addition to what the SNMA experience has in supplementing the medical education experience, and opening lines of communication, in 1970-71, Chairperson of the Board of Directors Vernon C. Smith considered that as the national headquarters expanded, SNMA

became characterized as a “social club,” and developed into a corporate structure capable of “administering grants, contracts, projects,” and “coordination of national programs (4).” These opportunities provided students with real-world experiences to supplement the formal education experience.

The Annual Medical Education Conference, for example, continues to be a revered tradition for many. At AMEC, people network and learn many real world skills (3). The anatomy of an AMEC program, according to Vicky Kerr, as of 1972 included:

- Stimulating and educational discussions
- Attend political strategy sessions
- Attend many scientific sessions
- Conduct business in the house of delegates
- Talk to exhibitors and visit the exhibits
- Enjoy entertainment

We can see that as AMEC continues to fulfill these needs, people continue to make it a tradition to attend AMEC each year.

However, there are hard times, as in any organization. In the 1970s, and early 1980s, relations between SNMA and NMA were strained. Students wanted to further assert themselves and forge a new group identity, separate from that of NMA. Some considered even changing the name from SNMA to another name. As a result, SNMA was not faring well financially, and did not have an Annual Medical Education Conference in 1977 as planned in New York City. The majority of the student body however, was not fond of a name change, nor was NMA willing to finance an organization that



Women in Medicine Conference, 1972



1996-1997 Board of Directors



2013-2014 Board of Directors

wanted to change the name to be wholly different from the parent name of the National Medical Association. After the 1977 conference was cancelled, and once there were talks of dissolving the SNMA, the two groups collaborated, learned from the past, and they are now stronger than ever.

One of the positive results in this period was the formation of the Journal of the Student National Medical Association, printed and distributed to the student body. This is after previously only having an “SNMA” section of the Journal of the NMA for years. Now, the student body had even more opportunities to communicate, publish research, and inspire creativity.

These events show that students do engage in real-world skills as they participate in the SNMA.

Milestones

In addition to AMEC, SNMA pipeline programs have met such needs in younger populations. Dr. Walker believes that “pipeline programs are significant” because “the earlier you expose young people to careers in healthcare and science in general the more likely they are to pursue that.” Concerning pipeline programs like MAPs, PMI, an HPREP, he states that these exposures provide “the foundation to really succeed, and they make a difference.” As SNMA celebrates its 50th anniversary, so also does MAPS celebrate its 25th anniversary.

SNMA goes global in the year 2000. SNMA organized its first international medical missions trip to Jamaica.

SNMA began the Physician-Researcher Initiative in 2007 as an effort to increase interest in pursuing careers in academic medicine. Some of the efforts include funding research projects to present at conferences and mentoring with people currently in academic medicine.

The Affordable Care Act was passed in 2010 and is being fully implemented this year. The ACA is a historic effort to increase health care access to Americans. This increased access to care is one way to combat today's health disparities, in that those who have not access to regular, preventative care will now be eligible. This group of previously uninsured Americans includes minorities and other underserved populations, and for this group to have increased access to insurance was a major milestone in addressing healthcare inequalities and changing the delivery of American healthcare.

In this publication, we not only reflect on SNMA's history but also SNMA's future in addressing the issues central to SNMA's mission.

Certainly the organization has become increasingly diverse; therefore SNMA has expanded to reflect the interests of members including research, health disparities, and mentoring programs. Finally, the SNMA continues to be a body of student expression, a professional network, and a diverse body of individuals who strive to achieve the social consciousness needed to carry out the mission of SNMA.

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THE PIPELINE MENTORING INSTITUTE: *Supplying the Next Era of the SNMA*

Robert Treviño, SNMA Pipeline Mentoring Institute Fellow

The 50th Anniversary of the SNMA's Annual Medical Education Conference (AMEC) is a perfect time to reflect on the important impact programs of the organization. The Pipeline Mentoring Institute (PMI) is the formal collection of SNMA programming that addresses the educational pipeline of underserved youth from elementary to college with the ultimate goal of igniting an interest in health and science. The history of PMI traces back to the late 1980s when the program components were first introduced.

- **MAPS**, the Minority Association of Pre-Medical Students, chapters serve as the front line of the future leaders of SNMA as these premedical students are exposed to SNMA and medicine through their strong connections and guidance with their base SNMA chapter. This began as a community service protocol within Region II under the Region II director, Jeffrey Sterling, in 1986. It became nationally recognized by the House of Delegates in 1991 and is still under the direction of the Premedical Board Member.
- **HPREP**, Health Professions Recruitment Exposure Program, is focused on exposing high school students to the field of health professions. Under the right guidance, these students could be led through pipeline programs to become the future of SNMA within the next decade. This protocol was approved in 1990-91 and added as a Board of Directors position with Daniel Laroche as the first chair.
- **YSEP**, Youth Science Enrichment Program, serves to engage elementary and middle school-aged children in science activities and motivate them for the future. This protocol was similarly introduced in 1994-95 and added as a Board of Directors position with June Elock as the first chair.

