

ONWARD AND UPWARD

CELEBRATING BLACK
UROLOGISTS IN AMERICA



**Onward and Upward:
Celebrating Black Urologists
in America**

the
William P. Didusch
CENTER FOR
Urologic History
American Urological Association

2024

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1000 Corporate Blvd.

Linthicum, MD

21090

www.AUAnet.org

Published by the American Urological Association.

Printed in the United States of America.

ISBN - 979-8-218-38213-1

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**“If Negroes qualify themselves
to practice medicine,
the accident of their color
ought not be a perpetual
barrier in their way.”**

*New York Times, May 7, 1870
(in observation of the American Medical Association
exclusion of Black physicians from being delegates)*

To see more from the 2024 exhibit, *Onward & Upward: Celebrating Black Urologists in America* visit www.UrologicHistory.Museum/OnwardandUpward

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Preface

The Legacy of Black Urologists in America is a vital, pivotal History. It is critical to know the past, to be aware and knowledgeable of the present, and to prepare, to assist, and to lead in the development of the future. We must acknowledge the past in order to improve the future. The history of urology reflects the history of medicine and, in many ways, the history of the United States, where we still confront racism and its legacy of dehumanization, invisibility, and silencing of Black Americans. The American Urological Association now has its own committee on Diversity, Equity, and Inclusion. Likewise, this publication is necessary to illustrate the importance of DEI in the education of future urologists, our health care environment, and the quality of our clinical care.

The American poet Pat Parker (1944-1989) described the challenge of learning from the past while moving forward with civility and respect. Her 1978 work *Movement in Black* includes the poem, "For the White Person Who Wants to Know How to Be My Friend." She begins, "The first thing you do is to forget that I'm Black. Second, you must never forget that I'm Black" (1). Parker's art urges us to see one another as human beings of complexity, individuality, and importance. Our heritage matters. Our knowledge matters. Our ethics matter. Our legacy as a profession that aims to heal, to prevent harm, and to strengthen humanity matters.

The Black experience in medicine and urology has been and still is marked by major challenges, especially in terms of representation. There has been no statistically significant increase in the representation of black physicians in the United States since 1900 (2). Accounting for changes in the US population, Black Americans only made up little more than 2% of all American physicians after 1965. In the United States there are approximately 4.21 urologists per 100,000 population. If a Black person wishes to be cared for by a urologist of the same racial background, it is a challenge, as there is only 1 Black urologist for every 140,000 Black Americans. According to the 2022 AUA Census, of the 13,976 practicing urologists in the United States, only an estimated 293 (2.2%) are Black.

Black history is American history. Unlike immigrants who sought refuge in the haven of America, most Africans' journey to the United States was one of captivity, abject cruelty, dehumanization and enslavement. The 1863 abolition of slavery in the states of rebellion, the end of the American Civil War, and Juneteenth in 1865 began the long struggle for dignity and freedom, held in check by entrenched racism and economic disadvantages. Black Americans continued to experience discrimination in education by the doctrine of 'Separate but Equal' far into the 20th century. This institutionalized racism was true in medical education as well. Medical education in colonial America was largely a crude, apprenticeship culture among white men based on one's literacy of European texts and archaic principles of Graeco-Roman and Medieval medicine (3,4). Abraham Flexner's 1910 report on the state of American medical education resulted in the elimination of many poorly run and badly taught schools but

was disproportionately critical of those focused on the education of Black physicians. The Report led to the closure of almost all Black medical schools and, by 1967, only two, Howard University (Washington DC) and Meharry Medical College (Nashville, TN) supplied 83% of all US Black physicians (5). Over the century, American organized medicine did little to correct the racial injustices of patient care. The American Medical Association (AMA) refused entry to physicians of color leading to the formation of the National Medical Association in 1895. It was only in 2008 when the AMA formally apologized for previous generations' discriminatory policies (6).

One of the major advances in achieving equity for patients and their physicians was the passing of Medicare in 1966. Very few, and uncredited, federal bureaucrats worked tirelessly in early 1966 to transform some of the most racially segregated and economically disadvantaged hospitals in the country into some of the most equitable in as little as four months (7). Federal mandates began modest improvements in Black representation in medical schools as well.

Still, the balancing act of battling for truth and humanity continues, especially in modern medical research. It is now well known that in the early 20th century, the United States government conducted medical research in the Tuskegee study on Black males without patient consent and may have barred some men with early syphilis from receiving a curative dose of penicillin (8).

In 2010, Rebecca Skloot (1972-) investigated and exposed the legacy of racism in medicine embedded in the story of the remarkable Ms. Henrietta Lacks, an African-American woman battling cervical cancer. In Skloot's searing book *The Immortal Life of Henrietta Lacks*, she reveals how modern medicine owes its vitality to this quiet woman of dignity (9). Without Ms. Lacks' knowledge and without her permission, Lacks' cells were harvested from a resected tumor, and those same cells became one of modern medicine's hallmarks: the first "immortal" human cells grown in culture. To generations of scientists, Ms. Lacks was reduced to an acronym: HeLa. Even as her family members were never informed and never gave their consent, her extraordinary cells were bought and sold in a multimillion-dollar medical industry. Ms. Lacks died at the age of 31 in 1951 but her cells have gone on to inspire scientific breakthroughs: HeLa cells were vital to the development of the polio vaccine, helped to reveal secrets of cancer, viruses, and the atomic bomb's effects. Her cells helped lead to in-vitro fertilization, cloning, and gene mapping. Ironically, her family could not afford to pay for health care or health insurance. Skloot's research revealed how the story of the Lacks family is inextricably interwoven with our country's disregard of the contributions of African Americans. The story of the Lacks family is vitally intertwined with the birth of bioethics as well. *The Immortal Life of Henrietta Lacks* explores the powerful impact of scientific discovery, yet it also emphasizes the importance of confronting racism in medicine.

A long history of questionable ethics by historical physicians, like Civil War era surgeon JM Sims (10), the Tuskegee study, the HeLa cell controversy, and less famous but equally important chapters have generated a certain mistrust of established Medicine

by Black Americans and may have hindered important attempts to improve health care access to the urban, underprivileged (11).

This book accompanies the History Exhibit at the Annual Meeting of the American Urological Association in San Antonio, Texas, May 3 - 5, 2024. The Exhibit is curated by Arthur 'Bud' Burnett, MD, Professor of Urology, Johns Hopkins University, and his team of Pamela Coleman, MD (Associate Professor of Urology, Howard University), Tracy Downs, MD (Professor of Urology, University of Virginia), Linda McIntyre, MD (MyMichigan Health), and Bart Ragon, EdD, MLIS (University of Virginia).



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Foreword

The objective of this volume, a companion to the History Exhibit of the 2024 AUA Annual Meeting, is to celebrate Black urologists in the history of urology in America. It provides an account of the historical events and experiences of a racial group in the field of urology, with the acknowledgment that this group has been marginally represented historically in this field. However, Black Americans have had a definite impact in urology, contributing broadly and deeply — and commonly in the face of societal and professional challenges. The richness of the history of urology in America truly reflects the influences and contributions of all its representatives, of diverse origins, backgrounds and perspectives. This richness includes Black urologists. The accomplishments of Black urologists merit recognition, and Black urologists deserve a much-earned place in the institutional ring of honor.

The production of *Onward and Upward: Celebrating Black Urologists in America* is timely. This volume comes at a time of increasing race consciousness in this country amid troubling racial tensions and concerns of inequities among various social and economic sectors that affect African Americans and other minorities as well. The inequities surrounding health care particularly are germane to the field of urology. As we purposefully move forward as a society in America to address inequities, a coincident purpose is to know the value of Black Americans and all racial and ethnic groups as urologists and foster their entry into the urology health professions workforce. As colleagues within the urological field and within our professional organizations, we must realize this purpose and recognize that it is appropriate, important and ultimately vital to each of our well-beings. It is hoped that readers appreciate this presentation as offering insights and revelations that will reinforce this collective purpose.

This volume provides an enduring literary reference source corresponding with the presentation of the History Exhibit, which will come and go. Similar to the structure of the History Exhibit, the volume presents the story of Black urologists in America as chapters framed in eras of Past, Present and Future. “Legacy” topics of the Past include structural racism in urology, systemic effects of historical organized medicine, early Black pioneers in urology, and the origins of the R. Frank Jones Urological Society (the Black urologists’ urological society, named after Richard Francis Jones, MD, who was the first board-certified Black urologist in America in 1936). “Journey” topics of the Present include non-traditional urology leadership roles, urologic innovators, academicians in urology, Black women in urology, and health determinants affecting the Black urologic community. “Destiny” topics of the Future include frameworks for mentorship and leadership in urology, proposals for a diversity, equity and inclusion urologic curriculum, and actionable interventions to improve the Black urology workforce and address urologic healthcare disparities.

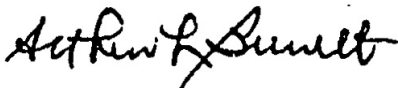
The strength of this volume reflects the multiple contributors, whose efforts to make these contributions are deeply appreciated. These were select individuals who graciously accepted their assignments and brought perspectives from diverse backgrounds and ranges of knowledge, which enhanced the quality and excellence of

this work product. Diversity of perspective exists among Black individuals, actually bringing a richness to understanding and telling the Black experience. Despite the commonality of some life experiences as a racial group, this observation informs the diversity that exists even within the group.

The Preface to this volume, as penned by the AUA Historian Ron Rabinowitz, MD and the AUA Historian-Elect John Phillips, MD, presents a wonderful opening for this text. It brings further perspective to the trials and tribulations of Black urologists in America, that in a sense exemplifies the story of Black men and women in America. The Black urologist story is a story of the Black American, who has faced and continues to face challenges by virtue of skin color. Under such circumstances, achievements by Black Americans in all sectors of professional life, urology and across all fields of endeavor, are noteworthy.

This volume closes with an invaluable contribution, a literary presentation by Dr. R. Frank Jones telling his exemplary life story in his own words. This testimonial remains as “interesting and poignant” as when it was introduced at the Forum on the History of Urology at the AUA national meeting on May 22, 1978, just one year before Dr. Jones’ death. It is included here, aptly closing this text. As such, it leaves the reader with a lasting message of the very real life challenges faced by Black urologists who, despite adversity, resolutely strive onward and upward. The life and legacy of Dr. Jones will become permanently exhibited at AUA Headquarters following this exhibition at the 2024 AUA Annual meeting.

I wish to acknowledge other individuals whose tireless efforts and support also account for the production of this work. I am indebted to the curator team, comprised of Pamela Coleman, MD, Associate Professor of Urology, Howard University, Tracy Downs, MD, Professor of Urology, University of Virginia, Linda McIntyre, MD, MyMichigan Health, and Bart Ragon, EdD, MLIS, Librarian, University of Virginia. I am also appreciative of the team at the William P. Didusch Center for Urologic History, Tupper Stevens, AUA Archivist, Jennifer Kennedy, AUA Creative Manager, Hannah Konetzki, AUA Graphics Designer, and Courtney Shelsby, Museum Marketing Coordinator. It is entirely by way of this teamwork that I am humbled to have served as the lead curator for our organization in the production of this momentous exhibition and document.



Arthur L. (Bud) Burnett, MD, MBA, FACS

*Professor of Urology
Johns Hopkins University*

LEGACY

Black American Physicians in Organized Medicine and Urology

Arthur L. (Bud) Burnett, MD, MBA, FACS
Johns Hopkins University

Black physicians' professional advancement in medicine and urology in the United States of America is contextualized by the evolution of organized medicine in this country. From the time of the Civil War to the Civil Rights era, the traditions of organized medicine dictated the medical training and professional practices of Black physicians. This history has wrought long-lasting effects on the size of the Black physician workforce presently in the United States and correspondingly contributed to health care disparities in this country.

Organized Medicine in American History

For practical purposes, the era of organized medicine in America was inaugurated with the establishment of medical societies in this country. Its beginnings likely equate with the founding of the American Medical Association (AMA) in 1847 (1). Since the AMA represented the national federation of medical societies and colleges, it institutionalized these societies regionally and nationally. The AMA and its affiliate societies secured the process for professional inclusion and advocacy as well as opportunities for academic advancement in medicine.

The AMA also controlled the structure of organized medicine in America by commissioning the Flexner Report in 1910 (1,2). Executed by Abraham Flexner and supported by the Carnegie Foundation for the Advancement of Teaching, the Flexner Report served to assess the quality of medical education in the United States and set standards for physicians to practice across the nation. The Flexner Report established requirements for teaching and research in medical education in accordance with mainstream science. Its publication resulted in the reduction of 160 medical schools existing at the time to 31 institutions.



Abraham Flexner

Library of Congress

Advancement Barriers for Black Physicians

The participation of any health care practitioner in organized medicine is relevant for achieving professional excellence and success. The practicing physician offers proficient and qualified health care in line with a supportive and collegial medical community through which clinical practice knowledge is exchanged. Medical societies



Class in Capillary Physics at Hampton Institute, VA

Library of Congress

and associations standardize the practice of medicine and crucially serve a systemic function for the approval of its members in clinical practice and their advancement as medical professionals.

Historical impediments to professional advancement in medicine for Black physicians are evident in many forms, most markedly in restricted membership in medical societies and associations. The AMA exerted a dubious role in this history. In its inception, the AMA issued The Code of Medical Ethics, which espoused the tenet that scientific accomplishment alone (in reference to a “regular” medical education) should qualify an applicant’s membership (1). However, in routine practice, AMA members uniformly opposed Black physician membership and interactions professionally or socially, and only by the 1940s had AMA constituent societies allowed occasional membership to Black physicians (3).

In line with this impediment, Black physicians were routinely denied medical licensure by state licensing and regulatory bodies (4). This practice limited membership in medical societies and precluded hospital admitting privileges, which also required documentation of medical society membership. Without medical society memberships and specialty board certifications, Black physicians endured professional isolation, deterioration of professional competencies, and reduced sources of income.

Despite the esteem accorded to the Flexner Report in developing medicine in America, it nonetheless adversely impacted the advancement of Black physicians. A repercussion of the Flexner Report was the discontinuation of “black” medical schools (1). Among the evaluated schools, 15 were “black” medical schools with proprietary or church affiliations, and seven were officially recognized “black” medical schools. By Flexner Report recommendation, all were closed with the exception of two schools of

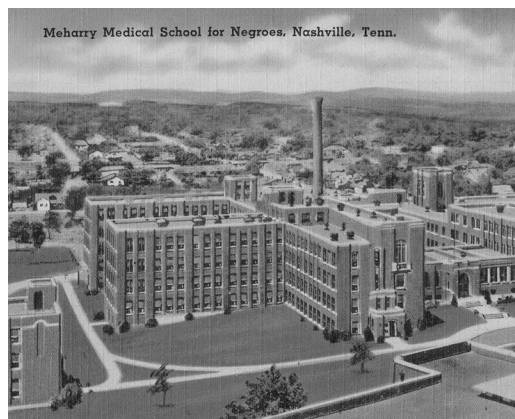
medicine, Howard University College of Medicine in Washington, DC, and Meharry Medical College in Nashville, Tennessee. The consequence of this action clearly was reduced opportunities for medical education of Black physicians since their admission into “white” medical schools was not uniformly possible.

The Flexner Report also specified that segregated and unequal medical education should be afforded to Black Americans (5). It further recommended that Black physicians should be trained differently, specifically that “negro doctors” should be educated not as surgeons or other specialists but primarily as “sanitarians” to “humbly and devotedly” teach hygienic principles to “their people.”

Origins of Black Medical Organizations

In response to the exclusionary intent of AMA-affiliated societies, Black physicians founded their own medical societies (6). These included local and regional medical societies such as the Tennessee Colored Medical Association, established in 1877, the Medico-Chirurgical Society of the District of Columbia, founded in 1884, and the Old North State Medical Society of North Carolina, founded in 1887, among others. At the national level, the first minority medical association was the American Medical Association of Colored Physicians, Surgeons, Dentists, and Pharmacists, formed in 1895, although its name was changed in 1903 to the National Medical Association (NMA). Such organizations have served to support Black physicians and promote the welfare of all racial populations in America. Over the years, the NMA has played an instrumental role in addressing and championing assorted societal causes, from civil rights legislation to health equity policy.

Formal acceptance by Black physicians into the medical profession may well have occurred



Meharry Medical School
Nashville, Tenn. Postcard
ca. 1930–1945



Washington Post, 1963
The Herb Block Foundation



Students studying at tables in a library at Howard University, Washington, D.C., 1958

Library of Congress

only by the late 1800s. Prior to this time, it was rare for any Black medical doctors to be trained at medical schools in the United States or abroad. In 1868, Howard University College of Medicine was founded as a “black” medical school. By the beginning of the 20th century, this institution and only six other officially recognized “black” medical schools afforded opportunities for Black physicians to train and enter clinical practice in America. In the era following the Flexner Report, Howard and Meharry medical schools are recognized for graduating 85% of trained Black physicians in the United States.

Leadership in Organized Medicine

A multitude of pioneering “firsts” in medicine are credited to Black physicians, who have persevered and charted progress through the difficult times of American history (7). Following the Civil War, Black physicians became faculty members at Howard and Meharry medical schools. Following the Civil Rights movement, increasing numbers of Black physicians achieved specialty board certifications, entered and led faculty ranks of predominantly “white” medical or graduate schools, and obtained leadership positions in integrated medical societies, including the American Urological Association (AUA). Given opportunity, Black physicians achieve competencies and participate actively in medical education and organized medicine. Within 100 years of gaining entry into organized medicine in the United States, Black physicians have demonstrated service in many roles, with estimates to include 38% participating in the area of medical education, 37% in organized medicine, and 25% in related health services activities (6).

Health Care Disparity Implications

The population of the United States comprises diverse ethnic and social backgrounds. A hard truth for the nation is that health disparities abound in this country, with Black Americans bearing a disproportionate share of the disease burden. Although many

factors relate to this truth, a shortage of Black health care professionals undoubtedly contributes to the issue.

The administration of health care across the nation requires a diversified workforce of physicians in service to minority as well as underserved populations. This insight emphasizes the value of underrepresented medical professionals, who may well foster care that is concordant with the cultural and ethnic backgrounds of disadvantaged populations (8). As demonstrated in many arenas, such diversity of thought and action produces measurable improvement in productivity outcomes.

Improving health care quality within these populations is a valid mission for organized medicine, although it is also purposeful for improving health care for Americans overall. The achievement of this basic outcome requires promoting the medical education and training, as well as the professional advancement of individuals of all races and ethnicities, including Black physicians.

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Systemic Racism in Urology: A Dream Delayed

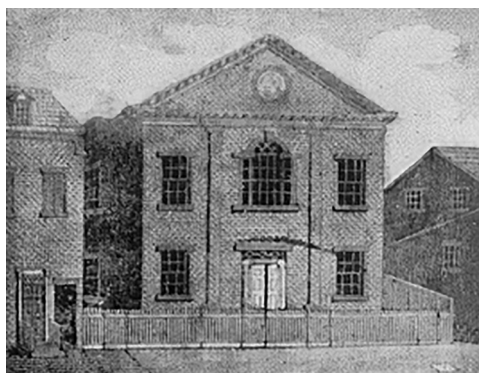
Randy Vince, MD, M.S.
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Systemic racism in urology represents a multifaceted issue deeply ingrained in the history and structure of medicine. This chapter provides a historical analysis of systemic racism by exploring its origins, manifestations, and consequences in the field of urology. We examine the roots of systemic racism from the antebellum era to the present day, focusing on highlighting discriminatory practices, both overt and covert, that have hindered the access of Black individuals to medical education and subsequently to careers in urology.