In 2006, then-President Kameron Matthews organized the pipeline programs under the umbrella of PMI. The hope was to secure funding to better support SNMA chapters for all types of pipeline programs. Through the support of various federal agencies, including the National Health Service Corps and the NIH/ National Library of Medicine, PMI has been able to financially aid chapters with strong pipeline programs through the PMI grant. Additionally, for the past five AMECs in Chicago, Indianapolis, Atlanta, Louisville, and now Washington, DC, PMI has supported local high school students to take part in conference activities and specialized leadership programming through GenNext to better engage them as our future leaders.

While the structure of national leadership overseeing pipeline programs and PMI may change over time, what will remain with the SNMA and its chapters is the strong focus of mentorship and providing guidance to the future leaders coming after us. My position as the PMI Fellow at the national level only exists because of the strong work in pipeline programming being led at the local level by amazing SNMA chapters. Those efforts, whether with second graders or second year college students, will provide us with the next era of the SNMA.

The PMI Fellow would like to give special thanks to Ms. Annette McLane for providing the historical context of PMI programs.



SNMA Stands Strong, Determined to Fulfill its Mission

By Oluwakemi Tomobi, Featuring William E. Hines, MD, MS

Fifty years from now, there will certainly be another celebration of SNMA. Fifty years from now, some members may attribute an interest in medicine to today's television shows, including ABC's Grey's Anatomy or even Dr. McStuffins. What about the television shows of Dr. Marcus Welby, and Dr. Kildare from the 1960s and 1970s? These were some of the most popular medical dramas on ABC. Characters from these shows, along with exposure to friends' illness and death, and a curiosity of the human body all are what sparked an interest in medicine for Dr. William E. Hines. Today, he is head of the Hines Family Care Center, as a private practice family medicine physician. He attended Northwestern University, Wayne State University School of Medicine, family medicine residency at Wayne State. He remains involved with the SNMA today.

He recalls his undergraduate struggles with "weed out courses," courses with enough difficulty to filter out those who are not serious about an area of study and to reveal those who are dedicated to an area of study. Because his high school did not offer these advanced courses, in college he had to put in time to study with tutors and learn the concepts. For example, upon failing his first anatomy exam, Hines went to a professor who tutored him to get his grade up to passing.

He remembers words of discouragement in pursuing medicine; initially, Hines would drop the course to retake it later. At times, he would change professors or counselors. While never giving up his dream to becoming a doctor, Hines developed an alternate career in teaching high school students and later developed a passion for medical education. He looked at the American Association of Medical College's resources on statistics for minorities applying to medical schools. The AAMC resource also had a list of the schools that had a "good track record" with minority students. "I did the search on what the

mean GPA for minority student accepted . . . and the schools recent history of graduation of minority medical students." He attended Wayne State University School of Medicine, in Detroit, Michigan; it was here that he got involved with the SNMA. He took on national leadership in 1984.

"When I came to my first convention in 1981 the big topic of discussion was dissolution of the SNMA due to enormous financial debt." Hines specifically recalled that some of the organizational challenges included "fiscal instability, inability to oversee consultants or staff charged with management of grants, turnover of staff, inability or failure of staff to pay taxes for a number of years on property." Despite these challenges, the SNMA remained focused on the organization's mission and forged ahead. Many members "believed in the mission." As a result, Hines made his leadership positions a greater priority, and believed that others who did the same, together, provided a "support base." Noting the strength from the local chapters, Hines believed that "the volunteer commitment of its members" makes SNMA "truly exceptional."

Concerning the national SNMA regions, Hines felt it a priority to establish regional endowments of \$10,000 for each of the ten regions. His reasoning was that "regions must develop, fundraise and maintain donated funds, and grants, in order to hire staff to carry out their mission in the cities in those regions." One group for which this is essential is the minority premedical student bodies in these regions. Hines deemed it essential that the SNMA regions increase these endowments with fundraising and file necessary documents to develop as a region, and maintain grants, donations etc in order to hire staff to implement their mission. Regional officers must however be trained in their fiduciary responsibility to those grants, and donations. The SNMA regions and chapters are a foundation in essence to achieving the mission of the organization.

“History is planned, made, and then you accomplish it.” Hines suggests that the best efforts to avoid issues with staffing and finances in the future, it will be necessary for the SNMA to obtain further grant funding and staffing to help accomplish its mission. Hines also suggests the following:

- The organization must learn to function within its role as a 501(3)(c) tax-exempt entity, and therefore it is necessary to train its medical student leaders for the roles that they have as fiduciaries.
- It must develop and maintain a roster of its alumni so that an annual fundraising campaign can be done for alumni and others.
- It must also broaden its financial base beyond convention revenues. Fundraising not associated with the convention must be the majority source of the cash flow if it is to stabilize.
- The SNMA must understand its true friends are tempered through time that spans many years. If SNMA is successful in its mission the health profession will be the better for it.

Hines believes that the mission of SNMA is “still relevant, even more so now,” and is glad for the volunteer spirit that keeps SNMA going. While some schools are doing better to increase diversity than others, Hines believes that the programs the SNMA has now or develops in the future will need to encourage and pursue various backgrounds. The young students want to hear from those currently in medical school about current issues and struggles. He credits the Pre-Medical part of the SNMA, MAPS, for increasing minorities and including more from various cultural backgrounds. Still, there are fewer males applying to medical school, and the percentages of minority students has not increased. Funding has diminished or in some cases is absent. Nevertheless, the SNMA has a rich history of overcoming struggles. Also, the continued presence of emeriti, and its Founding members help to remind all members of the past and help them “forge” ahead with a renewed strength.





Diversity 3.0: The Next Frontier in Health Care

Marc A. Nivet, Ed.D., Chief Diversity
Officer, Association of
American Medical Colleges

I remember attending my first SNMA conference in 1995 as a first-time medical school administrator. It was impressive and gratifying to see the enthusiasm and leadership qualities among the hundreds of African-American medical students there.

Today, as chief diversity officer for the AAMC (Association of American Medical Colleges), I am impressed at an even deeper level when I meet students at SNMA meetings. I see their passion and dedication in reaching back to support the pipeline of future physicians from their communities as they climb in their own careers. They have joined the front line to diversify the physician workforce—a critical piece in improving the health of all Americans.

With health care reform creating a more culturally and ethnically diverse patient base, the stakes are higher and we cannot sit back. To understand where our medical schools and teaching hospitals need to go to meet this challenge, I like to use the “diversity operating system” (DOS) that IBM put into place for its workforce.¹ This framework defines three diversity phases that have evolved since SNMA was founded 50 years ago: DOS 1.0, 2.0, and 3.0.²

In the 1960s, the civil rights movement helped remove basic barriers to health care access and equality stemming from segregation and racism. Medical schools typically added a minority affairs office to promote recruitment and training of minority students. Diversity efforts were compartmentalized, though, and success was measured only in terms of minority student head counts. This was **DOS 1.0**. Minority affairs offices functioned in isolation—apart from the education, research, and clinical care arms of their institutions. Plus, there often was an underlying current

within the larger organization that diversity came at a cost to excellence.

In the early 1990s, a deeper, more nuanced view of the role of diversity in academic medicine emerged. This was marked by the realization that excellence and diversity did not have to compete. **DOS 2.0** built on the compositional diversity started in DOS 1.0 and went further by adding multicultural subjects to the curriculum and expanding diversity programs. Medical schools introduced the notion of “cultural competence,” and there was growing recognition that a diverse faculty benefitted the organization. But minority affairs offices remained structurally detached and unaligned with their institution’s central mission.

Enter, **DOS 3.0**. Studies now suggest that patients prefer physicians who are culturally and linguistically compatible.³ What’s more, they achieve better health outcomes when this is the case.⁴ DOS 3.0 looks at diversity through this wider lens—that medical schools and teaching hospitals perform at a higher level by establishing a culture of inclusion. Offices focused on diversity and inclusion remain critical in DOS 3.0, but now the paradigm embraces the power of diversity to boost innovation, produce culturally competent doctors, attract physicians choosing to work in underserved areas, and improve health outcomes.

Today, as SNMA celebrates its 50th year, diversity is a strategic imperative for all forward-thinking health care institutions.

Fulfilling the Promise of DOS 3.0

The AAMC, like SNMA, is committed to moving diversity out of the periphery and into the core missions of academic medical institutions. We have adopted the 3.0 paradigm as a guide in this effort. Perhaps you already have benefitted from one of these AAMC initiatives:

- **The Holistic Review Project**

Established in 2007, holistic review is an individualized approach to assessing medical school applicants. Beyond test scores and grades, balanced consideration is given to an applicant’s experiences, personal attributes, and potential contribution as a culturally competent physician. The AAMC has held workshops and webinars and offers resources to medical schools on how to incorporate holistic review into the admissions process. Our Medical Minority Applicant Registry (Med-MAR) puts medical schools seeking to diversify their student body in direct touch with prospective students.

- **Summer Medical and Dental Education Program (SMDEP) (See photo)**

The SMDEP, celebrating its 25th anniversary this year, may be the AAMC's most important program to keep the pipeline of minorities in medicine flowing. This free six-week summer program, funded by the Robert Wood Johnson Foundation, is offered to outstanding college sophomores and juniors at 12 academic medical centers. The course includes tips about the admissions process and study skills, along with science and math instruction and community health clinical experience with mentors. Between 1989 and January 2013, 5,709 SMDEP participants earned medical degrees and thousands more entered careers in other health care professions.