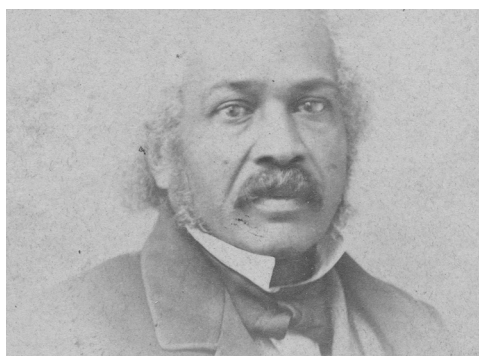
Antebellum Era: Barriers to Medical Education

The antebellum era, spanning from the early 19th century to the outbreak of the Civil War, was characterized by legalized slavery, racial segregation, and systemic oppression of Black individuals in the United States. One of the most profound manifestations of systemic racism during this period was the denial of educational opportunities to enslaved and free Black people, including access to medical education. Enslaved Black individuals were systematically deprived of education as a means of perpetuating their subjugation and maintaining the economic, social, and racial hierarchy. Laws and regulations explicitly prohibited the teaching of enslaved individuals, reinforcing their status as property rather than as autonomous human beings with the right to self-determination.

The story of Dr. James McCune Smith serves as a poignant example of the challenges faced by Black individuals in pursuing a medical education during the antebellum era. Born into slavery in Manhattan, New York, Dr. McCune Smith defied the odds and excelled academically, demonstrating remarkable intellect and determination despite the



New York African Free School, No. 2
Library of Congress



James McCune Smith
First Black American Doctor
New York Public Library

oppressive circumstances of his upbringing. Denied admission to American medical schools due to racial discrimination, Dr. McCune Smith embarked on a journey to Scotland, where he ultimately obtained his medical degree in 1837 from the University of Glasgow Medical School, becoming the first Black American to earn a medical doctorate (1).

Dr. McCune Smith's journey underscores the systemic barriers faced by Black individuals in accessing medical education in the United States during the antebellum era. His story is a testament to the resilience and tenacity of Black scholars and professionals who defied institutionalized racism to pursue their dreams of becoming physicians and healers.

It is documented that Columbia University granted the first medical degree within the United States (then the 13 colonies) in 1770. It was not until 1847, almost eighty years later, Dr. David Jones Peck became the first Black American to receive an M.D. in the United States, awarded by Rush Medical School in Chicago, IL (2).

Dr. Jones Peck was an exception to the rule because before the Civil War, most Black Americans were enslaved, and enslaved Blacks were prohibited from obtaining an education. Thus, medical school admission was closed to all Black people in the South. Additionally, even in the North, referred to as "free states" where Black Americans theoretically enjoyed more freedoms, deeply ingrained racial prejudices and discriminatory practices were pervasive in educational institutions, including medical schools. Admission criteria were often tailored to exclude Black applicants; consequently, admission to medical school for free educated Blacks was so rare that the number of Black American medical degree recipients before the beginning of the Civil War remained in the single digits (2).

Collectively, these stories highlight the oppressive experiences of many Black people, starting from our country's founding and, unfortunately, continuing throughout history.

Post-Civil War: Lingering Effects of Segregation and Pseudoscience

The end of the Civil War and the abolition of slavery marked a pivotal moment in American history. Still, the legacy of systemic racism persisted long after emancipation, despite the ratification of the 13th, 14th, and 15th Amendments, which abolished slavery, granted citizenship rights, and prohibited racial discrimination in voting (3). Black individuals continued to face institutionalized racism and discrimination in virtually every aspect of society, including healthcare and education. One of the most insidious manifestations of systemic racism in the post-Civil War era was the rise of pseudoscientific theories, such as eugenics, which sought to justify racial hierarchies and justify discriminatory policies and practices.

Influenced by notions of racial superiority and inferiority, proponents of eugenics promoted policies aimed at controlling and purifying the genetic composition of human populations, often targeting marginalized groups for sterilization, forced segregation, and other forms of reproductive coercion (4,5,6,7). In addition to pseudoscientific theories, legalized segregation and discriminatory laws and policies further

entrenched racial divides and perpetuated racial inequalities in the institution of education, including medical education. Decisions like *Plessy v. Ferguson* in 1896, which upheld the constitutionality of racial segregation under the “separate but equal” doctrine, sanctioned the segregation of public facilities, including hospitals and medical schools, based on race (8). Rulings such as this, coupled with the predominant medical organization, the American Medical Association (AMA), refusing to accept Black physicians, continued the impact of systemic racism and effectively relegated Black individuals to under-resourced institutions (9).

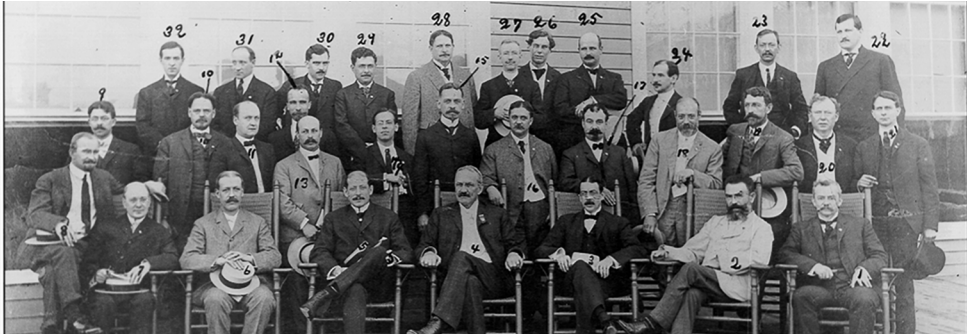
Black medical schools were opened in seven locations by 1904 to counteract these measures. During this time, these medical schools were responsible for educating over 90% of all Black physicians (10). However, these medical schools faced stark challenges and were highly underfunded. Coupled with the funding issues, Black medical schools came under tremendous attack after the 1910 publishing of the Flexner report, which insinuated that these schools lacked rigorous admissions standards, adequately trained faculty, and robust course offerings. This report resulted in the closing of 5 out of the 7 Black medical schools, with Meharry and Howard being the only two remaining schools by the 1920s. Additionally, “negro doctors” were recommended to receive a different education so that they could become “sanitarians” and only practice within their race. Ultimately, the aftermath of these actions made the path to becoming a physician and surgeon more arduous for Black people (11,12).

Urology and Systemic Racism: Exclusionary Practices

The field of urology, like many other medical specialties, was not immune to the pervasive influence of systemic racism. From its inception, urology was shaped by the prevailing social and cultural attitudes toward race and ethnicity, which often reflected and reinforced racial hierarchies and inequalities.

The American Urological Association (AUA), the preeminent professional organization representing urologists in the United States, played a central role in shaping the field’s norms, standards, and practices. Established in 1902, the AUA initially adopted bylaws and membership requirements that mirrored those of other medical organizations of the time, many of which were implicitly discriminatory and exclusionary towards Black physicians. While the AUA’s bylaws did not explicitly bar Black individuals from membership, they contained provisions that effectively excluded or limited the participation of Black physicians in the organization. For example, membership in the AUA required graduation from an American Medical Association (AMA)-approved medical school, completion of a hospital internship approved by the AMA, and endorsement by two current members of the AUA, all of which posed significant challenges for Black physicians due to pervasive racial discrimination and segregation in medical education and training (13).

Furthermore, the AUA’s annual conference, a cornerstone event in the field of urology, was often held concurrently with the AMA’s annual meeting, which itself was marred by overt hostility towards Black physicians and practitioners. This proximity to the



1904 Atlantic City AUA Urologists

The William P. Didusch Center for Urology History

AMA, combined with the AUA's endorsement and support of exclusionary practices and policies, reinforced the systemic barriers faced by Black urologists seeking recognition and acceptance within the medical community.

The consequences of systemic racism in urology were profound and enduring, contributing to the underrepresentation of Black urologists in the workforce and perpetuating racial disparities in patient care and outcomes. Despite significant advancements in medical education and diversity initiatives in recent decades, Black urologists, who make up 2.2% of the field (14), continue to face systemic barriers and challenges in accessing training opportunities, securing academic positions, and advancing in their careers, underscoring the need for continued efforts to address and dismantle institutionalized racism in the field.

Conclusion: Towards Equity and Inclusion

Addressing systemic racism in urology requires concerted and multifaceted approaches that acknowledge the historical legacy of racism and discrimination in the field and actively work towards creating a more equitable and inclusive environment for all practitioners and patients. Such efforts should include:

1. Recognizing and confronting the historical roots of systemic racism in urology, including the legacy of slavery, segregation, and pseudoscience, and their enduring impact on medical education, training, and practice.
2. Implementing policies and practices that promote diversity, equity, and inclusion within undergraduate academic institutions, medical schools, urology residency programs, and professional organizations, including targeted recruitment efforts, mentorship programs, and support networks for underrepresented trainees and faculty.
3. Investing in educational initiatives and resources addressing implicit bias, cultural competency, and structural inequalities in healthcare delivery, focusing on improving quality care for marginalized and underserved communities.

4. Advocating for systemic reforms and policy changes that dismantle institutionalized racism and promote equity in education, removing potential clogs in the proverbial pipeline that leads from primary education to medical school.

By acknowledging the historical injustices and structural inequalities that have shaped the field of urology and actively working to dismantle them, we can create a more inclusive, equitable, and socially just world that will undoubtedly improve the field of urology and the institution of medicine. The aim of the medical institution should be to serve the needs of all individuals, regardless of race, ethnicity, or socioeconomic status, and this is an impossible feat without truth and reconciliation, followed by thoughtful initiatives to combat the lasting impact of systemic racism. Together, let us strive towards a future where every aspiring urologist has the opportunity to thrive and contribute to the advancement of healthcare for all.

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The Arduous Journey to Board Certification in Urology for African Americans

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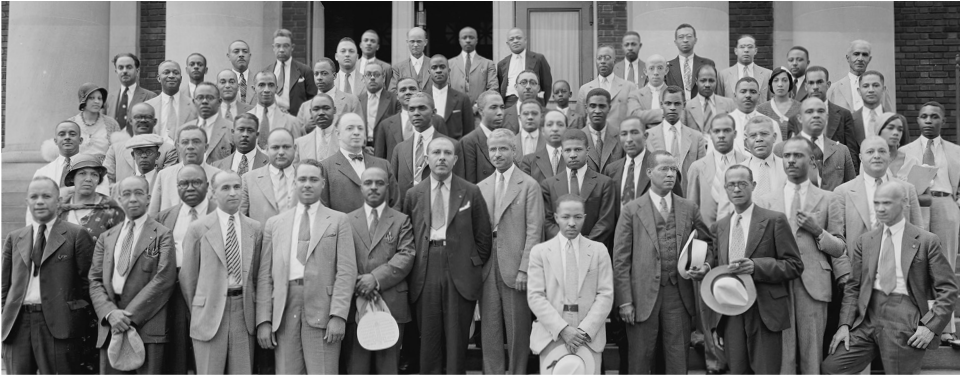
The process required to attain initial board certification in urology is rigorous. It represents an important step in a urologist's career and often marks the dedication of that career to evidence-based and patient-oriented care. Our field has begun to dedicate more attention to improving representation among urologic trainees with regard to both racial and gender differences, thus ultimately diversifying the urologic workforce that achieves board certification. However, the early trailblazers who paved the way by diversifying surgical subspecialties and urology as a field prior to this recent shift must be recognized. Moreover, the attainment of board certification by these early pioneers is set against the backdrop of the struggle Black and African American surgeons endured to achieve recognition as clinicians in the 1800s-1900s (1-4).

Race and Medical Society Membership

Founded in 1847, the American Medical Association's (AMA) policy on AMA membership held that states were allowed to deny a physician admission to local medical societies on the basis of race or gender. In 1868, the AMA Ethics Committee proposed allowing properly credentialed women physicians admission to local medical societies and the AMA but left it to state chapters to decide whether or not to admit Black physicians. At this time, the AMA, as well as local medical societies, served as important entities for promoting referrals, fostering career advancement, providing hospital admitting privileges, administering medical licensing, and training among its members (1,3).

Thus, non-membership to the AMA or a local medical society often meant professional isolation, fewer referrals, limitations on sources of income, and educational opportunities. Within this context, despite having all the necessary credentials for inclusion, Drs. Alexander T. Augusta, Charles B. Purvis and Alpheus W. Tucker were denied admission to their local medical society, the Medical Society of the District of Columbia (MSDC), in 1869 because they were African Americans. In response to this, Drs. Augusta, Purvis and Tucker formed the National Medical Society (NMS), comprised of African American and White physicians, and sought admission to the 1870 AMA annual meeting (1,3). Despite a congressional investigation confirming the MSDC's discriminatory exclusion of African American physicians from their society, the 1870 AMA Committee of Ethics denied admission of the NMS to the Annual Meeting along with Howard University Medical College, which was barred because it allowed women to serve on its faculty.

To further marginalize African American clinicians nationally, in 1874, the AMA declared a state-based federation that only allowed state and local medical societies,



National Medical Association

Scurlock Studio Records, Archives Center, National Museum of American History, Smithsonian Institution

those that routinely excluded African Americans, to be recognized officially by the AMA. This further barred Black physicians, particularly those in the South, from state-controlled board certification. In response to continued exclusion from state and national-level medical society membership, the National Medical Association (NMA) was founded in 1895 and comprised of local African American medical societies that did not discriminate on the basis of race or gender (1,3,4).

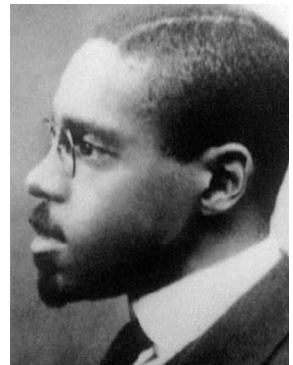


Dr. Daniel Hale Williams
Cardiothoracic Surgeon and
Cofounder of the NMA

Wikipedia

Scarce Opportunities for Specialty Training

In the 1920s and 1930s, society membership remained critical for attaining specialty training, as hospitals that offered specialty training required candidate physicians to be members of the AMA or a local society. Moreover, the majority of hospitals in the United States during that time remained segregated, further barring African American physicians' access to post-graduate specialty training. Thus, by 1931, only two of approximately 25,000 board-certified specialty-trained physicians were African American: Drs. Daniel Hale Williams, a cardiothoracic surgeon and cofounder of NMA, and William Harry Barnes, an otolaryngologist. The number of specialty-trained African American physicians remained low even until Dr. Richard Frank Jones became the first African American board-certified in urology in 1936.



Dr. William Harry Barnes
Otolaryngologist

*American Academy of
Otolaryngology*

Medical education in the 1920s began to evolve and become more standardized such that a formalized post-graduate internship became a requirement for additional specialty training and state licensure. Prior to this, the few practicing African American physicians who were able to obtain specialized surgical training did so through an ad hoc approach of assistantship with an established surgeon, additional post-graduate courses, or visits to prominent clinics that were not segregated. For example, Dr. Milton A. Francis, a professor of genitourinary surgery, received his urologic training as an assistant to Dr. Harry Fowler at Howard University in 1908; Dr. Francis ultimately trained Dr. R. Frank Jones (5). Thus, the internship requirement served as an additional barrier for Black and African American physicians seeking surgical specialization because the number of integrated hospitals with surgical internships that accepted Black physicians was low and included primarily Howard University's Freedmen's Hospital in Washington D.C., Providence Hospital in Chicago and Harlem Hospital in New York (2).

The internship requirement was an insurmountable barrier in the case of Dr. Isabella Vandervall, whose application for internship was accepted at four different hospitals in 1917, but she was rejected when she appeared for the position in person due to her race. Although Dr. Vandervall was unable to secure an internship position, likely barring her from specialty training, she was able to continue to practice medicine as the internship requirement for state licensing went into effect after she graduated.



Isabella Vandervall
Wikipedia ca. 1917

Urology Board Certification

The advent of formal surgical residency training soon followed in the 1930s, and with it the number of available surgical specialty residency positions for Black medical graduates slowly grew such that by 1939, thirty-four residency positions were available for approximately half of all African American graduates (2). In 1935, the American Board of Urology was established to further standardize the practice of urology. However, due to the largely limited opportunities for post-graduate genitourinary residency training for Black Americans, the first few board-certified urologists after Dr. R. Frank Jones were primarily his trainees including Dr. Kline A. Price in 1943, Dr. Robert A. Fullilove after him, and Dr. Merle B. Herriford in 1952 (6-8).

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Howard University: Premier Training Program for Early Black Urologists

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There is a well-known parable about a tiny mustard seed that grows into a large tree; it speaks to the extraordinary potential hidden in the seemingly insignificant.

The Howard University College of Medicine's (HUCM) current Urology Training Program began modestly as part of the Contraband Camp, then Freedmen's Hospital, and has grown into a towering presence in the field of medicine. This chapter explores the program's historical context, remarkable individuals, and impactful contributions, echoing the parable's message that greatness can arise from unassuming beginnings.

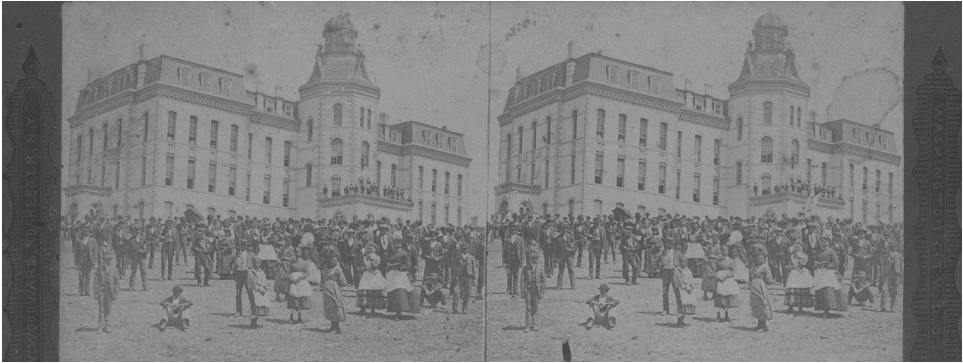
In the Beginning

The period following the Civil War was marked by various health challenges among the newly freed African American population, including epidemics of diseases like smallpox and cholera. Multiple humanitarian and relief organizations recognized the urgent need to provide medical care and support to millions of emancipated formerly enslaved individuals who were in poor health due to years of neglect, harsh living conditions, and lack of access to formal medical care.

A "Contraband Camp" contained one of the few hospitals that treated African Americans in Washington D.C. during the American Civil War and was staffed by nurses and surgeons who were largely African American. Patients were escaped formerly enslaved people who sought refuge in D.C., and, as they made their way across Union Lines, they were referred to as "contraband." The DC Camp was disbanded after a year and was no longer controlled by the U.S. Army. It became Freedmen's Hospital in 1863 and eventually a part of the Freedmen's Bureau. Prominent supporters and figures, including Clara Barton and the American Freedmen's Aid Commission, advocated for and contributed to the establishment of Freedmen's Hospital (1).

Although Freedmen's Hospital began as a small facility, it expanded its services over time to meet the healthcare needs of the African American population. It played a vital role in providing medical care and training for healthcare professionals and contributed to the development of Black healthcare infrastructure during a critical period in American history. Freedmen's Hospital continued to serve the population of Washington, D.C. over the next 100 years, expanding its facilities and offering its services to both Black and white patients.

Meanwhile, the Howard University College of Medicine grew from the efforts of Major General Oliver Otis Howard, the first Commissioner of *the Bureau of Refugees, Freedmen, and Abandoned Lands*, established on March 3, 1865, when the Freedmen's Bureau Bill, which included provisions for medical care for freed formerly enslaved peoples, was signed into law.