- **Cultural Competency Education and Training**

The AAMC has been a leader in developing cultural competency standards and promoting their use at medical schools and teaching hospitals nationwide. The association created the Tool for Assessing Cultural Competence Training (TACCT) to help medical schools examine their curriculum and identify any gaps in this area. The AAMC also offers a variety of resources to train faculty how to teach respect and culturally sensitive communications in addition to a working knowledge of social and cultural factors affecting patients.

The AAMC has been chronicling the progress of diversity in academic medicine for decades. Our latest report, *Diversity in Medical Education: Facts and Figures 2012*, shows that the number of nonwhite students admitted to U.S. medical schools since 1980 has almost tripled.⁵ There are still disparities we need to address, however. While Asian and Hispanic/Latino students have made tremendous inroads into medical school, the black and African-American community did not make the same significant gains.

This critical juncture in health care requires that we accelerate our efforts to modify curriculums and redouble partnerships with organizations that share our agenda. The AAMC, SNMA, and like-minded groups must find new ways to support black students who are in underperforming schools. We also need to create more

inclusive environments in which diverse faculty and students thrive so they are no longer underrepresented.

Through the DOS 3.0 model of inclusive excellence, diversity can be a solution to some important issues facing our nation. This is the next frontier of health care—ensuring that tomorrow's physicians are culturally competent and eradicating health care disparities. When fully realized, DOS 3.0 will enhance the experience of all medical students, faculty, and, most importantly, patients.

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Here, participants in the AAMC's 2013 Summer Medical and Dental Education Program get hands-on experience at the University of Texas Health Science Center at Houston.

A Year to Remember:

2001 – Commitment Despite Difficult Times in a National Emergency

By Oluwakemi Tomobi, Featuring Francine Garrett-Bakelman, MD, PhD

Injury after injury would not take her down. This was a lesson that Dr. Francine Garrett-Bakelman realized in her early years of gymnastics. She would soon come to realize that the same lessons rang true for a career in medicine and her time in SNMA leadership.



Left: 2001-2002 Board of Directors, Dr. Garrett-Bakelman, Chair of the Board of Directors, seventh person from the right, front row.; Above: Lighting Candle in honor of September 11 at Annual Medical Education Conference, 2002, in Houston, Texas.

Dr. Bakelman is currently a physician-scientist at Weill Cornell Medical College (WCMC). She serves as an attending physician on the inpatient Leukemia Service and an Instructor in Medicine, conducting research on acute myeloid leukemia (AML) in high-risk populations. Dr. Bakelman developed an interest in medicine at a very young age through her contacts with physicians, and her interest in health disparities lead her to the Student National Medical Association, Inc. Her research interests emanated from research opportunities in organic chemistry and cell biology during her undergraduate education. She attended Albert Einstein College of Medicine of Yeshiva University where she completed a combined MD and PhD program in 2005. She then matched at New York Presbyterian Hospital – WCMC – where she completed Residency training in Internal Medicine, a post-doctoral fellowship and fellowship training in Hematology and Medical Oncology. She joined the faculty at WCMC in 2012.

Dr. Bakelman, or Fran as many know her as, has enjoyed serving in leadership positions and mentoring students from all levels of education. She has held

several leadership roles in the SNMA; from chapter vice president and president, to Region 9 Director, and then as Chairperson of the Board of Directors. One of her hardest decisions as chair occurred in September of 2001, when the New York World Trade Center and the DC Pentagon were targeted by terrorist attacks. A Board of Directors meeting was scheduled 2 weeks after September 11, 2001, in Detroit, Michigan; however, the airports were closed for 10 days, people were hesitant to travel, and it was a challenging time for the US as we all recall. However, Chairperson Bakelman and President Johnson decided to keep the board meeting as scheduled and gave the national leaders the freedom of choice to come. “It was inspiring when over half of the board members decided to attend,” Bakelman remarked. Other individuals in absence participated via conference call. “This showing and participation spoke of the commitment that the board had during such a difficult time.” During the 2002 AMEC there was a special candlelight service in remembrance of September 11, 2001.

Over the years, Fran mentored many college and medical students and continues to do so now. She has



encouraged young and upcoming leaders to take active roles and as Region IX Director, she worked with her Associate Regional Director to assist MAPS members in organizing a premedical regional conference in order to address the needs of an expanding student body in the many schools in NY and NJ. After her activities with the SNMA in medical school, Bakelman joined the ranks of NMA membership as she started residency. Transition to NMA was smooth, as she had leadership positions in the SNMA and was already in touch with NMA members and had attended NMA conferences.