Stereograph of Howard University
*National Museum of African American
History and Culture*

Howard University College of Medicine, founded in 1867, and Freedmen’s Hospital, founded in 1863, entered a collaborative partnership with the shared mission of providing education and training of Black doctors to serve the underserved African American community in the aftermath of the American Civil War. This affiliation provided a fertile training ground for Howard University College of Medicine students to gain practical patient care experience, exposure to procedures, research, and essential hands-on clinical training, and ensured that healthcare services were provided to the Black community by both the hospital and the university’s graduates (2).

This partnership addressed the shortage of Black medical practitioners during a time of systemic racial discrimination. The influential 1910 Flexner report, commissioned by the American Medical Association, recommended closing half of all medical schools in the United States. Howard University College of Medicine and Meharry Medical College in Tennessee emerged as two select medical schools to meet the stringent new standards outlined in the Flexner report, allowing them to survive and thrive and continue their mission of training Black medical professionals. The Flexner report endorsed segregation and recommended limiting Black physicians to “Sanitarians” (3), leading to long-lasting negative impacts on their professional progress. This underrepresentation in medical specialties persists despite the African American population being around 12% of the total U.S. population. Lack of physicians, especially in fields like urology for prostate cancer, remains a pressing issue.

Key Figures in the Evolution of Howard University’s Urology Training Program

Early 20th-century racism and discrimination posed barriers for Black medical professionals. Still, Howard University-trained doctors and urologists overcame these challenges, underscoring their determination and Howard’s role in addressing healthcare

and education disparities. Several key figures drove change in the growing field of urology.

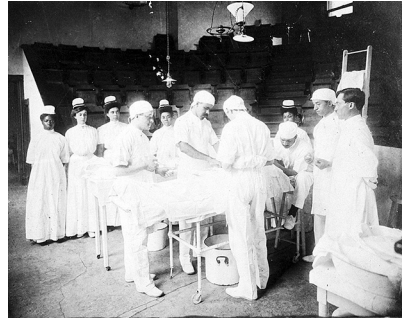
Historical records and manuscripts shed light on the training methods employed at the Howard University College of Medicine's urology program. These documents allow us to explore the training methods, the visionary individuals behind them, and the broader historical context that shaped the urology training program. As we delve into the program's early days, we will use these valuable resources to offer an in-depth view of the methods and principles that guided the program's success.

One manuscript, titled "The Surgical Resident Training Program at Freedmen's Hospital," authored by Dr. R. Frank Jones, provides a valuable glimpse into the training techniques, curriculum, educational strategies, and patient care methods employed during the program's early days (4).

Dr. Richard Frank Jones (1898-1979) was an early trailblazer in the field of urology and a prominent figure at Freedmen's Hospital. His grandfather had been enslaved and bought his freedom in 1847. His grandmother was "free born" and, at age 13, was indentured to a "doctor" who taught her midwifery skills.

Coincidentally, she delivered the baby of the founder of Howard University, General Oliver Otis Howard. As a Washingtonian, Dr. Jones was educated in D.C. public schools. In 1916, he attended Howard University to become a professional architect. That year, he underwent the surgical repair of what was believed to be an inguinal hernia but was instead a varicocele. This sparked his interest in surgery. He qualified for medical school in 1918 and was quoted as saying he "lived in a surgeon's scrub suit" as the second and third assistant to white gynecologists, Dr. Henry Fowler, Chief of Genitourinary department, and Dr. Hartford Burwell. The latter was known to have completed pelvic surgery skin-to-skin in 35 minutes with a "well-supported team." Dr. Jones learned open suprapubic skills, exemplified by his published research on two-stage prostatectomy and one-stage closure of perineal prostatectomy. Exhibiting an early form of microaggression, Dr. Fowler limited Dr. Jones' training to the use of cystoscopy and ureteral catheterization. This could have limited his surgical skill set, but Dr. Jones went on to develop the two-stage prostatectomy and the primary enclosure of perineal prostatectomy (5).

As an intern in 1922, Dr. R. Frank Jones surgically assisted Dr. Milton Augustus Francis, the first Black urologist at Howard University Hospital. Dr. Francis had served as an assistant to Dr. Harry Atwood Fowler, who trained under Dr. Hugh Hampton Young at Johns Hopkins University from 1908 to 1917. When Dr. Fowler went to serve in World War I from 1917 to 1922, Dr. Francis served as acting Chief of the Genitourinary Service at Freedmen's Hospital. However, when Dr. Fowler returned from the war, he



Freedmen's Hospital Howard University 1903
Moorland Spingarn Research Center

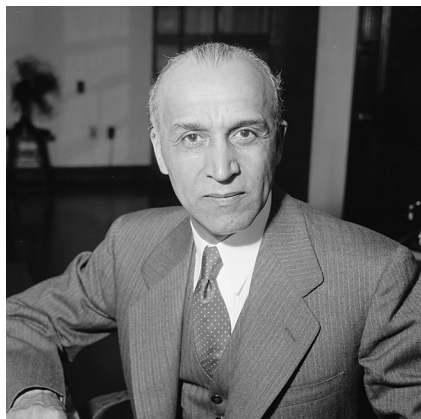
appointed Dr. T. C. Thompson, a white physician, as the new Chief of the Urology outpatient service division. Dr. Francis continued in a clinical role at Freedmen's, mentoring Dr. Jones between 1922 and 1929. In 1933, Dr. Milton A. Francis declined an opportunity to become inpatient Chief of the Division of Urology and passed the position to Dr. Jones. In 1959, Dr. Francis showed his devotion and affection to Howard University College of Medicine and asked that his savings of \$96,400 be donated to student loans and scholarships (6). He died by suicide on July 22, 1961, and gave his entire estate to Howard University.

Diversity and Inclusivity

At the helm of Howard University, President Mordecai W. Johnson, the 12th president (1926-1960), emerged as a beacon of change, advocating for diversity and inclusivity in medical education. Under his stewardship, the university steadfastly supported the training of Black urologists during an era when such opportunities were regrettably scarce.

As Chief of the Urology department, Dr. R. Frank Jones worked closely with Dr. Numa Pompilius Garfield Adams in the formation of a urology training program and the restructuring of the surgery residency program. Dr. Adams, another remarkable figure, brought his dedication to patient care, education, and pioneering research to the early development of the surgery program at HUCM. Dr. Adams was the first Black American to hold the position of Dean of the Howard University College of Medicine (1929-1940), as documented in Dr. William Montague Cobb's works, "Numa P. G. Adams, M.D., 1885-1940" and "Progress and Portents for the Negro in Medicine" (7,8). These articles offer a comprehensive understanding of the program's historical significance, the challenges it overcame, and its impact on medical education and healthcare in the African American community. Dr. Adams changed the curriculum, increased acceptance standards for students, and proposed integration of Howard University College of Medicine and Freedmen's Hospital.

Dr. William Montague Cobb, who graduated from Howard University in 1929, was a prolific writer and past president of the NAACP. Among the over 600 pamphlets he authored, it was the "Progress and Portents" pamphlet in which he outlined the history of Black medical education and practice in the U.S. He argued that the inadequacy of the education provided to African Americans from elementary school through college ensured that many of them began medical school with some educational deficits compared to better-prepared white students. While applauding the skills and dedication of



Dr. Numa P.G. Adams
Dean of Howard Medical School

Library of Congress

teachers at Meharry and Howard, Dr. Cobb concluded that these underfunded and overcrowded facilities could not provide an equivalent education to their students. Dr. Cobb believed that the completion of the integration of the nation's schools was necessary but also recognized that "every attempt by adherents of the status quo will be made to block or circumvent real changes in the entrenched system of segregation."

Training Excellence: The Role of External Support in Howard University's Urology Training Program

While Dean of the College of Medicine, Dr. Numa P. G. Adams improved medical education standards by assembling a faculty of young men skillfully trained in every branch of medicine who were dedicated to teaching preclinical, clinical, and graduate medicine. However, when it came to clinical training, he faced obstacles with the retention of residents, which led to the commencement of resident training at Freedmen's Hospital on October 1, 1935. The initial resident training phase focused on obstetrics, gynecology, and pediatrics.

The Howard University College of Medicine surgery training program was challenged in an era marked by limited resources, social and racial barriers, and the constant struggle for recognition. The Rockefeller Foundation, dedicated to advancing education, science, and public health, recognized the critical need for supporting medical education and research, especially in underserved communities. This foundation provided external financial support and played a crucial role by lending Dr. Edward Howes to oversee the surgical training program for five years, starting July 1, 1936.

The following notable advancements at HUCM were achieved because of this support:

1. Attracted distinguished medical specialists and educators to its faculty, fortifying its teaching and research capabilities. This influx of talent added depth and expertise to the program's academic offerings.
2. Facilitated cutting-edge research within the Howard University urology/surgery training program, contributing significantly to the field's knowledge, and enhancing patient care through innovative discoveries.
3. Contributed to scholarships and opportunities for aspiring urologists, particularly those from disadvantaged backgrounds. This commitment to inclusivity played a pivotal role in diversifying the field of urology, enriching it with a broader range of perspectives and experiences.
4. Encouraged a community-focused approach that aligned harmoniously with Howard University's mission of serving underserved communities. This approach improved patient care by fostering a connection between the program and the community and bolstered the program's reputation as a leader in compassionate, patient-centered healthcare.

The enduring impact of the Rockefeller Foundation's support for the Howard University College of Medicine urology/surgery training program cannot be overstated. It shows the vital role that external support plays in nurturing excellence and fostering diversity in medical education. This partnership between a philanthropic organization and an educational institution illustrates the power of collaboration in driving transformative progress.

In the early stages of the resident training program, trainees were sent for further evaluation and training to institutions such as Columbia, Michigan, and Iowa. Dr. Charles R. Drew, a general surgery resident who succeeded Dr. Edward Lee Howes in 1941, continued to advance the training program, with specialized divisions contributing candidates for certification. Certification became a routine part of the program.

The effectiveness of the resident training program was expected to increase as the faculty took on full responsibilities at D.C. General Hospital. Here, residents received additional surgical training in addition to their work at Howard. Moreover, expanding the program to include more affiliate hospitals was seen as an opportunity to provide a broader range of experience and services.

Board Certification and Accreditation

One fundamental tenet of Dr. Jones' urology resident training program, established in 1947, was the emphasis on excellence and board certification because it ensured that Howard University College of Medicine graduates were not only well-prepared but duly recognized for their exceptional expertise. Board certification, in particular, was important to broadcast the program's commitment to rigorous standards, top-notch patient care, and staying at the forefront of the latest advancements in the urological field.

The focus on unwavering dedication to diversity and inclusion set this urology program apart. By opening its doors to aspiring urologists from diverse backgrounds, it achieved a dual-purpose goal: the field of urology was enriched because it embraced a wealth of perspectives and experiences, and it addressed healthcare disparities by promoting representation and understanding of diverse patient populations.

In contrast to the recommendations of the Flexner Report, which discouraged specialization, Dr. R. Frank Jones' leadership of the Howard University College of Medicine Urology program recognized the unique demands of urology as a distinct surgical specialty. This commitment to specialization allowed for in-depth training and expertise in a field rife with intricate patient needs and complex medical conditions, such as urological issues and the ever-pressing challenge of prostate cancer. Another fundamental principle upheld by the program was the importance of careful documentation, wherein meticulous record-keeping is indispensable. It ensures patients' comprehensive and effective care by tracking their histories, treatment plans, and outcomes precisely and thoroughly.

The legacy of Dr. Jones extends to the present day as The Howard University Urology Training Program. Howard University alumni continue to make substantial contribu-

tions to the field of urology. With their groundbreaking research and cutting-edge clinical practice, graduates continue to push the boundaries of urological knowledge and patient care.

Through the foresight of Dr. Jones and others who championed diversity and inclusion, the Howard University Urology Training Program has played a pivotal role in addressing healthcare disparities and ensuring that the medical profession reflects the diversity of the communities it serves. Its meticulous documentation and specialization have set a high standard for medical practice across various disciplines. It provides opportunities to aspiring urologists from diverse backgrounds and enriches the field with a multitude of perspectives and increased access to care for marginalized communities. It stands as a shining example of how diversity strengthens medicine and broadens the scope of healthcare.

The Howard University Urology Training Program symbolizes resilience, excellence, and inclusivity. Its historical importance, ongoing contributions to urology, and broader role in advancing healthcare and diversity make it a source of inspiration and a reminder that dedication to education and the principles of equity can transform the field of medicine and the lives of countless individuals.

Why is Howard Urology a Premier Program?

1. Expert Faculty-Founders and Visionary Doctors
2. Clinical Excellence
3. Research Opportunities
4. Residency Training
5. Academic and Professional Networking
6. Diversity and Inclusivity
7. Graduate Success
8. Community Engagement



Warfield Clark, MD was a professor of author Dr. Pamela Coleman
Howard University Hospital

The Howard University Urology Training Program is the tree that continues to grow from that tiny mustard seed, cared for and nurtured by many remarkable physicians who struggled to ensure that Black patients and others had superior medical treatment at a time when they were challenged by discrimination as individuals and physicians.

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The History of the R. Frank Jones Urological Society

Linda L. McIntire, MD

MyMichigan Health

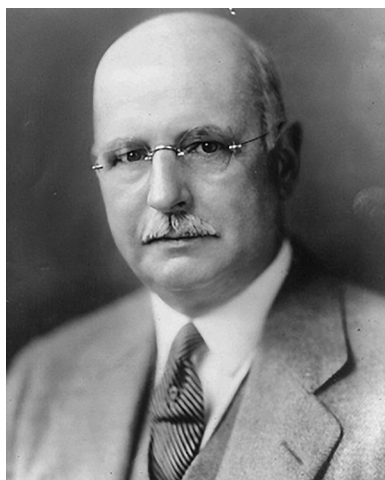
The National Medical Association (NMA), established in 1895, is the largest and oldest organization representing Black physicians in the United States of America. The R. Frank Jones Urological Society originated as the Urology Section of the National Medical Association. In 1952, Browning Allen, MD, Chauncy Morton, MD, R. Frank Jones, MD, and David Bradley, MD met in a classroom at De Salva High School in Chicago, Illinois, and discussed forming the Urology Section of the NMA. Intern Randle Pollard, MD was in attendance.

In 1953, Howard O'Brien Gray, MD, spoke with the Scientific Council regarding the formation of a Urology Section of the NMA. In 1954, the Urology Section was formed. The officers were as follows: Chairperson: R. Frank Jones, MD, Vice-Chair: R. E. Fullilove, MD, and Secretary: Chauncey L. Morton, MD.

Prior to forming the Urology Section of the NMA, Dr. Jones had many firsts in the field of urology. In 1936, Dr. Jones, under the tutelage of his mentor and sponsor Dr. Milton Augustus Francis, became the first Black man to become board-certified in urology. Dr. Jones received board endorsements from two local urologists: Dr. Ralph M. LeComte, Professor of Urology, Georgetown University, and Dr. Francis Hagner, Professor of Urology, George Washington University.

In 1936, Dr. Jones applied for membership to the American Urological Association (AUA) Mid-Atlantic Section, a prerequisite for national AUA membership. Dr. Jones was elected for membership, only to have his membership revoked three weeks later. The Mid-Atlantic section stated the reason for the revocation of membership was due to the lack of necessary endorsements. Dr. Jones applied multiple times but was never accepted by the Mid-Atlantic Section. Finally, 30 years later, in 1965, the AUA established an at-large member category. At that time, Dr. Jones was accepted directly into the AUA.

Dr. Jones was concerned about the lack of Black urology trainees and fought tirelessly to form a urology training program that would accept Black applicants. In 1947, Dr. Jones was approved for a urology training program at Howard University. At that time, Dr. Jones ascended to become Chief of the Division of Urology with the title of Professor of Urology. Dr. Jones successfully trained twenty-six men of African descent



Francis Hagner, MD
Professor of Urology, George Washington
University who endorsed R. Frank Jones
for board-certification

William P. Didusch Center for Urologic History

in the residency program at Howard University.

Throughout the years, the Urology Section of the NMA continued to grow. The organization was recognized by the American Urological Association in 1965. Dr. Jones died in 1979, and the name of the organization was changed from the *Urology Section of the NMA* to the *R. Frank Jones Urological Society* (RFJUS) in honor of the great man and skilled surgeon who demonstrated incredible resilience throughout his lifetime. RFJUS hosts a CME-accredited scientific session at the annual meetings of both the American Urological Association and the National Medical Association.

During the 2000s, Urology was one of the premier sections of the NMA. The urology section offered free PSA blood tests and rectal exams for prostate cancer screening at the National Medical Association annual convention in exchange for admission to concerts of top-rated artists.

In 2012, the *National Cooperative Study of Hereditary Prostate Cancer in African Americans* recruited Dr. Isaac Powell, a leader in prostate cancer genetics, to enlist the support of RFJUS members to recruit Black families for the study. RFJUS members who served as project directors were James Bennett, MD, Atlanta, Georgia; Gerald Hoke, MD, New York, New York; and Curtis Pettaway, MD, Houston, Texas. RFJUS members were able to recruit over 150 families to the study. Prior to the involvement of the Black urology society, the study project coordinators had only recruited 7 Black families. This historic event underscores the need for Black urologists to serve as coordinators of clinical trials.

Under the leadership of Dr. Cheryl Lee, RFJUS was established as a nonprofit organization. During Dr. Tracy M. Downs' leadership, advocacy on behalf of the RFJUS led to the first-ever AUA Diversity and Inclusion task force. Dr. Downs served as chair of the AUA D&I task force which concluded by delivering fourteen recommendations to the AUA to increase diversity and inclusion in the organization.

The R. Frank Jones Urological Society has been the leading voice of advocacy to increase the number of Black students in urology training. Members of RFJUS participate in mentorship programs across the nation, and RFJUS sponsors a mentorship reception for students at each AUA and NMA annual convention. At the reception, medical students and urology trainees are given the opportunity to foster relation-



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ships with practicing Black Urologists. In addition, underrepresented-in-medicine (URiM) students are educated regarding the resources available to engage and expose students to the field of urology.

In 2022, RFJUS instituted an award system to recognize its members for their outstanding accomplishments in urology. The Stellar Award is given to a senior RFJUS member who has demonstrated an excellent urology career dedicated to eliminating health care disparities through research and service.

Excellence in Urology Award 2022

Cheryl T. Lee, MD

O. Lenaine Westney, MD

Carol J. Bennett, MD

Stellar Award 2022

Isaac J. Powell, MD

Excellence in Urology Award 2023

Arthur L. Burnett, MD

Ronald Morton, MD

James K. Bennett, MD

Stellar Award 2023

Curtis A. Pettaway, MD

In addition to recognizing the outstanding contributions of Black urologists, RFJUS also sponsors the William Baker Research Forum annually at the NMA convention. In this forum, led by Willie Underwood, MD, Black medical students and urology trainees present their urology research. Prizes are awarded for the most exceptional presentations. Participation in the William Baker Research Forum is a rite of passage for most Black urologists. RFJUS members fondly reminisce on the time they presented as a student or urology trainee at the William Baker Research Forum.

In concert with our mission to increase the numbers of and support for Black urologists, RFJUS also endeavors to decrease health care disparities for Black patients who suffer from urologic disease. To help address this disparity, RFJUS began offering free prostate cancer screenings to members of the community in the host city of the NMA annual convention. In 2023, under the leadership of John McGill, MD, and Lawrence Jenkins, MD, and in conjunction with supporting partners, RFJUS held a prostate cancer screening in New Orleans, Louisiana, screening more than 100 men. In addition to prostate cancer screening, RFJUS provided educational resources for men who suffer from prostate conditions and erectile dysfunction.