In all of her leadership positions, she values the importance of diversity. However, it is her actual encounters with her patients that lead her to believe that diversity is imperative in medicine. While still junior in her career, at times, patients feel more comfortable coming to her. In terms of sensitivity to culture and trust in the medical system, URM physicians can definitely make a contribution in that way. It's not necessarily quantifiable, but qualitatively the contribution is very important. These patients will go home, speak with their families and encourage them to receive the care they need as well.

Nevertheless, there are challenging times. Bakelman recalls examples of patients who did not realize she was their physician, despite her leading rounds. After twenty years of college and professional education and training to become a faculty member at an academic institution, these situations can be initially disheartening, however, are quickly resolved. It is difficult to assess whether this is due to cultural background or a female professional, but regardless, these can be challenging moments. However, these are also opportunities to deliver medical care that can make a difference in a patient's life at a difficult time and while doing so, she hopes, the next time they have a female doctor or doctor of color, they will not have a preconceived notion of which role that individual plays. Every physician in training will have his or her own challenges and will find their own unique solutions and insights.

While SNMA was assembled to address the needs of African Americans, the organization has diversified since then. The question then becomes how to encourage people of various backgrounds to be part of SNMA? Bakelman suggests the following:

- Encourage people to focus on medical problems that affect all disadvantaged people, such as

obesity. Even though obesity prevalence is high in the URM population, it is something people from all backgrounds can come together to support, since it is a national problem.

- Encourage all qualified citizens to take advantage of the Affordable Care Act.
- Definitely in this day and age, continue to encourage high school students to consider the health professions. There is still a need to target URM, especially men. URM women outnumber men in the medical profession and this is an area where organizations such as the SNMA and NMA can make an impact. At the NMA level, we should continue to work together to support individuals as they climb the academic ranks. Joining the faculty at an academic institution introduces a new chapter in one's professional book. There are many possible requirements have the ability to make significant impacts on the education system in medicine and where research efforts are focused, URM's must become leaders. These lessons and guidance are invaluable and should be pursued from a very early stage.

Her vision for the next era of SNMA reflects her dedication to health disparities. In this information age, people have more and more access to information independently. However, Dr. Bakelman believes that learning cannot replace networking through AMEC and other conferences. It cannot replace interactions between people during their medical education. She compares the guidance and networking needed for medical students to that of role modeling that kindergarteners need, affirming that the internet form of learning is not effective. As one becomes an adult learner, there is also a need for meaningful learning experiences, professional relationships, and connections, and these can be strengthened by networking at professional conferences. As the URM numbers in the physician workforce increase at the 50 year junction, there is a continued need to ensure this pipeline continues, to encourage these graduates to "pursue continued advancements in their careers and to continue to focus on health and other social challenges that many members of our nation face." It could be a variety of things, depending on the needs of the nation, including: "Helping people get access to health insurance plans, continuing health fairs, lobbying for government programs that support research impacting URM's and other underserved individuals, and more."

By Oluwakemi Tomobi, Featuring Kameron Matthews, MD, JD, SNMA Strategic Planning Council, Director, Tour for Diversity in Medicine

SNMA has social benefits for its members and SNMA's mission meets the needs of the healthcare workforce

“I learned about SNMA on the medical school interview trail” and was told “the way to get to know the black students at the school was through the SNMA chapter.” Furthermore, “now coming through SNMA, people that I’ve worked with are all my best friends. So my support system has definitely expanded because of the personal relationships I developed while working with SNMA, and I think that’s something a lot of students need to keep in mind.”

Dr. Matthews had an early interest in medicine from a policy and advocacy focus, instead of a family focus. Her father was a family physician, and her exposure to an internship on Capitol Hill, as well as her path to law school further intensified her interest in medicine from a policy perspective. In medical school at the Johns Hopkins University, she joined SNMA “to get involved in the leadership for medical school.” Matthews was a first year representative, then became chapter president in her second year, national region 6 director in her third year, and SNMA national president in her law school years. Since then, she has remained with the strategic planning council as she pursued a family medicine residency and currently practices medicine in Chicago, Illinois. She remarks that she “learned a lot in clinical training, learned a lot in law school” yet credits a lot of her “real world training” to her experience in the SNMA.

One of the SNMA traditions that she continues to this day is the Annual Medical Education Conference. She recalls her first AMEC experience. “From the very first conference in 2001, without a doubt” she continues to make it to every conference. “To see so many people like myself – that was enriching.” Therefore, she has “not missed a single one since that time.”

AMEC has further exposed her to a diverse group that she would not have otherwise experienced in medical school. She values diversity in medicine because she believes that for “equity’s sake,” that minority physicians should represent the “same proportion of people.” Kameron delves deeper to suggest that because minority physicians are more likely to treat minority patients, lower income patients, and “sicker patients with chronic illness in underserved areas,” the need for minority physicians and a more diverse physician workforce is paramount.

To increase diversity in the healthcare workforce, Kameron believes that there are “different levels of programming” needed to address unique needs of diverse populations. One need is that of education, because some students may come from educational systems that may not prepare them for the colleges that will get them into the medical schools. For example, she credits SNMA pipeline programs such as HPREP and the Minority Association of Pre-Health Students because everyone gets far with some mentorship, exposure and other assistance, and the earlier the exposure, the better. She also credits the AAMC’s Student Medical and Dental Education Program because of its structured, longitudinal exposure



over several weeks that exposes participants to the foundations needed in medical school. Finally, a program such as “Tour for Diversity in Medicine” motivates and exposes students to medicine to help them believe that they can pursue a career in medicine. She also believes that financial needs may keep minorities out of medicine, and programs to address financial needs may further help with recruitment.

One of SNMA's strengths is that it continues to reflect the “diversity of interests of our members.” For example, SNMA members have expressed an increased interest in research and in academic medicine; therefore the Physician-Researcher initiative was created in 2007. In the 1960s and 1970s, in the early years of SNMA, leaders suggested that SNMA develop an organization that does everything and has everything for its members, to reflect the needs of student members at the time. However, to reflect the needs of current membership, as well as today's healthcare needs, Dr. Matthews believes that in 2014, SNMA does not “need to be that organization that does everything for all students.” There is no need for SNMA to spread itself thin, but to use its resources effectively. The climate of medical education has changed significantly since 1964, such that there are other organizations that are available now, so it would be great if SNMA “partnered better” and remain mission-centered, and focused more on SNMA-specific programming.

She also believes that advocacy would be a great role for SNMA moving forward.

Dr. Matthews has advice for people at every level of SNMA involvement. She advises premeds to “avoid the burn,” to achieve balance, and enjoy oneself in the process, and to “know that the field you want to dedicate yourself to” is “worth it.” To medical students, she advises that “time management” is key, and to the alumni, “remember what SNMA has provided you in terms of support, and “some may not have had as strong a relationship on campus,” while some may have “mentors to look up to or to learn from” and finally, to “not give up on the ones that come behind us.”



Has the Dream Been Fulfilled in Camden, New Jersey?

Imoh Ikpot, SNMA Chapter Secretary, and Sandra Peña, SNMA Chapter Social Chair:
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Fifty years after the Birmingham Civil Rights Movement, the legacy of Dr. Martin Luther King, Jr. has stood the test of time. Through his life and teachings, he consistently reminded us of the values of courage, justice and humility. One teaching in particular holds special meaning for those of us in the medical profession. He philosophized, "Of all the forms of inequality, injustice in health care is the most shocking and inhumane." He was not alone. Dr. William Montague Cobb, A.B., M.D., Ph.D., a National Medical Association member, shared a similar zeal for change. As a result, amidst all the political and social changes of the time, Student National Medical Association (SNMA) was created and marks its 50th anniversary. Therefore, as we celebrate the birth of our organization we must also reflect on Dr. King's words to ensure that we do not fall into the trap of complacency.

As minority medical students living and training in the disadvantaged city of Camden, New Jersey, Dr. King's words have never rung any truer for us. After once being a thriving, industrial city, Camden has fallen on hard times and the city's inhabitants were left to bear the brunt of this economic downturn, particularly in terms of health outcomes. Despite being located within 10 minutes from Philadelphia, which houses the second largest concentration of medical schools (after New York City), Camden is designated as health professional shortage area. The aforementioned schools are affiliated with world-renowned hospitals and are in close proximity to Camden, yet there is little to no interaction with Camden residents.

Like many disadvantaged urban areas, Camden has increased rates of common chronic conditions. The first step in the management of many of these diseases is lifestyle modification, however proper diet and exercise is rarely an option for Camden residents. For a city with nearly 80,000 inhabitants, there is no grocery store located within the city's limits. Instead, citizens must go to local *bodegas* to obtain their groceries. This harsh reality makes it all the more challenging to obtain healthy meal options. Furthermore, the frequent crime, prostitution and drug deals which occur in plain sight, renders the simple activity of walking as an unfeasible form of exercise. These limitations, compounded with low socioeconomic status and equally low education levels contribute to the health disparities that Dr. King warned against.

In 2012, members of the inaugural class of Cooper Medical School of Rowan University (CMSRU) founded

Camden's first SNMA chapter. Eager to get involved, we utilized the SNMA National Protocols to organize special projects to address the glaring health disparities in our community. In order to see changes in the areas most affecting Camden's population, we have focused our efforts to target obesity, smoking, and HIV/AIDS.