To broaden the reach of RFJUS efforts to support and mentor aspiring urology trainees, Kymora Scotland, MD, PhD, spearheaded the RFJUS Social Action Media Committee. Dr. Scotland's committee has initiated a novel RFJUS spotlight series where aspiring medical students and urology trainees interview successful Black urologists and post

their interviews on social media. The medical students and urology trainees create the interview questions and format. The spotlight interview series aims to inspire, engage, and inform aspiring urology students on the critical elements necessary to succeed in urology. The RFJUS Social Action Media committee aims to make urology a career choice accessible to all.

There is much work to do to address the health care disparities that Black patients face and the dismal numbers of Black students who are accepted and graduate from urology training programs. RFJUS has remained a steadfast voice for Black urology trainees, junior faculty, and patients. The executive board of RFJUS promotes Black rising stars in urology by recommending them for panels, updates, articles, guidelines, and to lead plenary sessions. RFJUS will never waver in its commitment to diversifying urology by providing resources and support to our students and trainees and advocating on behalf of our patients. It is without question that the spirit of Dr. Richard Francis Jones lives on in our efforts.

RFJUS/NMA Urology Section Chairs

- | | | | |
|-------------|-----------------------|----------------|---------------------|
| • 1966-1972 | Howard O'Brien Gray | • 2000-2002 | Jenelle Foote |
| • 1972-1974 | Robert F. Blythe | • 2002-2004 | Gerald P. Hoke |
| • 1974-1978 | Bennie L. Davis | • 2004-2006 | Curtis A. Pettaway |
| • 1978-1980 | Randle E. Pollard | • 2006 | William Baker* |
| • 1980-1981 | Delutha H. King, Jr. | • 2006-2008 | Brian A. Stone |
| • 1981-1984 | John H. Norton, III | • 2008-2010 | Chiledum Ahaghotu |
| • 1984-1986 | George Lightbourn | • 2010-2012 | Cheryl T. Lee |
| • 1986-1988 | Aaron G. Jackson | • 2012-2014 | Walter Rayford |
| • 1988-1990 | Jackson L. Davis, III | • 2014-2016 | Kevin Billups |
| • 1990-1992 | Ray H. Littleton | • 2016-2018 | Jacqueline Hamilton |
| • 1992-1994 | Michael B. Scott | • 2018-2021 | Tracy M. Downs** |
| • 1994-1996 | James K. Bennett | • 2021-2023 | Linda L McIntire |
| • 1996-1998 | W. Bedford Waters | • 2023-Present | Robert Waterhouse |
| • 1998-2000 | Terry Mason | | |

**Due to his sudden death, Dr. Baker was not able to finish his term as Chair. The William Baker Research Forum for Medical Students and Urology Trainees held at the NMA is named in his honor.*

***During the COVID-19 Pandemic, Dr. Downs served as Chair for an additional year.*

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JOURNEY

Social Context of Health

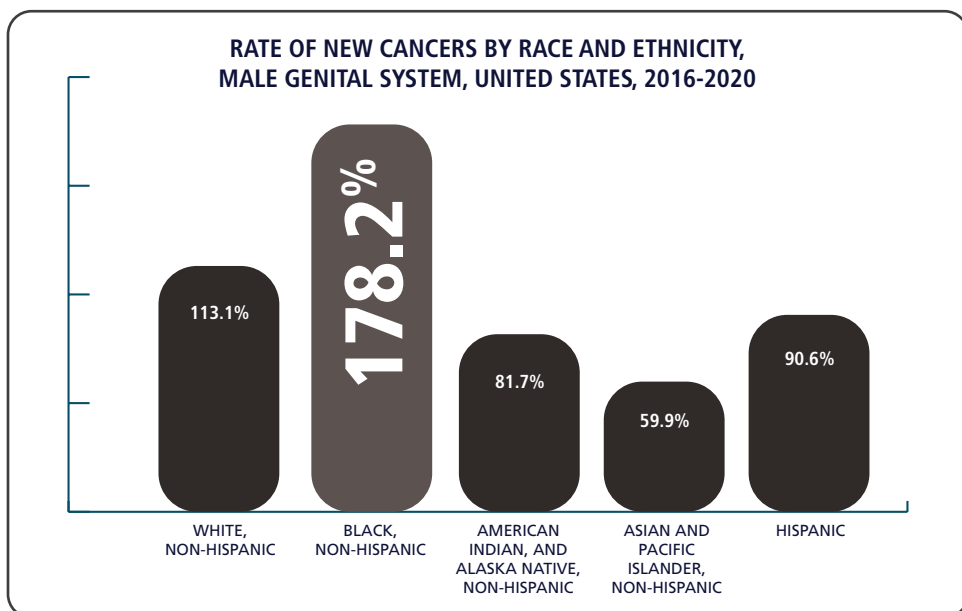
Christi M. Butler, MD

David Bayne, MD, MPH

University of California, San Francisco

Health inequities are undeniable and pervasive throughout our society. Unfortunately, this extends into healthcare and broader health outcomes on a population level. It is well established that life expectancy in the United States varies along racial lines, with American Indian/Alaska Native and Black people having 65.2 and 70.8 years of life expectancy, respectively, compared to White people (76.4) (1). The causes of these life expectancy disparities are largely related to the interplay of societal factors that influence how individuals from different ethnic groups and their communities interface with the health care system. In addition to ethnic minorities, other populations historically marginalized along lines of sex, gender, sexual orientation, and socioeconomic status (SES) face social challenges in sustaining healthy lifestyle habits and accessing quality health care. These inequities are reflected in urological care treatment outcomes and have become more apparent as contemporary research increasingly identifies existing health disparities within urology.

From benign to oncologic pathologies, urological disease outcomes are affected by social determinants of health (SDOH). According to the World Health Organization (WHO), SDOH include the conditions in which people are born, grow, live, work and age, and are shaped by the distribution of money, power, and resources at global, national and local levels. The Centers for Disease Control (CDC) categorizes these



social factors as education access and quality, health care and quality, neighborhood and built environment, social and community context, and economic stability (2,3). These SDOH undoubtedly contribute towards disparities in urological outcomes. For example, patients from low SES communities, underinsured groups, and minority ethnic groups present to care with more advanced prostate cancer and larger stone burden (4,5). In patients with bladder cancer, ethnic minorities and impoverished patients are less likely to receive guidelines-based care. In general, these patients wait longer for urological care, resulting in a need for more invasive and morbid treatments (6,7). They are also grossly underrepresented in research studies that influence the guidelines for urological care standards (8).

Barriers to access to timely and appropriate urological care are also influenced by regional factors. Urologists are highly concentrated in urban areas such that most counties in the United States do not have urologists (9). Patients from rural areas and counties with fewer urologists are less likely to receive treatment for prostate cancer and often present for care with more advanced and complex stone disease relative to their urban counterparts (10,11). This effect is amplified exponentially in the context of urological care access in low and middle-income countries (LMICs). Of the 7 million cancer deaths in the world, 5 million are in LMICs (12). Age-standardized mortality rates for urological cancers such as prostate cancer are higher in these countries (13). For the majority of patients in LMICs, SDOH severely inhibit access to urological care, and urologists in these countries face the added burden of limited access to the necessary diagnostic and surgical resources to properly care for their patients (14).

Sexual and gender minorities are impacted profoundly by SDOH and have faced pervasive discrimination, rejection, and even violence in society as a whole, as well as within the field of medicine. When it comes to the trans and gender-diverse (TGD) community and, more broadly, those from the gender and sexual minority (GSM) community, there has been a longstanding history of disparities in healthcare treatment and outcomes. Although there are a multitude of contributing barriers in place, many of these disparities are rooted in trans and queerphobia. Such prejudices and discrimination have prompted TGD patients to develop an internal stigma, mistrust, and expectations of negative experiences, which result in poorer health outcomes (15,16). Specifically, 33% of TGD patients reported a negative experience in the medical field (17). In a qualitative study, individuals have reported experiences of misgendering, looks of confusion, irrelevant invasive questioning, improper documentation, and the burden of educating providers (18). Further, a 2012 study conducted by Harvard Kennedy School found that trans-identifying patients experienced medical care refusal at a rate of 14-20% (19). This, in conjunction with a history of denial for insurance coverage, a lack of providers equipped to treat TGD patients, and a culturally incompetent health system, has resulted in patients avoiding medical care (20). Although, as providers, we cannot be difference makers in all of the facets that compose SDOH, we must become empowered to improve patient access to timely and high-quality urological care collectively.

As urologists, we must be aware of the breadth of SDOH, their impact on urological disease outcomes, and how we can navigate them to improve care for our patients.

Breaking down barriers to care caused by SDOH is not easy and requires participation and investment at all levels of healthcare infrastructure. As providers, we can have an impact through dedicated efforts to combat cultural knowledge gaps and address inequities or discriminatory behavior head-on. Proposed mechanisms to combat these disparities include developing dedicated interventions to improve access to timely and appropriate specialist care for underserved populations, increasing representation of underrepresented healthcare providers in specialist care, and research-informed healthcare policy reform. We must continue to support innovative solution-directed research wherein all patients are represented. We must also invest in SDOH-awareness education and training domestically and internationally.

When it comes to advancing the field of urology to provide optimal care to all patients, it is essential to reflect on the impact of urological care on individuals from varying backgrounds and socioeconomic levels. In many instances, urological diseases predominate among the socially vulnerable and marginalized patient groups. Disparities in the treatment of these diseases are rooted in obstacles derived from SDOH that are asymmetrically distributed throughout our society. This includes systemic injustices along lines of race, gender, sexuality, income, social class, etc, resulting in disparate access to care, patient-related historical trauma, and provider miseducation and bias. We must cultivate knowledge and awareness of the historical context of the social determinants that have led to health disparities in urology. We must make concerted efforts to address and close any knowledge gaps. This is particularly important as we develop interventions to improve health outcomes and eliminate disparities to better serve our patients.

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Black Urologists in the U.S. Workforce: Advancing Diversity and Promoting Equity in Urology

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Ensuring that our healthcare workforce reflects the diverse fabric of our communities is crucial for improving access to care, reducing healthcare disparities, and delivering optimal care to our diverse patient populations (1). However, within the field of Urology, the number of Black Urologists remains alarmingly low and has remained static over the past several years: Black Urologists comprise only 2.2% of the total Urology workforce, which may contribute to the challenges in achieving health equity (2). While recent data show an increase in the percentage of underrepresented minority (URiM) Urology graduates by 0.1% per year, at this rate, in 2061, there will still be an underrepresentation of URiM urologists relative to the population of minoritized Americans (13.3% vs 44.2%) (3).

This disparity in representation is congruent with broader trends in medicine, where Black physicians remain consistently underrepresented compared to their White counterparts, despite years of diversity initiatives (4-6).

Systemic barriers, such as limited opportunities for medical education, discrimination in medical training and hiring practices, restricted participation in medical societies, and socioeconomic disparities have historically hindered the advancement of Black individuals in medicine (7). The “leaky pipeline” to careers in science, technology, engineering and medicine (STEM), biases in the residency selection process, decreased retention and higher attrition rates of non-White trainees, challenges of microaggressions, decreased mentorship, support or allyship, the prevalence of the



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American Urological Association

minority tax, and subsequent burnout, all contribute to the underrepresentation of Black Urologists in the workforce (8).

The scarcity of Black urologists has significant implications for patient care and health outcomes, particularly within Black communities, who disproportionately bear the burden of disease in the United States. This demographic experiences the highest mortality rates and lowest survival rates across various cancers and other leading causes of death such as heart diseases, stroke, and diabetes (9). Additionally, cancer incidence among minoritized individuals is projected to increase 99% by 2030 compared to 31% in their White counterparts (10). The pervasiveness of racial inequities in the screening, diagnosis, and treatment of urologic cancers is intrinsically linked to adverse social determinants of health and institutional racism (11,12). Similarly, suboptimal patient-provider dynamics, unconscious biases, or communication barriers can also play a role in worsened cancer outcomes. Minoritized individuals frequently report difficulties in communicating with physicians, feelings of disrespect and bias, and encountering greater obstacles in healthcare access compared to their White counterparts (13). Conversely, racially-concordant patient-physician relationships have the potential to mitigate cancer disparities by enhancing screening rates, treatment adherence, survivorship, and ultimately, improving patient outcomes (14). In a recent study in JAMA (15), greater Black physician representation was associated with higher life expectancy and was inversely associated with all-cause Black mortality and mortality rate disparities between Black and White individuals. The dearth of Black urologists implies that Black patients may lack access to racially-concordant care, potentially exacerbating existing urologic disparities. The endeavor to increase representation demands comprehensive strategies spanning medical education, recruitment, retention, and mentorship/sponsorship (8,16-18).

Against this backdrop, the perspectives of distinguished Black urologists, Dr. Tracy Downs and Dr. Jennifer Miles-Thomas, are poised to shed light on their individual experiences as Black urologists, the importance of diversification and its impact on patient care. Dr. Downs is a renowned Urologic Oncologist with a sub-specialty focus on bladder and prostate cancer. As a trailblazer in the field, Dr. Downs serves as Chief Diversity and Community Engagement Officer for the University of Virginia and has paved the way for future generations of Black urologists. Dr. Miles-Thomas is a urologist, business leader, and healthcare advocate with over 14 years of experience in the field. She is currently the President and CEO of Urology of Virginia and holds leadership positions in other organizations. Dr. Miles-Thomas was elected to become Treasurer of the American Urological Association (AUA) for a four-year term beginning in 2025.

In this interview, Dr. Downs and Dr. Miles-Thomas share their perspectives on being Black urologists in the United States and the profound impact of diversification.

Can you speak to your experience as a Black urologist in your practice setting?



Jennifer Miles-Thomas,
MD

Jennifer Miles-Thomas, MD (JMT): Being a Black urologist in my practice setting is a double-edged sword. Managing patient expectations along with my clinical duties is a balancing act. Culturally, since there are so few Black urologists, the expectation is that you will take “extra” care of all of your Black patients. In reality, you treat all patients well, but I do spend extra time with patients of a similar background to make sure they understand their options and help remove the barriers that may have limited their care in the past. This “extra” time is not compensated and contributes to burnout. However, it is important, and studies have proven that patients do better with physicians that look like them. Hopefully in the future, we will have more Black urologists so the tax will not be as great on any one individual.



Tracy Downs, MD

Tracy Downs, MD (TD): My previous practice was in a non-diverse state and perhaps when I walked into rooms, I was the first African American physician that some have seen. There were very rare sightings of more than one African American physician at a time. Though, one advantage I have seen is that, for those individuals who have not had a lot of interaction across diversity or have not seen diversity in leadership roles, (my visibility) has the ability to reshape their mindset of “what does Black look like in America?” It looks smart, it looks dedicated, it looks committed, it looks giving and compassionate. So there is an opportunity to role model. Early in my training, I encountered a situation with a patient who refused to have a Black doctor. I recall my

colleagues rallying around me and informing the patient that they were making a tremendous error because “he is one of our best doctors”. We call it allyship now. I felt like I belonged, and I felt included. That is also what we need to ensure and provide for our learners and trainees.

Can you speak to the importance of race concordant patient-provider relationships?

TD: My current practice is very diverse. You can see when you walk into a room and the patient trusts you or they feel like they are being heard. When I think about PSA screening for an African American male, I’m seeing more than that patient: I’m seeing the data that we’re aware of, I’m seeing my brother, my roommate that had prostate cancer and the known disparate outcomes. I understand the lived experiences: What

could look like anger in a patient could actually be fear because of past experiences in the health care system. Further, the data shows that the presence of Black physicians is associated with a lower all-cause mortality. We make a difference in the delivery of health care on an individual basis.

What is necessary to improve diversity in your practice?

JMT: Recruitment of a diverse workforce is important. Patients who are from a minority culture trust doctors who are from a similar culture. (To) increase diversity in our practice, we must show others that we value diversity. We accomplish that by hiring diverse physicians. We also make sure that patients can see the photos and diverse backgrounds of all our physicians on our website. It is always hard to recruit the first person to a non-diverse environment. But once you have the first, others will be signaled that your practice is a welcoming environment.

TD: Oftentimes in medicine, we can think “I’m more meritorious. I deserve that spot.” But, in being patient-focused, we should think about building the best team. For instance, in football, you need to have linemen to block, quarterbacks to throw, receivers to catch. You cannot have a team comprised of one position. To address the needs of our public, in our health systems and practices, we need individuals to relate to diverse types of people. Since, in large part, our centers are diverse, we need a diverse workforce. But it is a mindset.

Conclusion

Enhancing the representation of Black urologists in the workforce and, consequently, fostering an increase in racially-concordant patient-provider relationships will contribute to addressing disparities and promoting health equity. Achieving this necessitates coordinated endeavors from academic institutions, professional societies, and healthcare organizations, as well as individual-level commitments, to establish an inclusive and equitable system.

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Black Excellence in Academic Urology

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Introduction

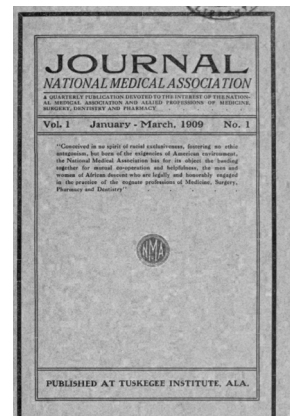
Black excellence refers to the noteworthy accomplishments, contributions, and resilience demonstrated by Black individuals and collectives across various settings. The ability to challenge traditional narratives and promote diversity and inclusive initiatives within academia highlights the particular significance and value of this concept in disciplines such as urology. Black excellence is celebrated in academic urology due to its impact on patient care outcomes, research advancements, and the broader medical community. However, the historical journey to realizing these milestones has been fraught with obstacles and systemic barriers which have required often tremendous efforts to overcome.

Importance of Black Perspectives in Academic Urology

Black perspectives in academic urology bring unique viewpoints and approaches to the field. The inclusion of diverse voices and experiences enhances the understanding and treatment of urologic conditions in a more comprehensive and culturally competent context. Understanding the unique challenges faced by Black patients facilitates more tailored and effective interventions with the goal of promoting health equity. This is pivotal to address urologic health disparities that disproportionately affect Black communities and to improve outcomes for underserved populations (1). Furthermore, Black urologists may offer fresh insights into scientific research, challenging conventional practices and contributing innovative solutions to medical needs. In turn, this may promote creativity, collaboration, and the advancement of the field.

Overcoming Historical Barriers in Academic Urology

Black individuals have faced considerable barriers and discrimination in virtually every aspect of healthcare including academia. As in broader society, Black physicians historically found themselves excluded from medical societies and associations. The National Medical Association (NMA) was founded in 1895 in response to racial discrimination and exclusion of Black physicians from these groups (2). Additional impediments in the ability of burgeoning Black academicians to disseminate medical and scientific information through academic publication in



Journal of the NMA,
ca 1909

Countway Library, Harvard

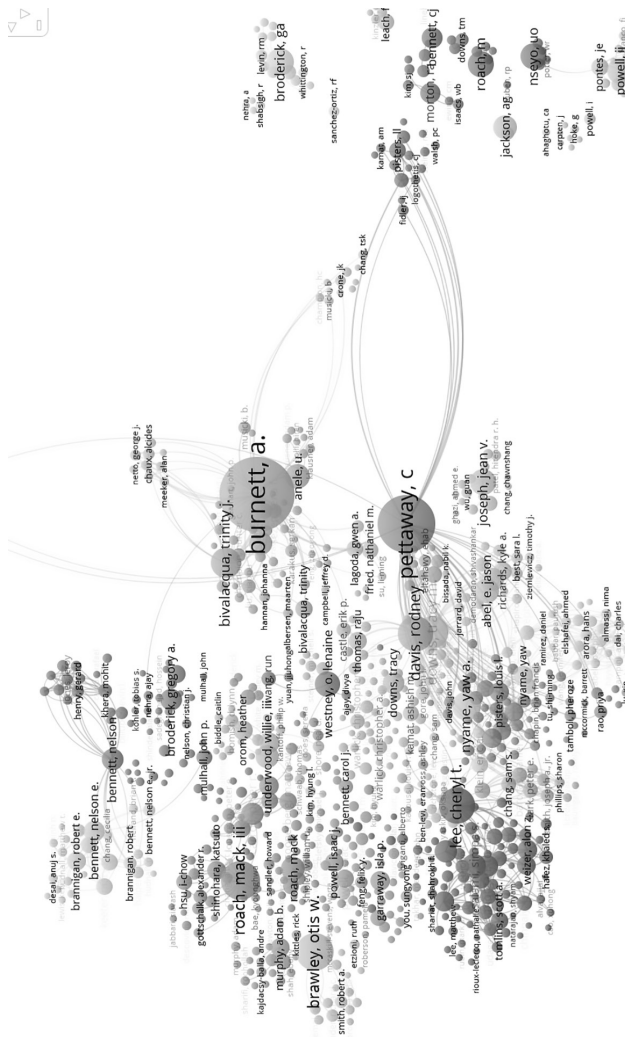


Figure 1.