To address obesity, we have partnered with local community members to revitalize and maintain a community garden. This project has allowed us to be a part of a longitudinal weekly project to address the fruit and vegetable shortage in Camden. Grateful for our services, residents have taken initiative and are also becoming involved.

In addition, we have identified the high occurrence of smoking as a targetable risk factor. As we learned about the detrimental effect of smoking for individuals and their families, we developed our Smoking Cessation Campaign which we implemented in our student-run clinic. We have shared these resources with our classmates and trained each of them on how to address smoking with their patients.

Lastly, we organized a World AIDS day celebration which highlighted the Shared Responsibility tradition. As part of the celebration, we sought to target our clinic patients and encourage disease awareness. As a result, we sponsored HIV counselors to counsel and provide rapid HIV testing to our patients. This program served a dual purpose by raising awareness and screening those at risk.

Dr. King's words provide a historical context for health accessibility and advocacy, but it is up to us and future generations of physicians to ensure that his dream becomes a reality. At CMSRU, our SNMA chapter has worked diligently to make strides in helping our community. While there is still more work to do, we are hopeful that our efforts will make a difference. Furthermore, as future physicians, we must always be mindful of the timeless teachings of Dr. King and continue to aid those who need it most.



The Ones We've Been Waiting For

Kristin Gates, MD

PGY-3

Middlesex Hospital, Family Medicine Residency Program

Throughout time, men have erected monuments—immovable structures built as objects of tangible praise. Monuments implore those who live in the present to honor what has passed. So at the dawn of 2014, as the Student National Medical Association (SNMA) embarks on its 50th year, there is pause for reflection as we consider, “What shall we erect in this moment?” Yet in all of our looking back, I cannot help but feel the weight of those who pressed forward, urging, as if to remind us that movements, unlike monuments, were never destined to be things of history. There is a torch to be passed, a baton to be carried, for the future is waiting on us.

In 1964, 10 years after *Brown v. Board of Education* commenced the battle on inequity in the classroom, the National Medical Association (NMA) addressed educational disparity of another sort. In his inaugural address as the 64th president of the NMA, Dr. William Montague Cobb made this statement: “The openings for Negro students in medical schools significantly exceed the number of qualified applicants to fill them. The National Medical Association has a definite duty to do all in its power to supply the deficit [1].” This challenge set the stage for the Student National Medical Association’s origin. In 2014, as the Affordable Care Act becomes a legislative reality, our country steps into a new era in healthcare. As paths to access widen, questions about the strength of our workforce to meet the medical demand of the underserved abound. Laws cannot wear white coats. They have no stethoscopes to auscultate a heartbeat, no prescriptions to treat illness, and no scalpels to dissect disease. *We must do it all*; for it has always been our duty to do all in our power to supply the deficit.

As a resident, I stand in that period of transition from student to attending and I can’t help but wonder: Can I make an impact on the chasm of disparity that lies before me? Do I know enough to reverse the statistics? Do I have the courage to use my position as platform in order to give voice to the injustice I see? I take comfort in the fact that a movement is never the story of individual effort, but the efforts of a people propelled by a common goal.

For 50 years, SNMA has been a keeper of the flame. Let us not fail to continue to carry this torch. The present and pending challenges of caring for the underserved are undoubtedly daunting, but history reminds us that difficulty has never been a deterrent to our movement. We must not stop now, for today’s challenges have chosen us. This is our chance. In 1964, those before us did their part to enable the progress of our generation. Now, let us do the same. Young physicians of 2064 are waiting on us.

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NEW VISIONS FOR ELIMINATING HEALTH DISPARITIES: A Call for Critical Race Theory in Medical Education

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Despite ballooning increases in annual health spending, advances in medical science, and increased attention towards the elimination of racial and ethnic health disparities over the past decade, many troubling inequities in health outcomes have persisted (RWJF, 8). Medical schools have attempted to address racial/ethnic health disparities through curricular changes to teach “cultural competence,” which has been shown to improve medical students’ attitudes towards caring for diverse populations over the short term, as well as increased patient satisfaction and perceived quality of care (Brach and Fraser, 2000; Betancourt et al., 2013; Beach et al., 2005; Paez et al., 2009).

However, it is unclear whether current interventions actually translate into improved equity in health care delivery and/or enduring attitudinal changes over time for medical professionals. For example, five years after the Liaison Committee on Medical Education (LCME) changed its guidelines on cultural competency accreditation standards for medical schools, first-year residents who had just graduated were reporting that they didn’t feel prepared to care for diverse populations (Weissman et al., 2005). Furthermore, it’s unknown whether these clinical-level changes, even if effective, contribute to broader-scale health disparities reduction.