Schematic illustration (by Bart Ragon) demonstrating the influential and complex relationships fostered through publication collaborations by prominent Black academic

existing medical journals compelled the NMA to establish the Journal of the NMA in 1909. Though initially faced with limited resources and struggles to gain recognition in the broader medical community, this initiative gradually gained prominence. Thus, early academic urologists were able to disseminate research, share knowledge, and address health issues affecting minority populations. In much the same way, early pioneers triumphed over existing systemic barriers by creating new pathways to success, thereby laying the foundation to further promote Black excellence.

Excellence of Contemporary Black Academic Urologists

The sacrifices and efforts of the early academic forerunners of Black excellence facilitated the career paths of those who have subsequently risen to prominence in academia. The academic successes and achievements of these individuals are manifested in the roles of many as full professors, residency/fellowship program directors, chairpersons, principal investigators, and more. The influence of renowned Black urologists is demonstrably far-reaching as evidenced by the often-formative collaborations involving aspiring trainees and young urologists (Figure 1). Many of the notable contributions made by Black urologic academicians span the wide breadth of the field (Figure 2). These accomplishments of Black urologists in academia serve as inspiration for aspiring medical professionals from similar backgrounds and emphasize the importance of representation in shaping the future of the field.

Remaining Barriers in Academic Urology

Despite the monumental academic achievements of these select trailblazing Black urologists (Figure 2), obstacles remain, including implicit biases, lack of diversity in leadership, and insufficient academic pipelines. Implicit biases in medical academia can begin as early as medical school admission and may contribute to the comparatively lower urologic residency match rates of Black applicants. In the setting of a career, these biases may translate to limited professional advancement by influencing decision-making processes related to recruitment, promotion, and leadership positions, thus perpetuating existing disparities. A lack of representation in decision-making roles can impede the implementation of inclusive policies and initiatives to advance Black excellence. Furthermore, Black faculty may be relegated to responsibilities that impose excessive burdens that do not contribute towards academic advancement - the "minority tax." Finally, insufficient pipelines, including to medical school, residency programs, and research opportunities, curtail the collective growth potential of a diverse pool of future academic urologists.

Establishing representation in academic urology is an essential catalyst for propagating diversity and inclusion within the field. Recognizing and celebrating the accomplishments of Black urologists encourages institutions and organizations to address existing barriers and biases that hinder the progress of those underrepresented in medicine. By actively supporting and investing in the success of Black urologists, academic institutions can cultivate a more inclusive and equitable environment that

benefits all urologists and enhances patient care outcomes. Collaborations among Black academic organizations and support within groups can also help achieve global impact of the field. The exchange of knowledge and expertise leads to collective advancement and progress in eroding several of these historical barriers.

Inspiring Future Generations

Black excellence in academic urology serves as a source of inspiration and motivation for aspiring Black trainees. By witnessing the achievements of Black urologists who have overcome obstacles and succeeded in academia, young individuals from similar backgrounds are encouraged to pursue careers in urology, knowing that their contributions can make a meaningful impact on patient care and medical research. The representation of Black excellence in academic urology cultivates a sense of possibility and fosters mentorship opportunities, creating a pipeline for future generations of Black urologists.

Mentorship and sponsorship programs are instrumental in promoting diversity and inclusion in academic urology. Pairing underrepresented individuals with concordant mentors who can provide guidance, support, and opportunities for professional growth can help overcome barriers and navigate the challenges of training in academic settings or even a career in urology. Sponsorship programs, which go beyond mentorship by advocating for career advancement, are particularly effective in creating opportunities for underrepresented individuals. However, these changes require support at organizational levels due to the widespread nature of institutional perceptions.



Drs. Bobbilyn Hawkins and Nyemkuna Fortingo at the RFJUS meeting at AUA2023.

R. Frank Jones Urological Society

Educational initiatives and outreach programs play a critical role in developing and nurturing the pool from which Black academic talent arises. Within medical schools and residency programs, targeted recruitment efforts, scholarships, and pipeline programs can be implemented to attract and support students. Establishing Black residents in leadership positions can help inspire future generations and shape institutional policies. Such diversity in leadership helps to ensure that the perspectives and needs of Black and other underrepresented residents are considered in decision-making processes, fostering a more inclusive environment. Recruitment and retention strategies can also be employed at a community level to engage underrepresented students, thus inspiring and supporting students to pursue careers in urology.

Conclusion

Black excellence in academic urology is a powerful force that challenges historical barriers and promotes authoritative representation within the field. The accomplishments and contributions of Black urologists inspire future generations, foster collaboration, and drive advancements in patient care and research. Recognizing the significance of Black excellence in academic urology is essential for creating an equitable, diverse, and thriving field that provides high-quality urologic care for all patients.

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Onward and Upward: Celebrating Black Urologists in America

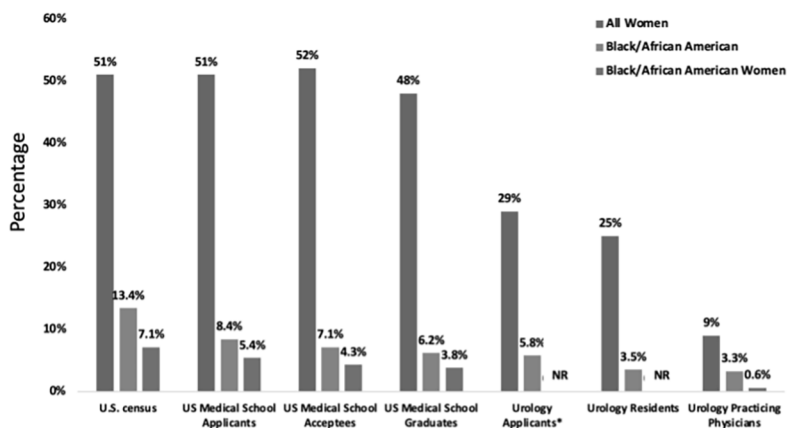
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Black Women in Urology

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In 2019, only 0.6% of urology practicing physicians identified as Black women (6). This is in the setting of Black urologists and women urologists representing 3.3% and 9% of the workforce respectively. The first woman to be certified by the American Board of Urology (ABU) was Dr. Elisabeth Pauline Pickett in 1962. It was not until 1987 that Dr. Carol J. Bennett became the first Black woman in the United States to be board-certified in urology. In the subsequent years, there has been slow entry of Black women into our specialized field.

An examination of the continuum from medical school applicant through graduates, urology residency applicants and residency graduates and finally, urology practicing physicians reveals that at each stage of the pipeline there are fewer and fewer Black women, ultimately resulting in their marginal representation (Fig. 1). Several studies have indicated that women and under-represented in medicine (URiM) individuals are less likely to have early exposure and appropriate mentorship required for successful



Black Women in the Urology Workforce

Fig. 1. Distributions of Black Women for 2019 in order of descending representation of the U.S. population, U.S. medical school applicants, U.S. medical school acceptees, U.S. medical school graduates, Urology applicants, Urology residents, Urology Practicing Physicians. These figures are expressed as percentages of the total population of a given cohort. All data represented were obtained from publicly available websites.

Data from United States Census; ACGME Data Resource Book, Academic year 2018-2019¹; AAMC Diversity in Medicine: Facts and Figures 2019²; AAMC 2020 FACTS: Applicants and Matriculants³; AAMC ERAS Statistics⁴; AUA Urology and Specialty Matches⁵.

**Numbers for Urology Applicants were obtained from the AAMC ERAS website and not from the AUA Residency Match Statistics since AUA does not report Race/Ethnicity data.*

NR = Not Reported

entry into urology (7-9). Black women therefore have the dual challenge of facing barriers attributed to their identities as both woman and Black. This phenomenon is encapsulated by the term *intersectionality*. As the American Urological Association increases its commitment to championing equity in all domains, including representation in our workforce, efforts can be made to facilitate the recruitment, retention and promotion of Black women in urology.

Dr. Carol J. Bennett: First Black Woman in Urology

In 1987, Dr. Carol J. Bennett became the first Black woman to be board certified in Urology. Prior to this, she was the first woman to pursue urology residency at the University of Michigan. She trained under Dr. Edward J. McGuire, giving rise to her establishment of the spinal cord injury fertility program which led to the first pregnancy in the United States from a semen sample obtained from a paraplegic man by electro-ejaculation. After training, Dr. Bennett was appointed to the faculty at the University of Michigan, initially as the Chief of Urology for the Wayne County hospitals and then as Chief of Urology at Veteran Affairs (VA) hospital, making her the first woman on the urology faculty at the University of Michigan. In 1988, Dr. Bennett joined the faculty at the University of Southern California (USC) as the Chief of Urology at Rancho Los Amigos National Rehabilitation Center. In 1996, she accepted a position as Chief of Urology at West Los Angeles VA as the first-ever woman on the faculty at the University of California Los Angeles (UCLA). In 2019, Dr. Bennett was appointed to an endowed chair, the Henry E. Singleton Chair in Urology in recognition of her impeccable service to our veterans for over 25 years, her dedication to education and her highly regarded scholarly work in neuro-urology. In 2022, she was honored at the R. Frank Jones Urological Society meeting at the AUA annual meeting and in 2023, was awarded the Lifetime Achievement Award by the Association of Black Women Physicians (ABWP).



Dr. Carol J. Bennett, ca 1970s

David Bloom, MD

Dr. Bobbilynn Hawkins: First Woman Urologist in The United States Army

Dr. Bobbilynn Hawkins Lee, like Dr. Carol Bennett, completed her medical education at the Georgetown University School of Medicine where she joined the United States Army. She began her urology residency training at Walter Reed Army Hospital and completed it at Emory University in 1986. In 1989, the American Board of Urology awarded her urology board certification, thus making her the first woman urologist in the United States Army. A few years later, she pursued a fellowship in pediatric urology

at the University of Florida, completing it in 1994. Despite her fellowship training, Dr. Hawkins took an interest in voiding dysfunction and ultimately became the Director of Urodynamics and Female Urology at the Charlie Norwood Veterans Affairs Medical Center in Augusta, Georgia. Her outstanding clinical research led to the discovery of the gene responsible for uro-facial syndrome.

Healthcare Delivery and Urologic Outcomes for Black Women

As in almost every field of medicine, health care disparities exist in urology for non-White patients, and these disparities may be more pronounced for Black women. Although Black women have higher incidence of overactive bladder, they are less likely to receive care from a specialist for this condition (10-12). Of those who have stress urinary incontinence, Black women are less likely to undergo sling procedures (13,14). When Black women do receive pelvic organ prolapse surgery, they are more likely to have higher morbidity and longer hospital stays (13). Race-concordant care has been demonstrated to lead to improved healthcare outcomes; however, given the very low numbers of Black women urologists, this strategy alone to address healthcare disparities is not feasible (15). As we contemplate possible ways to ensure equity in healthcare delivery and in patient outcomes for all patients including Black women, urologists ought to strive to provide culturally-competent care.



Drs. Jeunice Owens-Walton, Bobbilynn Hawkins and Emilie Johnson at the RFJUS meeting at AUA2023.

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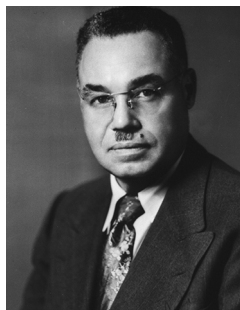
Black Innovators in Urology

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University of California Los Angeles

Innovation is often considered the development of breakthrough products or services, but it can also mean the creation and use of new ideas or methods. The first Black urologists have been innovators by nature. Matriculating into urology for many was a feat that required many skills in addition to their academic, clinical, and research excellence. Many Black urologists have continued following matriculation to effect change that directly improved patient well-being and expanded the definition of what it means to be a urologist.

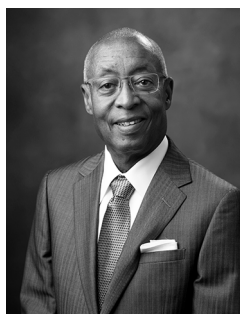
In this article, we will highlight the various ways in which Black urologists have been at the forefront of advances in the field of urology. Black urologists have played a vital role in driving innovations in technology, clinical care, curricular development, patient-centered efforts, and community engagement. This began with Dr. Richard Frank Jones.

Curricular Innovators



R. Frank Jones, MD

In addition to being the first board-certified Black urologist, Dr. Jones developed the first residency program for Black urologists (1). He struggled to be accepted as a urologist and recognized that other Black physicians would face substantial challenges in their attempts even to receive the required training. Thus, he established the training program at Howard University Hospital, formerly Freedmen's Hospital in 1947. This allowed Black physicians to train in urology. He considered this his "greatest professional contribution".



W. Bedford Waters, MD

Medical education was a focus of the innovations of several of the earliest Black urologists. Dr. Bedford Waters was a pioneer in urologic oncology. Dr. Waters was the first African American full professor of urology at a majority institution and the first Black Chair of a Urology Department at the University of Tennessee Medical Center. He subsequently developed their residency curriculum, eventually training 62 residents (2). His commitment and creativity in developing educational programs extended to the global community. He recognized the benefit and spearheaded the development of urologic research and

global partnerships for education in the practice of urology in African countries. This was recognized in his designation of “Friend of PAUSA”, the Pan-African Urological Surgeons, for his help in developing the urologic practice and education programs in Africa (3).

Clinical/Surgical Care Innovators



Curtis A. Pettaway, MD

Dr. Curtis Pettaway is a distinguished Professor of Urology at The University of Texas MD Anderson Cancer Center in Houston, Texas. His expertise is in genitourinary malignancies, focusing on prostate, penile, and urethral cancers. Dr. Pettaway has significantly contributed to the field, explicitly developing innovative approaches to treating penile cancers, a rare and challenging malignancy.

Inguinal lymph node dissections can be particularly morbid for patients. Through his innovative surgical techniques, Dr. Pettaway has successfully reduced the extent of inguinal lymph node dissections while maintaining accurate staging, resulting in improved patient care and quality of life (4). Additionally, his dedication to improving the treatment of advanced penile squamous cancer has resulted in substantial breakthroughs, including a Phase 2 study investigating the potential benefits of a combination therapy involving cisplatin, paclitaxel, and ifosfamide (5). This groundbreaking study demonstrated enhanced outcomes for patients with advanced-stage disease, leading to the adoption of this regimen as the standard approach for treating penile cancers.

Beyond his clinical practice, Dr. Pettaway is also a principal investigator for the International Penile Advanced Cancer Trial (InPact), a pioneering study aiming to determine the optimal sequencing and relative benefits of surgery, chemotherapy, and chemoradiotherapy for patients with penile cancer who present with inguinal lymph node metastases (6). By leading this international collaboration, Dr. Pettaway is shaping the future of penile cancer management and ensuring that patients receive the most effective and tailored treatments available.

Dr. Pettaway’s pioneering contributions to the field of urology, specifically in the realm of penile cancer, have redefined the standard of care and improved patient outcomes (7). His unwavering commitment to advancing the field of urology serves as an inspiration to future generations of healthcare professionals.

Basic/Translational Research Innovators



Carol J. Bennett, MD

Dr. Carol J. Bennett is the Henry E. Singleton Professor of Urology at the University of California Los Angeles. She was the first Black female urologist who was board-certified in 1987 at a time when fewer than 1% of urologists were female. After completing her residency, she had the foresight to see the importance of post-residency training prior to the establishment of fellowships. She trained in what is now called neurourology, then went on to establish the spinal cord infertility program at the University of Michigan. Her pioneering work there on electroejaculation enabled the first

pregnancy in the United States from a semen sample obtained from a paraplegic man. Dr. Bennett became a world-renowned expert in medical rehabilitation research and sexual function and infertility in the setting of spinal injury (8).



Arthur L. Burnett, II, MD, MBA

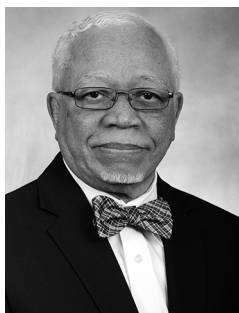
Dr. Arthur L. Burnett, II, holds a position as a Distinguished Professor in the Department of Urology and serves as the Director of the Basic Science Laboratory in Neuro-Urology at Johns Hopkins University School of Medicine. Internationally recognized as a preeminent authority in the scientific and medical aspects of male erectile dysfunction, Dr. Burnett has made significant original discoveries related to the biochemical mechanisms involving nitric oxide in erectile tissue. In a groundbreaking study using a rat model, Dr. Burnett and his team explored the role of nitric oxide in erectile function. They

discovered that nitric oxide, a vasodilator endothelial cells produce, plays a crucial physiological role in penile erection. Through their investigation, they localized the synthetic enzyme for nitric oxide, known as nitric oxide synthase, in penile neurons innervating the corpora cavernosa and neuronal plexuses in the adventitial layer of penile arteries (9). These findings established nitric oxide as a fundamental mediator of erectile function, paving the way for significant advancements in understanding and treating erectile dysfunction. His groundbreaking research has paved the way for transformative advances in the clinical development of oral medications to treat erectile dysfunction, benefiting countless individuals worldwide.

Dr. Burnett has also significantly contributed to understanding the molecular mechanisms behind sickle cell disease-associated priapism. His research has examined reduced nitric oxide signaling, oxidative stress, and dysregulated signaling pathways in priapism (10). Dr. Burnett emphasizes the importance of basic science studies to uncover new therapeutic targets for priapism, restore erectile function, and prevent its occurrence (11).

In 2018, Dr. Burnett and a team of surgeons performed a groundbreaking total transplant of the penis, scrotum, and lower abdominal wall on an injured veteran, addressing the devastating consequences of genital tissue loss (12). Using a unique surgical technique, he helped re-establish blood supply and nerve connections, resulting in near-normal erections, orgasms, and improved pleasure. The patient regained sensation and the ability to urinate while standing. Dr. Burnett's innovation offers hope, restored function, and improved psychosocial well-being for others facing similar challenges.