Critical Race Theory (CRT) as a compelling alternative framework for teaching medical students about health disparities that may help address gaps in current methods. CRT was first developed in the mid-1970s as an offshoot of Critical Legal Studies to respond to the persistence of racial inequity despite breakthrough legal advances such as *Brown v. Board of Education* (Crenshaw et al. 1995; Delgado & Stefanic, 2001). The framework emphasizes the “historical, contextual, political, or other social considerations” that define and construct race, as well as the dynamic ways racism is perpetuated through institutions and policies (Ford & Airhihenbuwa, 2010, p. S31; Delgado & Stefanic, 2001).

This initiative was started at Harvard Medical School in the fall of 2010 with the goal of making changes to the medical school and residency curriculum. With SNMA chapter co-sponsorship, students have already hosted class-wide town hall forums, and have several ideas in place, such as with getting a third year intersession module as well as a residency training module.

CRT analyses in education have focused primarily on five tenets (Solorzano, 1998). When applied to medical education, these tenets suggest that a CRT-informed medical education would:

1. “Center” race conceptually as a key determinant for understanding health disparities.
2. Challenge the dominant biomedical model as a “master narrative” in medical education that marginalizes the impact of social, political, and historical processes on health.
3. Emphasize the importance of medical students and health providers engaging in social justice work to combat health disparities.
4. Privilege the voices of people of color and value their knowledge of racism, gained through their experiences.
5. Incorporate multidisciplinary perspectives from histories of science, sociology, anthropology, and public health.

Although few medical schools incorporate a comprehensive, CRT-informed framework throughout their curriculum, there are some promising examples taking place. In the U.S., physicians and social scientists have teamed together to promote the incorporation of “structural competency” as a core competency in medical education, proposing a five-step conceptual model that emphasizes an understanding how historical, social, and political forces, including racism and oppression, contribute to health (Metzl, 2012; *Metzl and Hansen, forthcoming*). Initial integration of these types of standards is occurring at the residency level in the form of systems-based practices (Englander et al., 2013, p.1092). At Harvard Medical School, students formed the Race in the Curriculum Working Group and, with the support of our school’s SNMA chapter, worked with faculty



to integrate a deeper analysis of race as a social determinant into the first-year curriculum.

Even as these interdisciplinary initiatives move forward within medical schools, CRT will remain useful as a unique methodology and framework for grounding health disparities and their manifestations within the context of race, racism, and power. In fact, Florida Atlantic University already lists CRT as one of 12 topics included in the social science portion of their integrated medical sciences curriculum (FAU, 2013). Other schools could benefit from similar moves to explicitly incorporate CRT.

To be clear, the argument for CRT isn't meant to discount the valiant efforts of physicians, researchers, and patients pushing for cultural competency to be included in medical curricula. In fact, the amount of change that has occurred just in the past decade in this arena is quite impressive. Nevertheless, it does seem that a CRT framework could help strengthen certain aspects of the cultural competency frameworks that are currently being deployed.

The incorporation of CRT into medical curricula will require action by various stakeholders. More specifically, the following recommendations should be considered:

1. Medical school faculty and administrators should incorporate a CRT perspective as one of the components of the LCME guideline for "socioeconomic subjects."
2. LCME requirements should be strengthened to include specific guidelines requiring a variety of socioeconomic subjects (i.e. critical understanding of race, ecosocial model, etc.)
3. Medical school administrators should allocate more resources and faculty time for CRT programming and teacher training.
4. Medical students should agitate and push for a health disparities curriculum that incorporates critical perspectives to ensure they get a full and comprehensive understanding of the issue.

Having a more robust understanding of the determinants of health disparities is essential not only because it helps develop our understanding of those disparities and outline pathways to action, but because it actually helps us to develop a more rigorous analysis of the production and healing of disease in general. CRT in medical education offers a dynamic way to begin to develop these more nuanced frameworks within medical education. It is clear that addressing health disparities

requires innovation, and the adoption of new and compelling models for change. It is time that medical schools and leaders in the field step up to the task.

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Mother of SNMA

The mother of a dream!
The guardian of our fragile beginnings!
The spark of our conception!
The sunshine of our soul!
You recognized an idea and brought it to reality

In awakening the medical community to the needs of its children
You bravely laid the foundation of SNMA
By gathering the fruits of a labored harvest,
You nurtured our hopes and crystallized our direction.

Like the narcissistic child who only thinks of his basic needs,
We were lost in a room of mirrors and frightened by the reflection,
You sensitized our hearts and brought order to a confused mind.

You taught us the beauty of our normality
You sought not so much to change as to awaken,
Yet you asked so little and gave so much.

With a voice as persistent as a beating heart,
And a mind quick to perceive and able to defend,
You have been an articulate spokesman in our call for unity.

Like a child who wants to give the world but can not,
We humbly offer our love and respect,
Knowing your gift was priceless.

**Poem written in honor of Dr. Alyce Gullattee
Presented by Howard Chapter of SNMA, 1970.*