Patient-Centered Innovators



Isaac J. Powell, MD

Dr. Isaac J. Powell is a urological powerhouse with immense contributions in the fields of research and patient care. Dr. Powell, Professor of Urology at Wayne State University School of Medicine, is a pioneer in prostate cancer research, particularly in addressing the health disparities faced by African Americans. His innovative work takes a multifaceted approach that examines barriers to care, genetic factors, and the influence of the environment and behavior. Dr. Powell's extensive publication record has significantly advanced our understanding of prostate cancer. One of Dr. Powell's studies examined the CYP3A4 gene variant, which plays a crucial role in androgen metabolism. This variant was more common in African American men and associated with aggressive prostate cancer characteristics, particularly in older men (13). Dr. Powell's research sheds light on the genetic factors underlying prostate cancer and the potential implications of the CYP3A4 variant in disease progression. In addition to investigating genetic variations, Dr. Powell's research has explored the role of ERF genes. ERF has been identified as a prostate cancer tumor-suppressor gene, and Dr. Powell's team discovered recurrent loss-of-function mutations in ERF not previously observed in this context (14). These mutations were present in a significant percentage of localized primary hormone-naïve prostate cancers in African American men.

Dr. Powell's holistic research approach encompassing genetic and environmental influences has transformed our understanding of prostate cancer (15). His invaluable contributions have shed light on the underlying mechanisms and paved the way for targeted interventions and personalized treatment strategies. Dr. Powell's investigations into genetic factors have provided crucial insights into the disparities in prostate cancer outcomes among African American men.

Dr. Powell's dedication to urology and pioneering spirit in elucidating the genetic intricacies of prostate and bladder cancer have advanced the field and paved the way for a more inclusive and equitable approach to urological healthcare. His research underscores the importance of addressing healthcare disparities and promoting equality in prostate cancer prevention, diagnosis, and treatment. Dr. Powell's remarkable contributions inspire urologists and researchers, amplifying the significance of genetics and

personalized approaches in mitigating the impact of prostate cancer among African American men.

In addition to being at the forefront of translational research and focusing on racial disparities, Dr Powell expanded this work to incorporate the contributions of community members. He was one of the earliest urologists to understand the importance of community engagement in this type of work. Prostate cancer disparities research initially developed as a field largely due to his efforts, which included the establishment of a collaborative, patient-centered research group.



Cheryl T. Lee, MD

Dr. Cheryl T. Lee is the Chair of Urology at the Ohio State University. Dr Lee is the first Black female urology department chair in the U.S. and has spent her career advocating for patients with bladder cancer (16). She created a model care plan for bladder cancer survivors, including a record of their past treatments and future visits. She has also worked to emphasize improving quality of life, surgical outcomes and survivorship for bladder cancer patients, holding multiple leadership roles that facilitated her patient-centered initiatives.

These roles include her membership on the Board of Directors and former Presidency of the Bladder Cancer Advocacy Network as well as the Chair of the Outreach Committee of the Society of Urologic Oncology.

Community-Centered Partnership Innovators



Frank E. Staggers, Sr., MD

Dr. Frank E. Staggers was a leader in urology in California and the nation. He was one of the first Black Americans to complete a naval residency, eventually becoming Assistant Chief of Urology at the US Naval Hospital in Oakland prior to becoming Chief of Urology at Highland General Hospital. Dr. Staggers was President of the California Medical Association and President of the National Medical Association. He understood the importance of stakeholder involvement in urological care decisions and developed a way to connect his large academic center directly to the community: he envisioned, established,

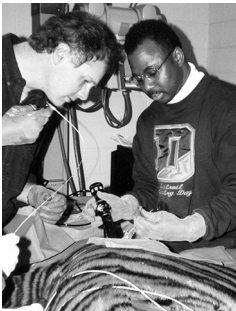
and was Founding Chair of the UCSF Helen Diller Family Comprehensive Cancer Center Community Advisory Board. The Community Advisory Board (CAB) benefits from the wisdom of 23 health, social science, and community leaders representing the Bay Area (17). Dr Staggers also founded the Prostate Conditions Education Council, a non-profit organization dedicated to educating men about prostate cancer, and was co-founder of St. Luke's Society, an alliance between East Bay Black doctors and ministers who use the Church as a way to spread accurate health information to the

community. Dr. Staggers built and then leveraged his own relationships within the community to develop collaborative efforts aimed at improving urological care and outcomes in the Bay Area (18). These innovative initiatives inspired the development of similar attempts at community involvement at other institutions.

Terry Mason, MD and James K. Bennett, MD

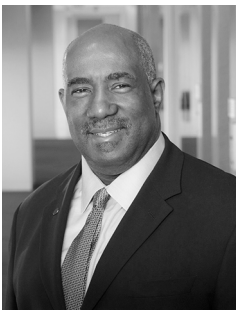
Other inspiring early Black urologists focused their efforts on outreach to the patient community. These efforts include the work of Dr. Terry Mason, who came to realize the importance of directly speaking to the patient community, and has had a weekly radio show focusing on all things health-related in the Black community with a special emphasis on urologic issues. Similarly, Dr. James K. Bennett produced a series of educational films aimed at explaining issues to patients in ways that they could understand. Both of these doctors were involved in outreach not only to Black patients but Black physicians as well, using an innovative way to get Black male physicians to focus on their urologic health: they organized very popular concerts at the annual National Medical Association meetings to encourage men to participate in prostate screenings. These and other events in the community shed a light on the need for ongoing advocacy and education for those at risk for urologic diseases.

Beyond Urology



Ray H. Littleton, MD

Several urologists have utilized their urology backgrounds and expertise to inform their work in related areas. Dr. Ray Littleton called upon his endourologic skills in veterinary care. He was one of the first urologists to perform minimally-invasive surgical urinary stone treatment in animals. In one memorable instance, he adapted endourologic instruments to treat a bladder stone in a tiger at the request of his local zoo in Detroit.



Willie Underwood, III, MD

Dr. Willie Underwood, III, is a Renaissance man. In a recent interview with the Healthcare Executive Forum, he said, “I consider myself a clinician, scientist, entrepreneur, and a social change agent.” In addition to his basic research focused on developing prostate cancer biomarkers, Dr. Underwood has committed to addressing health disparities for prostate cancer patients and beyond (19). He was one of the first urologists to understand the importance of changing healthcare policy an effective means of addressing disparities for patients and

physicians. Very early in his career, Dr. Underwood became actively involved in national leadership beyond urology, and was innovative in cultivating support for his various committee roles by leaders in urology and general surgery. He currently serves as Chair of the Board of Trustees of the American Medical Association. He is also a current and former board member of several healthcare-related organizations including the Joint Commission and Highmark Blue Cross Blue Shield and is the Executive Director of the Buffalo Center for Health Equity (20).



Fenwa F. Milhouse, MD

Dr. Fenwa F. Milhouse is a Female Pelvic Medicine and Reconstructive Surgeon in private practice. Dr. Milhouse recognized that patients and the population at large are very poorly informed about urologic issues. She understood the unique role that social media could play in facilitating outreach to large numbers of people and has developed an online persona focused on sharing accurate urologic information in short, concise posts. The popularity and utility of these posts has led to the development of her own television show on a

major national network.

Conclusion

Through their unwavering dedication to innovative research, patient care and community-focused initiatives, these urologists have made remarkable achievements. They and other Black urologists have not only revolutionized the field of urology but played a pivotal role in expanding the frontiers of knowledge surrounding benign and oncologic urology. Their contributions have benefited patients globally and inspired Black urologists to make their mark in the field, fostering a more inclusive and diverse future for urological advancements.

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Black Excellence and Nontraditional Pathways of Leadership – Leading Outside of the C-Suite

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University of Virginia Health System

Servant Leadership in Action – Leadership is Not Static

Names such as Mother Teresa and Reverend Dr. Martin Luther King Jr. come to mind when one thinks about great examples of servant leadership throughout history. Servant leaders characteristically put others first and lead by serving their people, not by exalting themselves. Amongst the 10 most important characteristics of servant leaders (1), two in particular stand out in our contemporary and non-contemporary Black non-traditional leaders: (a) Commitment to the growth of people and (b) Building community.

In John Maxwell's 25th anniversary edition of his book entitled "The 21 Irrefutable Laws of Leadership" (2), he emphasizes that leadership requires the ability to do more than one thing. Amongst the 21 laws, the 5th law: The law of addition – Leaders add value by serving others, is embodied by many contemporary Black urologists such as Arthur L. Burnett, MD, MBA; Linda McIntire, MD; Shenelle Wilson, MD; Brian McNeil, MD, MBA; Willie Underwood III, MD, MSc, MPH and Pamela Coleman, MD, to name a few. These modern day "Change Agents" have benefited from the paths and pathways that have been established by prior generations of Black urologists and surgeons.

On the Shoulders of Giants – Black Surgeons as Community Champions

Facing numerous obstacles, many of the early Black pioneers in medicine astutely identified the challenges leading to health disparities and forged a pathway forward, not waiting for systemic barriers to be acknowledged and removed, those related to segregation, discrimination and an overall lack of resources to health care.

On describing the late Levi Watkins Jr., MD, first black surgical resident at Johns Hopkins Medical Institutions, Dr. Selwyn Vickers, President and CEO of Memorial Sloan Kettering Cancer Center (MSKCC), characterized Watkins' legacy in the following manner:

*Levi understood **sacrificial leadership**...He said we are going to be diverse, before diversity was popular. At some point he decided that there were things he was willing to stand and fight for that might prevent him from becoming the chair of a department of surgery or reaching some of the higher offices in national surgical leadership. The stances he took around civil rights and diversity were not popular. But he chose to take them because he felt they were important (3).*

In many ways, non-contemporary and contemporary Black urologists continue the thread of early Black surgical pioneers by building their own leadership capacity to grow nontraditional pathways.

Black Urologists “Lifting as We Climb”

Lifting as we climb (the motto of the National Association of Colored Women – NACW, founded in 1896) seeks to build on legacies of struggle and determination, community and hope like a countless number of Black educators and activists who have led efforts to promote educational opportunity and human rights. *Lift as you climb* also embodies both the concept of sacrificial leadership and non-traditional leadership. Many Black urologists have led in this way through major contributions in the following domains: medical missionary trips, mentorship and sponsorship, nonprofit boards, administrative positions, and many others.

Frank Eugene Staggers, Sr., MD (1926 – 2013)

Born on August 23, 1926 in Charleston, SC as the fifth of nine children, Dr. Frank E. Staggers was a Sergeant in the US Army, in Belgium during World War II, and, upon returning home, completed his undergraduate education at Virginia State College in Petersburg, VA, earning a BA in Zoology. He then graduated from Meharry Medical College in Nashville, TN, leading to a residency in the Navy as a Lieutenant Commander with a surgical subspecialty in urology. He later retired from the Navy as a Commander in 1963 (4,5).

“Dr. Staggers’ contributions to organized medicine, the medical profession, public health policy and the health and welfare of patients locally and nationwide are innumerable,” said Donald Waters, Alameda Contra Costa Medical Association (ACCMA) Executive Director.

Dr. Staggers was a board-certified urologist in Oakland, California and served as the Chief of Urology at the Alameda County Medical Center from 1989 – 2001. Locally, he was president of the Alameda-Contra Costa Medical Association (ACMA) and co-founder and Chair of the Alta Bates Summit Ethnic Health Institute (EHI), which had a mission to promote health and well-being of the community with a focus on underserved and minority populations. Regionally, Dr. Staggers served as the California Medical Association (CMA) President in 2001 and was a cofounder of the CMA Foundation’s Network of Ethnic Physician Organizations and longtime member of the CMA Foundation’s Board of Directors.

Nationally, Dr. Staggers served as President of the National Medical Association (NMA), the nation’s oldest and largest professional, education and scientific organization representing the interests of more than 25,000 African American Physicians. Dr. Staggers was also an active member and officer of many professional organizations such as the NAACP, American Medical Association, Chairman, AMA Consortium on

Minority Physicians, Sinkler Miller Medical Association, the American Urological Association, not to mention being involved with many historic Black colleges.

Dr. Staggers received local, state, and national recognition through several resolutions, commendations, and awards. These include, but are not limited to, the Recipient of Resolution from California State Legislature, Golden State Medical Association, Outstanding Services Award, National Medical Association, Distinguished Service Award, Meharry Medical College Alumni of the Year and Smith-Kline French Pharmaceutical, Inc. National Achievement Award, and the AMA Foundation Distinguished Service Award.

Dr. Staggers had a strong belief, passed down from his family, that elders must provide a foundation for the next generation to reach its highest promise, and that family incorporates the entire community, not just those biologically related. It also involved an understanding that the health of an individual and the health of a community are always integrally linked, and it is because of this foundation that Dr. Staggers' practice was centered on identifying and developing strategies/solutions to eradicate health-care disparities, truly pioneering the principle that healthcare is a right, not a privilege.

Bobbilynn Hawkins, MD (1953 – Present)

Dr. Bobbilynn Hawkins is the nation's first African-American full professor of urology and the sixth female urologist to be certified by the American Board of Urology. She also became the first female urologist in the United States Army and served more than 30 years as a military command surgeon, earning the rank of Colonel and serving in the Gulf War. Dr. Hawkins began her journey into medicine at Emmanuel College in Boston, Massachusetts. In its early years, Emmanuel College, founded by the Sisters of Notre Dame de Namur, was a day college preparing women for professional fields such as education, nursing and social work (6,7).

During her undergraduate studies, officials told her that medical school was out of reach and that no prior students had ever been accepted into medical school. These words provided the fuel for Dr. Hawkins to prove them wrong. "My father who was a colonel in the United States Army, raised me to be a leader and I was not going to let them stop me from following my heart." Unfazed by the remarks, Dr. Hawkins went on to do several studies at Harvard Medical School, earned a master's degree from Baylor University, and subsequently went to Georgetown University's School of Medicine where she studied urology and began her military career. For a second time, Dr. Hawkins was discouraged from pursuing her dreams and faced an obstacle in gender-bias; her male colleagues tried to discourage her from studying urology, saying that it was no place for a female. But she defied those remarks as well and went on to become the nation's first female urologist in the US Army.

Among Dr. Hawkins' many accomplishments, the study of the Ochoa Syndrome, a rare condition that turns smiles into grimaces and impedes bladder and bowel control was a significant contribution. For nearly 13 years, Dr. Hawkins worked with a team of researchers to study the DNA taken from urofacial patients in Antioquia, Colom-

bia to perform genetic mapping to identify the chromosomal regions containing the suspected genes. Dr. Hawkins, focusing on urological research over the last decade of her career, transitioned into urologic cancers. She worked as Professor in the section of urology and Center for Biotechnology and Genomics at the Medical College of Georgia at Augusta University. She also held clinical and leadership roles as the Director of Spinal Cord Urology, Urodynamics and Female Urology at the Charlie Norwood VA Medical Center-Downtown Division. Dr. Hawkins retired in February 2019.

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Microaggressions

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The term “microaggressions” was first coined by African-American Harvard psychiatrist Dr. Chester Middlebrook Pierce more than 50 years ago (1). It was used to convey the daily verbal and nonverbal slights, snubs, or insults that communicate hostile, derogatory, or negative messages to degrade African Americans. Sue et. al. in 2007 described microaggressions as everyday slights, insults, put-downs, invalidations, and offensive behaviors that people of marginalized groups experience in daily interactions with generally well-intentioned people who may be unaware of their impact (2). Merriam-Webster defines microaggressions as “a comment or action that subtly and often unconsciously or unintentionally expresses a prejudiced attitude toward a member of a marginalized group (such as a racial minority)” (3). Today, the definition has been expanded to include the subtle denigration of any marginalized group, whether intentional or not. Examples of groups who typically fall victim to microaggressions due to race, sexual orientation, and gender are also seen in urology. In contrast to overt discrimination or racism, microaggressions tend to be more personal and covert. People who fall into multiple underrepresented groups face what is coined “double jeopardy” in terms of the effects and frequency of microaggressions due to the intersection of biases faced by the various groups (4).

Microaggressions can be either environmental or interpersonal (4). Environmental microaggressions, or macro-level, societal, or institutional microaggressions are more covert than interpersonal microaggressions. Examples include a work environment that supports objectification of women through signage in the office. Environmental microaggressions have invariably contributed to the low numbers of various underrepresented groups in medicine and higher education.

There are three major subtypes of interpersonal microaggressions: microinsults, microinvalidations, and microassaults (5). Microinsults are comments or actions that are unintentionally discriminatory (5). Examples of microinsults include statements such as “Are you the doctor?” or “You people are so articulate.” Microinvalidations are comments or actions that invalidate the experience of marginalized groups (5). This includes heteronormative language and assuming binary gender identification or heterosexuality. An example of a microinvalidation is the phrase “I don’t see color.” Finally, microassaults are intentional discriminatory or derogatory statements or actions against a marginalized group (5). An example of this is a sexist joke: “You are pretty smart for a woman.”

Microaggressions stem from widespread implicit biases. Although microaggressions have been pervasive in medicine for decades, there is growing recognition of the psychological damage microaggressions have on underrepresented groups in medicine. Microaggressions in the workplace have significantly impacted workforce retention, job satisfaction, and self-esteem of physicians from underrepresented groups.

Although in isolation a single incident may be deemed a mistake or out-of-character incident, the impact on the recipient of the microaggression is often understated. The repetitive offenses and sustained exposure over time by the recipients can have serious deleterious psychological effects. Psychological effects of microaggressions include depression, anxiety, stress, and overall poorer health outcomes (4). Environmental microaggressions also reinforce imposter syndrome, an internalized sense of inadequacy, in the underrepresented groups (6). Imposter syndrome hinders professional and personal growth (6).

The *bystander effect* is important when considering the response to microaggressions. This term, coined in the 1960s, refers to a reduction in assistance in the presence of other people (7). There are several factors that affect bystander intervention, termed *bystander apathy* (8). The recognition of wrongdoing may not occur immediately and may delay responses. A bystander may have a relationship with the victim or perpetrator and be less inclined to get involved. People may fear embarrassment if they respond in the moment or address a microaggression, a concept termed *evaluation apprehension* (8). People often fear the personal risk and fear of consequences should they respond. *Diffusion of responsibility* refers to people feeling less responsible when other bystanders are present (8). Finally, *pluralistic ignorance* refers to diminishing the severity of the situation due to others not treating the matter as serious (8).

Addressing microaggressions is an important aspect of creating a truly diverse and equitable work environment. There are several proposed solutions to combatting microaggressions at both organizational and interpersonal levels. Several validated questionnaires and workshops focus on addressing microaggressions in the moment, with a framework for bystanders and victims to respond productively. Other organizational solutions include the implementation of policies on microaggressions and bias training, and encouraging safe reporting policies. Additionally, empowering allies is important to cultivate inclusive environments. As the field of urology becomes more diverse, it is imperative that we acknowledge and address what microaggressions are, how we can minimize microaggressions in urology, and how to continually support underrepresented groups in urology. Diversity enriches urology and contributes to excellence in care for our patients. It is up to us to support the entire medical workforce and eliminate microaggressions.

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DESTINY

Sharing Our Power to Improve the Health of Our Marginalized Patient Communities—A Case for Engaging Black Patients and Communities in Urologic Care and Research

Yaw A. Nyame, MD, MS, MBA

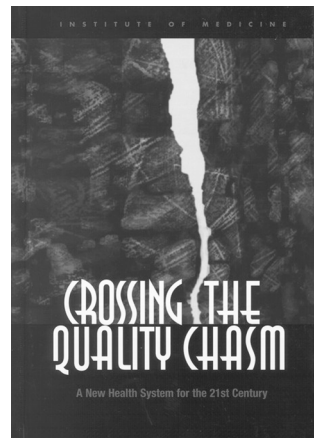
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A recent study evaluating the relationship between race and health in the US estimated that the 1.63 million excess deaths among Black Americans between 1999-2020 accounted for 80 million years of life lost among Black individuals (1). This sobering statistic reflects the fact that structural and social determinants of equity and health have and continue to drive inequitable healthcare access, delivery, and quality (2). Within the field of urology, we have the largest racial disparity in cancer death, with Black men being 2-3 times more likely to die from prostate cancer than the average US population (3-5). There are also well-documented racial disparities in incidences of benign urologic disease, such as benign prostatic hyperplasia (6), female urinary incontinence (7), and kidney stones (8,9).

Formulating an Effective Strategy

In its 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, quality health care was defined as safe, effective, patient-centered, timely, efficient, and equitable (10). The question remains: how do we overcome structural and social determinants of equity and health, such as systemic racism, economic systems, laws and policies, and healthcare infrastructures that disadvantage Black Americans and other marginalized communities from accessing equitable, safe, timely, efficient, and effective care? Current investigation of inequities in urologic care and outcomes has focused solely on describing healthcare inequities among Black urology patients and other marginalized patient populations.

An effective strategy for eradicating racial inequities in health and urologic care must develop interventions to address the underlying root causes of health inequities and must rigorously test and evaluate population-level interventions to create more equitable care and outcomes for marginalized communities.



Institute of Medicine, *Quality of Health Care in America*, 2001

The Charge to the Urologic Community

Ultimately, it is up to the urologic community to develop, implement, and sustain interventions that will improve the health of our Black and marginalized communities.

The challenge is that a history of experimentation, trauma, and abuse combined with a power differential between the medical field and marginalized communities creates opportunity for exclusion and distrust that drives Black urologic patients away from high-quality care and important clinical studies. As a discipline, community partner participatory research and patient-centered outcomes research both rely on fundamental pillars of trust, cooperation, and cooperative learning to empower patients and marginalized communities to participate in care delivery and research as equal partners with established medical institutions and practices (11,12). This approach, which is a challenging and resource-intensive endeavor, allows us to transfer power to our patients and communities by centering Black individuals and communities as true partners in our clinical and research activities (3,13). This transfer of power is an important step in overcoming the structural and social barriers in the US that have served as the foundation for inequities that we observe in urologic care and outcomes. By sharing our power, we allow ourselves to understand the lived experience of the Black community, to value their concerns about their care, to honor their desires for care delivery in their communities, and to elevate the activism of our Black communities in seeking better health outcomes.

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Diversity, Equity and Inclusion: A Visionary Curriculum for the Urological Surgical Specialty

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Academic education in urology has traditionally focused on anatomy and the impact of disease on the genitourinary tract. While these core sciences are foundational to medical education, the social sciences have mostly been omitted. There is no better opportunity to examine the intersectionality of the social sciences and medical science than in the study of diversity, equity, and inclusion (DEI). Ethnicity, socio-economic status, and race impact the detection and outcomes of disease in America; this was exemplified by the disproportional impact of morbidity and mortality experienced during the SARS COVID-19 Pandemic of 2020. A DEI curriculum in Urology is as important as foundational knowledge of basic sciences in the education of an astute physician and is instrumental in the development and maturation of future leaders in medicine and urology.

Traditional Urologic Curriculum

Urological residency encompasses five years of graduated responsibility in the diagnosis and management of medical and surgical urological disease. Surgical case logs with minimal requirements are essential for promotion to board certification. These data points are devoid of racial/ethnic demographics and cannot be tracked due to HIPAA regulations. Therefore, the American Board of Urology and Residency Review Committee lacks data as to the diversity of patient contact experiences in each residency program. Although surgical case logs may be equivalent to individual residency programs, patient experiences will likely differ. Establishing DEI curriculum as part of the AUA Core Curriculum would be an effective adjunct in residency training.

DEI Education in Lifelong Learning

The demographics of the U.S. population are changing. The number of white individuals under the age of 18 will decrease from 53% in 2012 to 33% in 2060. The Hispanic population will increase from 24% to 38%. Additionally, there will be an increase in multiracial individuals. Unfortunately, diversity in the U.S. population may not translate to equivalent diversity in trained urological specialists. DEI curriculum into Lifelong Learning Modules sponsored by the AUA and ABU would be instrumental for the continued adaptation of our specialty toward the needs of society.



The AUA Diversity and Inclusion Committee met at the AUA 2023 Annual Meeting in Chicago.

American Urological Association

Development and Implementation

The development of a DEI curriculum is a noteworthy task that would involve various stakeholders in the AUA and ABU. Diversity Taskforces at each of the AUA sections would be best suited to comprise regional curriculums that, when combined, would diversify and improve comprehensive national educational material. Adaptation to the AUA core curriculum through the Office of Education would be the best model to disseminate this material by developing questions for the AUA Self-Assessment and Study Program and subsequent Field Test Items for the ABU Qualifying Examinations. Validation of the curriculum would allow it to then be applied to AUA medical student curriculum as well as other continuing educational platforms.

NOW is the time to be visionary in the pursuit of a new urological curriculum encompassing the needs of a changing U.S. population.

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The Value of Mentorship Programs

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Mentorship programs serve as a cornerstone in the professional development of individuals across various fields, including medicine. In urology, these programs are not just a formality but a fundamental component that supports and strategically develops career paths, enhancing the growth and success of its mentees. A mentorship program's value is multifaceted, providing meaningful benefits to both mentors and mentees, contributing to personal and professional growth, and fostering a supportive and constructive environment.

Creating a successful mentoring program is challenging, as it hinges on the success of the mentor-mentee relationship, and the structure and organization of the mentoring program as a whole. Such programs are particularly vital in fields like urology, where the complexity of the specialty demands comprehensive knowledge and nuanced skill sets.

Similar to mentorship, pipeline programs are a comprehensive and structured system designed to increase the representation of underrepresented or disadvantaged groups in a specific field. The main goal of a pipeline program is to create a continuous and supportive pathway for individuals from these groups to enter, progress through, and ultimately excel in a profession. The primary difference between a pipeline program and mentorship is the scope. A pipeline program is a comprehensive, long-term initiative aimed at increasing diversity and inclusion by creating a pathway into a specific profession (4). In many cases, pipeline programs utilize mentorship as a strategy within their framework to ensure that individuals progressing through the pipeline have access to guidance and support from experienced professionals in the field.

What Makes a Mentorship Program Valuable?

While there is no one-size-fits-all approach to running a mentorship program, successful and valuable mentorship programs exhibit certain characteristics. They set clear objectives and goals, provide training and support for mentors and mentees, and they offer sufficient resources, such as learning materials, tools, and platforms, to enhance the learning experience of participants and contribute to the program's success.

Setting goals in mentorship is crucial because it helps both the mentor and mentee focus on what they want to achieve. Goals can provide a clear overview of what each party expects to gain from the relationship, offer accountability if goals are not being met, guide the mentor on what advice to give, give the mentee tangible milestones to work toward, and ensure both parties benefit from the relationship in measurable ways.

Providing training and ongoing support to mentors and mentees is essential to the success of any program. Mentor training programs are designed to prepare mentors to be as effective as possible in their roles. Training should cover mentors' goals and expectations for the mentor/mentee relationship, mentors' obligations and appropriate roles, relationship development and maintenance, ethical issues that may arise related to the mentoring relationship, and sources of assistance available to support mentors. Mentor training programs can also help mentees gain career development tools and resources, prepare for leadership positions, gain relevant skills and mentoring experience, and develop effective mentoring relationships within the organization. Mentees also learn how to seek and receive feedback while gaining an understanding of time management and accountability (1).



Meyerhoff Scholars at the Fulbright Award Ceremony

UMBC

The Goal of Mentorship Programs in Urology

In the field of urology, mentorship programs have specific goals that include increasing gender and racial diversity in the physician workforce and in leadership positions, streamlining and enhancing promotion and tenure amongst academic faculty, writing successful research grants, and encouraging residents to pursue subspecialty fellowship training. Despite these efforts, participation of Black individuals is low, and efforts to increase racial diversity are the least successful.

Traditional mentorship programs in medicine often fail Black individuals due to a range of systemic, cultural, and structural factors. Understanding these challenges is essential to address the disparities and create more inclusive and effective mentorship programs. In many cases, there is a lack of Black mentors in medicine. Without mentors



Meyerhoff Scholars Program

Class of 2023, UMBC

who share similar racial and ethnic backgrounds, Black mentees may struggle to find relatable role models and receive guidance that addresses their unique experiences (3). Medical institutions may have policies, practices, and cultures that perpetuate racial disparities. These systemic barriers can hinder the success of Black individuals in medicine and affect their mentorship experiences.

Existing Mentorship Programs in Medicine

There are programs that have been successful in the mentorship of Black individuals in medicine. **Urology Unbound**, an organization dedicated to the recruitment, retention, and promotion of underrepresented urologists, provides mentorship for individuals at all career stages and has a pipeline program for medical students pursuing the field. A pipeline program is offered to medical students to help them navigate the complex and competitive field of urology. Medical students are provided personalized support, including research opportunities, residency application review, and mock interviews, to ensure they are fully prepared for the competitive residency application process. Over the past three years, Urology Unbound has seen 92 of its pipeline program members successfully match into urology residency programs, a testament to the program's effectiveness (8). Ongoing mentorship is also offered to urology residents beginning with a two-day boot camp to equip underrepresented minority residents with the practical skills and knowledge they need to succeed in the field.



Drs. LaMont Barlow, Peace Orji (2023 winner of the first Dr. Ifeanyi Onyeji Medical Student Travel Award from **Urology Unbound**), and Shenelle Wilson at AUA2023.

Urology Unbound

Nth Dimensions is another organization that provides mentorship and pipeline programs with the goal of eliminating healthcare disparities by diversifying the physician workforce. They provide early exposure to students with different clinical correlations and bioskills workshops in various specialties. They also support students in residency through the development of a toolkit designed to assist programs in providing a safe, equitable learning environment that ensures the success of all residents. Nth Dimensions has matched 133 students into orthopedic surgery residency programs, with 104 being underrepresented minorities. Over the past five years, the match rate for participants has been 92%. To date, this organization has produced 65 board-eligible/board-certified orthopedic surgeons, many of whom are now mentors, preceptors, and faculty for the program (6).

How to Support Black Mentorship Programs

Mentorship programs can be an effective tool to address racial disparities and promote diversity, equity, and inclusion in urology. To be effective, mentorship programs must set clear goals, provide training to its participants, and provide sufficient resources to mentees. The success of these programs is not just measured in the immediate outcomes but also in the long-term impact on the healthcare system. Financial support for these initiatives is crucial. It enables the continuity and expansion of programs, allowing them to adapt to changing needs and reach a broader audience. Investment in mentorship programs is an investment in the future of healthcare, ensuring a diverse and robust workforce capable of meeting the needs of a changing population. It is also a commitment to equity, recognizing that the upfront costs are far outweighed by the long-term benefits of a diverse and inclusive healthcare environment.

By actively promoting and supporting Black mentorship programs in urology, the field can help diversify its ranks, reduce disparities, and ensure that Black individuals have equal opportunities to excel and contribute to the urology community (2).

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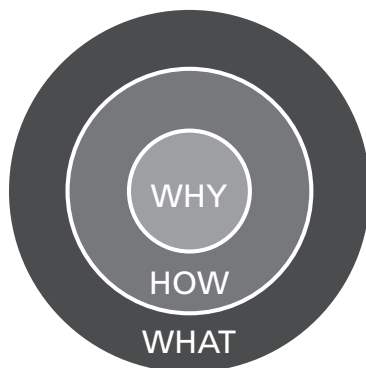
Purposeful Leadership and the Ideal Black Urology Leader

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Let's Start with "WHY": The Golden Circle Concept

The "Golden Circle" concept, popularized by the author Simon Sinek, provides a framework for understanding purposeful leadership by Black pioneers in urology (1). The components of the "Golden Circle" include the clarity of "Why", discipline of "How" and consistency of "What." Yet, it all starts with "Why." Through the lens of "Why", we are not only able to examine what drove leaders of the past, but also create a blueprint for purposeful leadership in the future.



The principles highlighted in this chapter should not only prove useful for Black leaders in urology but for all who aspire to lead. One of the most enlightening things we can do is to look outside our areas of interest for examples of purposeful leadership. The story of Sir Ernest Shackleton, an Anglo-Irish Antarctic explorer, should resonate with everyone (2). His heroic leadership allowed him and his crew to survive a perilous expedition to Antarctica in 1914 on the ship *Endurance*, which ultimately sank after being trapped in ice. He and a small group needed to leave some of his crew members behind in order to seek help. He ultimately returned to rescue everyone he left behind.

Sir Shackleton's leadership demonstrates several principles that must reside at the core of any leader, Black or otherwise. He was motivated by a sense of duty to those who followed him, determined to lead and willing to sacrifice in order to learn. As an apprentice, he paid attention to everyone around him and did his best to learn from everyone. He learned various roles that some who aspire to leadership may ignore. Forsaking the glamour that some associate with sailing, he sought a true understanding of the nuts and bolts of sailing. He also seemed to ignore the class divisions that sometimes exist on ships and nurtured camaraderie with everyone. Every person was important to him. With this at the core of his character, it should be no surprise that he risked everything to go back for his men who were stranded waiting for him to return. This was his "Why."

Characteristics of Black Leaders in Urology: The "HOW"

The ideal leader was previously thought to be an academic triple threat. However, the characteristics of an ideal leader in medicine have evolved over time to not only include those who are active clinicians, teachers and researchers, but also those who manage private practice entities and exert local, regional, national and international influence.

There has been a paradigm shift for Black leaders in urology. The idea of success has evolved from how many accolades one can amass. Leaders of the future must mimic their predecessors and “lift as they climb” to expand opportunities for others. Leaders must understand the varying roles of coach, mentor, advocate and sponsor. Those who personify these roles and the accompanying skills plant seeds of longevity for dynamic organizations.

Principles of Purposeful Leadership

There are five principles of purposeful leadership that should guide all who aspire to lead (3). These include:

1. Be clear about your purpose
2. Be clear about your role
3. Be clear about whom you serve
4. Be driven by integrity and values
5. Be authentic

These principles will position leaders to serve our specialty, trainees and patients from all backgrounds. Although not always the easiest or most expedient, taking the time to employ the principles of purposeful leadership has the potential to reap the impactful rewards.

The Impact of Purposeful Leadership: “WHAT” this Does

Similar to the “Doughnut City” concept, used to describe booming economic centers surrounded by concentrated pockets of poverty, some patient groups have access to state-of-the-art treatments while other, more vulnerable, populations lack access to standard of care therapy. Purposeful leadership can have a halo effect, minimizing the negative effects of social determinants of health and improving various aspects of our lived experience.

When implementing the five principles of purposeful leadership, the sustainable impact could be monumental. Some examples of impactful purposeful leadership include:

- Increased innovation: ‘thinking outside the box’ because you are more in tune with whom you serve and what is needed to truly address their needs.

- Paradigm shifting: changing the way things are done to improve the delivery of care by imparting Shackleton's values of 'everyone has something to contribute' and 'leave no one behind'.
- Building trustworthiness and respect: this grows from all 5 principles, but the door to trust is opened with authenticity, principle #5. If you are authentic with yourself, your purpose and those you serve, more often than not, trust and respect will be returned.

In addition to applying the principles of leadership, great leaders must understand the environment and culture of the places that they work and seek to affect. Having a deep understanding of the differences in environmental and cultural norms outside of one's own background is vital to being of service. Remaining authentic to one's core values and respecting those of others is characteristic behavior of great leaders. This awareness of 'seeing others' and 'being seen' by others is a testament to understanding the people and environments that leaders wish to impact. The Kabi leadership paradigm is an example of this type of leadership.

The Kabi Leadership Paradigm

Professor R. Kabaliswaran "Kabi" is a Professor of Management and Organizations at the New York University Stern School of Business. He coined the Kabi Leadership Paradigm which has several components to consider regarding leadership (4).

One must first consider the **environment** in which one is raised which may ultimately shape their worldview. The world is dynamic and leaders of all backgrounds must evolve and adjust to their circumstances.

A leader must **envision** the impact that they would like to have.

Successful leaders are able to **energize** their peers, whether through inspiration, intimidation or a combination of both. Professor Kabi highlights the need for leaders to choose their energizing device wisely, as varying approaches are necessary to accomplish one's aims.

Inspiring leaders then **execute** their plan and implement their agenda. However, not all leaders survive to see the results of their efforts. Martin Luther King Jr. is one example of a leader who did not live to see the wide-ranging impact he had on the United States and greater world.

Lastly, thoughtful leaders should consider their **exit**. Grooming the next generation of leaders is important, and one cannot remain at the pinnacle of leadership indefinitely. Most leaders do not think of their exit and invest too little in grooming their successor for fear of losing their seat too soon. Some hold onto their position for too long. Pop culture has given us multiple examples of fraught battles for power in fictional organizations. The HBO drama *Succession* is one recent example. However, there are actual companies who have had what some consider to be less-than-optimal leadership transitions when moving on from an iconic Chief Executive Officer. GE, Disney, Starbucks, Microsoft, X (formerly known as Twitter) are marquee companies that have

stumbled during transitions (5). One organization that seems to have handled their leadership transition smoothly is Morgan Stanley, where Ted Pick was recently chosen to succeed James Gorman, Morgan Stanley's outgoing chief executive after a period of robust growth. One thing to note is that Gorman has been focused on a smooth leadership transition since he assumed the role of CEO in 2010. It is rumored that he presented a succession plan to the board of directors three weeks into his tenure (6). How often does that occur in medicine?

The ideal Black urology leader must understand several themes in order to be successful and contribute to our beloved specialty. Leaders must simultaneously exist as conquerors, coalition builders, creators, and problem solvers, while understanding who followers are and why they follow particular leaders. One must also consider the perils and mythology of leadership. All leaders should understand and be able to communicate the importance of the mission, establish a fair culture and remain aware of dangers of hubris.

The Importance of “We” Not “Me” Leadership, a Blueprint for the Future

The ideal Black urology leader must be able to interchangeably serve as an advisor, mentor, sponsor or promoter depending upon the circumstances. Some have shared the importance of race concordant mentorship and how it can provide fertile ground for the professional development of the next generation of practicing urologists (7).

Kimberle Crenshaw, a law professor, coined the term “intersectionality” in 1989 to describe the complex, cumulative way in which the effects of multiple forms of discrimination combine, overlap, or intersect, especially in the experiences of marginalized individuals or groups (8). The ideal leader must recognize the importance of overcoming intersectionality.

The full range of Black leadership tackles issues beyond diversity, equity, inclusion and health disparities. The determined leader must innovate, navigate, and sometimes placate to achieve their goals.

Recognizing the importance of “we”, not “me” leadership, past, current and future Black leaders in urology have and continue to add to the tide of our specialty, realizing that “all boats rise with the rising tide.”



Kimberlé Crenshaw

Wikipedia

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AFTERWORD

Trials of a Pioneer

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Introduction

On May 22, 1978, the Forum on the History of Urology at the Washington Meeting of the AUA honored Pasquale Bruni, Ernest F. Hock and Adolph A. Kutzmann for their generous support of the Didusch Museum. Eleven excellent papers were also presented. By far the most interesting and poignant was that of R. Frank Jones. Dr. Jones, advanced in years and unwell, asked his successor as Director of the Department of Urology at the College of Medicine at Howard University, Dr. George W. Jones, to read his paper on his behalf while he listened from a wheelchair in the front row. Except for a few changes, which include deletion of data of a bibliographic nature, this chapter is as it was read on that Monday afternoon. Dr. Jones died on April 16, 1979, so that he did not review this final form of his presentation.

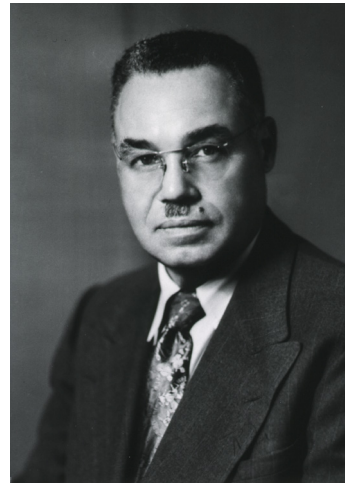
Mister Chairman, international visitors, members of The American Urological Association and guests:

To be invited to address you is one of the highlights of my career. My relationship with the Association spans many of my 81 years – and I must admit, not always as a member-at-large.

During this talk you will hear the names of other black urologists who, despite barriers to proper training, became successful because they were persistent, inventive and dedicated to their field.

If I have been persistent, inventive and dedicated, the credit accorded me is not fully mine. It truly belongs to two incredible men who were my earliest recorded ancestors: Robert Gunnell, a slave in Virginia; and Samuel W. Jones, a slave in Maryland. Both men achieved freedom and moved toward economic and cultural substance some two decades before the Emancipation Proclamation of 1863. It was they from whom I inherited the spiritual, economic and cultural standards which unmistakably held me to my purpose.

The incredible thing about both of these slaves was that they acquired freedom on the “installment plan” through permission of tolerant owners. Their stories are documented by records available in the County Court House of Fairfax, Virginia, and in the Court House of Washington County, Maryland.



R. Frank Jones, MD
National Library of Medicine

Ancestry

In the mid-1840s, Gunnell had completed purchase of his freedom, and by the late 1840s he had purchased a six-acre farm in Langley, Virginia. He then married Harriet Lee, a slave on a nearby plantation, and eventually bought his own eight children which she bore. He registered them as his personal slaves so they would not be kidnapped and sold as slaves in states farther south. Records in the Office of the Recorder of Deeds of the District of Columbia substantiate those registrations. The records further show that, when slaves were freed in the District of Columbia by an Act of Congress, April 16, 1862, and owners were compensated, Gunnell was paid \$2,168.10 for 10 slaves - two adults and his own eight children.(1) Gunnell's grandson, Richard Payne, was the father of my mother, Mary. At the age of 10 years she lost her mother and went to live with her father's sister, a housekeeper for an ophthalmologist, and his wife, Frances Hodgson Burnett, author of *Little Lord Fauntleroy* and other literary classics. The cultural atmosphere of that home helped shape the preferences of Mary Payne, the ones she was to instill in her own children.



Samuel W. Jones, the paternal grandfather shown with his wife, Eloisa, and two of their children, Samuel L. (Dr. Jones's father, at top) and Frank (c. 1870).

My paternal ancestor, Samuel W. Jones, was brought to Washington — with the consent of his owner — by Mrs. Anna Wormley to serve as coachman for her husband, a hotel and livery stable operator at 15th and H Streets, N.W. By 1847 Jones had completed purchase of his freedom.

Now free, Jones married Eloisa Benson, whom the records describe as a “free-born, light-skinned Negro from the Eastern Shore of Maryland.” At the age of 13 years, she was indentured to a “doctor” who taught her the skills of midwifery. She was proficient at her calling and in demand locally as well as in other states. She traveled, for example, to Cincinnati and Chicago to deliver the babies of Charles Howard and his brother, General Oliver Otis Howard, most notably known as the founder of Howard University in 1867.

Jones, by now a music-reading “fiddler,” and his busy wife, Eloisa, prospered. They purchased a frame house at the rear of a lot at 1745 L Street, N.W., where two sons and a daughter — Samuel L. (my father), Frank and Irene — were born. Later, they built a three-story house out to the building line at that address. The ground floor was rented to businesses.

Their children were deeply involved with music: Frank became an accomplished organist; Irene married James Bland, an international minstrel who composed “Down By the Old Mill Stream,” “Carry Me Back to Old Virginny” — official State song of the Old Dominion —and other songs still sung today; and Samuel became a

pianist who hoped for success in New York City. But once there, he found his talent acceptable only in houses of prostitution. He returned home disillusioned. Soon after his return to Washington, he met Mary Payne, a high-school-aged girl. They eloped to Baltimore.

By the time Samuel L. and Mary's children were coming along, he turned his talent to playing for church affairs, dances, and soirees of the "gentry." To ensure proper support of his growing family, my father's basic employment was as "engineer" (janitor) at M Street High School, forerunner of Dunbar High School.



Samuel L. and Mary Payne Jones
Parents of R. Frank Jones, MD

My two sisters and I were born in Grandpa Samuel W.'s house at 1745 L Street. In 1904, when I was seven years old, we moved to LeDroit Park, an area of the city that formerly had been sealed off by guarded gates to prevent access by Negroes — even as visitors. The "Old Man" (Samuel W.) came to live with us and remained until his death in 1907.

The great pride I take in having grown up in LeDroit Park is based on the fact that - contrary to the almost universal misconception that blacks as a group are only now struggling for cultural and economic gains - the families who were our neighbors had no offspring who fell short in their struggle for complete education through college and/or professional school.

Education

My entire formal education was obtained in the public schools of the District of Columbia and at Howard University. In the fall of 1910, I entered Armstrong Manual Training High School to develop the trade skills of such importance to my father in his work as "engineer." After graduation in 1914, I entered the Liberal Arts Department at Howard University because I dreamed of becoming a professional architect.

In the summer following my second year at Howard, I worked as a waiter in Saratoga, N.Y. When I returned to Washington, my father arranged to have me hospitalized on a between semester date for what was thought to be an inguinal hernia, but was actually a varicocele. I spent 14 days in the hospital completely fascinated by what went on! Luckily, following my return to school, there was enough time to take the biological sciences required to qualify for medical school in the fall of 1917.

Then came our entry into World War I in April 1917, and all of my efforts were directed toward working with a committee for creating a climate in which an officers' training

camp for Negro college men could be established. Our efforts were successful, but I was six months too young to qualify.

That summer I married my childhood sweetheart. School regulations required that students who married remain out of school for one year. I worked hard at a series of jobs, losing or quitting them in rapid succession, and grew more depressed over my bride's health — within weeks of our marriage she was pronounced a severe diabetic. She died in the preinsulin era in March 1918. Lonely and bewildered, I attempted to enlist in the Air Corps but was rejected.

Then my world began to brighten. I was formally admitted to medical school and subsequently joined the Army Medical Reserves.

Medical Training

From the beginning I was successful in my medical studies. Between the end of my junior year and graduation, I lived in a surgeon's scrub suit and was available to any surgeon as second or third assistant for all kinds of operations at any time that did not conflict with medical courses and lectures (then generally given in the afternoon).

I became an assistant to Dr. Hartford Burwell in an October-to-April gynecologic inpatient service, and served as assistant to Dr. Milton A. Francis in a year-round genitourinary inpatient service starting in July.

Dr. Burwell had a modern, forward-looking attitude and provided an excellent exposure to surgical techniques, executed with dispatch. (The usual pelvic operation was completed skin to skin with 35 minutes as a goal, accomplished only through well-developed team work.)

On the other hand, Dr. Francis encouraged me to take over surgery. Yet despite his willingness to allow me to perform operations, there were severe limitations to what I could do. For even Dr. Francis, who spent years, beginning in 1908, as assistant to Dr. Harry Fowler, the white head of the GU service at Freedmen's Hospital — now Howard University Hospital — had been allowed only to peep into the cystoscope at such times as Dr. Fowler's whims permitted. (Dr. Fowler went to war in 1917 and never returned to hospital service.)

In 1922, when I was an intern in the GU service, Dr. Fowler walked through the clinic accompanied by another white, Dr. T.C. Thompson, and gave no greeting to Dr. Francis. Dr. Thompson subsequently became head of the GU outpatient division, and Dr. Francis remained in charge of the GU inpatient service. Although Negro community hospitals existed in Kansas City, St. Louis, Chicago, Philadelphia and Baltimore, no residency training programs in urology had been undertaken at those hospitals. Until 1936 or 1937, when I instituted a four-month program for assistant residents in general surgery, there were but four black men in America who had received any formal training in urology. All are noteworthy:

Dr. Walter S. Grant, a graduate of Northwestern University, who served a 1½ -year internship and six months of residency — ending in 1923 — at Cook County Hospital in Chicago, and who became a Diplomate of the Board as late as 1947;

Dr. Lionel A. Mahone, a Northwestern graduate in 1924, who also interned and served a residency at Cook County Hospital, was appointed Chief of the Urologic Service of the VA Hospital, Tuskegee Institute, Alabama, in 1930 and became a Diplomate of the Board in 1951;

Dr. Chester Ames, a graduate of Wayne State University, who interned and had six months of residency in urology and proctology at Detroit City Hospital, ending in 1931; and *Dr. Conrad Vincent*, the first Black to gain formal training as early as 1920 after graduating from the University of Pennsylvania and serving one year of internship and one year of residency at Bellevue Hospital, New York City. It is important to note that Dr. Vincent did not receive appointment to a hospital staff until five years after he completed formal training. His contribution to urology is a description of the varicocele operation in the inguinal region 2 as reported in *Urology*, a standard textbook by Edward L. Keyes, Professor of Urology at Cornell University and urologist at St. Vincent's and Bellevue Hospitals.

My progress as a surgeon was not only impeded by the racial bias rampant at the time, but was limited by lack of knowledge and new techniques. Though Dr. Francis accepted the surgical techniques I had developed in gynecology under Dr. Hartford Burwell, and permitted me great leeway in suprapubic cases, my progress in cystoscopy and ureteral catheterization proceeded very slowly.

Although Freedmen's Hospital was a government facility, it was used as a teaching hospital for students of the College of Medicine at Howard University. The hospital staff, therefore, was not necessarily of the university faculty. It was not until 1930 that the organizational charts of the hospital and of the College of Medicine officially became related. It was also at that time that I was given the choice of becoming either a gynecologist or a urologist. I chose urology.

Chicago Experience

In 1933 and 1934 I visited Chicago's World's Fair. While in the city, I observed Dr. Walter S. Grant at work in his clinic at Provident Hospital. The man's thoughtful, conscientious and meticulous efforts were the inspiration that prompted me to (1) study more carefully every clinical problem to an end that was the best possible solution, and (2) keep intelligent records of every case so that proper summaries could provide materials for teaching and reporting. (Grant incidentally introduced me to the game of golf in 1933. Years later, in 1973, I entered the AUA golf tournament and won the much-coveted Golden Cystoscope, which I donated to the College of Medicine of Howard University.)

During those Chicago visits I also made rounds with Dr. Harry Rolnick at Cook County and other hospitals. I also observed Dr. Herman Kretschmer during two mornings of transurethral resection at Presbyterian Hospital. From my observations, I gained a



Years later, in 1973, I entered the AUA golf tournament and won the much - coveted Golden Cystoscopy, which I donated to the College of Medicine of Howard University.

healthy recognition of the difficulties encountered in the first 50 cases of transurethral resection by the early resectionists in the Chicago area. As a result, I decided not to establish resection at my urologic service at Freedmen's. Since the number of patients requiring a prostatectomy was approximately 50 per year, I could not visualize my starting the use of transurethral resection and achieving no more success with it than what I observed in Chicago. I settled for staying with the two-stage suprapubic prostatectomy while continuing an innovative approach to the perineal operation.

Board Certification

To be accepted for Board evaluation in 1936, it was necessary to get endorsements from the two local certified members: Drs. Ralph M. LeComte, Professor of Urology, Georgetown University, and Francis Hagner, Professor of Urology, George Washington University.

My experience with Dr. LeComte was ambivalent. He made it known that he could not endorse me because, "I do not know you," and then followed immediately with, "I have known two Negro surgeons of great ability who operated at Garfield Hospital when I was there. I'll write the Board that if both of these surgeons will endorse you, the Board should admit you for examinations." Dr. LeComte added, "If you are seeking endorsement for the AUA, be advised that it's a social organization and..."

Despite the prevalent venom of that day, I was examined with other urologists from this area. Nine of us were successful in becoming Diplomates of the Board that year (1936).

The year after I was certified, I applied for membership in the Mid-Atlantic Section of AUA, a prerequisite for AUA membership. I talked with Dr. T.C. Thompson who, by then, had served eight years at Freedmen's Hospital as the representative of Dr. Harry Fowler, last mentioned here as Professor of Genitourinary Diseases in the College of

Medicine of Howard University. While in Dr. Thompson's office, I asked him, "Whom do you think I could get to endorse my membership in the Mid-Atlantic?" He looked squarely into my eyes and said, "I don't have the slightest idea!" I next had an interview with Dr. Francis Hagner, Professor of Urology at George Washington University. He heard my request for endorsement, stood and paced his 60-foot private office. His hands clenched and unclenched at his back. As he retraced his steps, I heard, barely audibly, "...a member of the Mid-Atlantic? ... a member of the Mid-Atlantic?" He abruptly turned to face me and said, "I really don't know; but I'm going to our next meeting and I'll play it by ear!"

Somehow, I was undaunted by the unpopularity of my plans. The persistence of Grandpa Jones who bought his freedom on the "installment plan" revived itself in me! I wouldn't give up!

Dr. Arthur Hooe, at the time president-elect of the Mid-Atlantic, had had a most pleasant relationship with me when a staff member of Freedmen's Hospital. I phoned him. He told me that he was not going to the next meeting, but would write a letter supporting my application.

Three weeks after the Mid-Atlantic meeting, I was notified that I had been elected to membership. I immediately sent \$25 for the initiation fee, then proceeded to get endorsements from Dr. Harry Rolnick, and from Dr. Guy Hunner of Johns Hopkins University. Case presentations were delivered posthaste to the AUA and approved. The AUA notified me to come to the Quebec meeting for induction. Unfortunately, I could not attend on the date specified and notified the AUA of the difficulty.

About three weeks after the meeting in Quebec, I was shocked to receive a letter from the secretary of the Mid-Atlantic section stating that my acceptance for membership was faulty because I did not have the necessary endorsements. At intervals thereafter, I applied directly for a membership application. I never received one. Thirty years later, in 1965, when the at-large category was established, my application was accepted directly into the AUA. I am now pleased to be a member of the American Urological Association!

Medical Milestones

In 1937 I was appointed Clinical Assistant Professor in Urology. That year I instituted a program for the training of urologic residents. My office assistant, Dr. Kline A. Price (my cousin, who came to live with us when he was two years old), began his apprentice training toward Board qualification. By 1944 he was the second Black to acquire Board certification. In September 1952, *The Journal of Urology* published Dr. Price's report of a most unusual case concerning an accidental transection of the three corpora of the penis (3). Primary repair was physiologically satisfactory.

In 1941 Dr. Robert E. Fullilove - now an eminent urologist in Newark, New Jersey, and a Diplomate of the Board since 1946 - joined our staff as a Fellow to fulfill part of his qualifications for Board certification. In September, Dr. Fullilove discovered Freedmen's first case of severe congenital bladder neck obstruction in a newborn. During

the 1940s there followed a number of similar cases. All succumbed. However, in 1953 our innovative techniques resulted in a cure for one case in which a nephrectomy followed in two years. Retrospective analysis revealed an obstructive compensatory hypertrophy of the bladder muscle, causing ureteral and pelvic distention.

In 1942 I was appointed Clinical Associate Professor in Urology and in 1945 became Clinical Professor. My training program for residents in urology was approved in 1947 for a three-year period. However, I extended it to a fourth year through financing by the College of Medicine. Dr. Merle Herriford was the first graduate from the approved training program. He graduated in 1948 and was certified by the Board in 1952. Dr. Herriford developed an approved residency program at the Homer G. Phillips Hospital in St. Louis.

C. Warfield Clark was one of three classmates graduating in 1944 who sought Board certification. Dr. Clark wished to gain certification via apprenticeship as my office assistant. A vacancy occurred in 1952 for Chief Resident in my hospital training program, in which Dr. Clark served to complete his training and acquire Board eligibility. He was certified in 1959.

In 1950 and 1951 two graduates from the training program could find no U.S. hospital where they would be allowed to gain the two years of private patient experience necessary for Board certification. They too were added to my office staff, were paid salaries, and thus were provided the two years of private patient experience required for examination by the Urology Board.

There were 23 selectees for my training program. The 23rd, Dr. George W. Jones, is now Chief of Urology of the College of Medicine of Howard University. 18 of the 23 trainees I selected were immediately approved when seeking Board certification.

From August 1 to October 1, 1958, I served as Acting Dean of the College of Medicine while Dean Robert Jason served as consultant for the construction of an American hospital in Vietnam. During my stewardship, the Promotions Committee recommended that eight students be expelled for deficient scholarship. I did not approve this action and following my meeting with the committee, they withdrew the recommendation. The ultimate performance of the students justified my stand: Six graduated with their class in 1962, three of whom ranked in the middle third. The other two graduated in 1963.

While I was Acting Dean, President Mordecai Wyatt Johnson, Chief Architect of the University, Julian Cook and I discussed the proposed addition to the TB annex that was to occupy all of our parking facilities. On the spot, I proposed that all plans to build a new facility adjacent to the TB annex be scrapped and to aim at construction of a first-class, modern hospital on the adjacent Griffith Stadium site. Although the Washington baseball and Redskins football teams were still playing there, the stadium was to be vacated for a new one. My proposal was accepted and successfully completed.

On October 1, 1958, I was appointed Medical Director of Freedmen's Hospital. I immediately focused my attention on the Emergency Service. Until then, records had been kept in a ledger which recorded the impression of the intern, the medication and/or treatment given, and whether the patient had been referred to a clinic or private physician. In a few months, as a result of my pleas to the Executive Committee, every patient applying to the Emergency Service was accepted as our responsibility and given a complete workup.

At the same time, my attention was directed toward the care of inpatients. In January 1960 a plan I devised for peer review of inpatient cases was presented at a staff meeting of the Katie Bittens Memorial Hospital in Winston-Salem, N.C. Soon after, when the incident and plan were reported to Freedmen's Executive Committee, the plan was approved and authorized for use at Freedmen's. The plan proposed that within each clinical division, the most knowledgeable clinician be appointed to review the records of all patients whose diagnoses fell within the clinician's area of assignment, make a critical analysis of each case and report his findings at monthly staff meetings.

Public Service

Through the years I have served in several public service capacities, although the Hospital and University made great demands on my time. From 1943 to 1948 I was Senior Surgeon on the Public Health Service. In 1952 I was asked by the U.S. military to travel overseas to observe progress of the newly decreed desegregation of our military installations, especially of the American medical facilities at Heidelberg and Frankfurt am Main.

In 1959 I traveled with a group to Berlin for the cornerstone laying of the Medical Center of the Free University, in the planning of which I had served the Benjamin Franklin Stiftung as consultant. While abroad, I extended my trip ten days in order to observe the urologist Dr. A.M. Gasparyan at work in the Soviet Union. Dr. Gasparyan's techniques were not unusual except in the area of urethral stricture. He employed as routine the subcutaneous implantation of chlorinated human placenta at regular intervals. No urethral instrument was used. I have serial photographic evidence of the progressive improvement of the patients so treated. (I planned to use his dramatic approach in my own clinic, but lost my nerve!)

Having spoken of my extended trips, I think it important that I tell you of my philosophy on fees. It is quite antiquated for these times, but from the beginning of my professional career I realized the limitations of income in the Black community. In those days, widespread health insurance coverage had not come into being. I never initiated any discussion about fees with any urologic patient before surgery. Nor did I ever collect a fee before surgery. At a strategic interval in the convalescence of the patient, my office rendered a bill. During discussion that followed, the patient was told that he could meet the obligation within a reasonable time as was dictated by his budget.

In my letter of December 11, 1975, to Dr. Ralph Landes, which culminated in an invitation to address this Forum, I gave a detailed urologic report on the procedures

and analyses I now ask your Committee on the History of Urology to consider as warranting inclusion in the proposed History of Urology in America. The series contains reports on surgical procedures I developed and performed at Freedmen's Hospital, the descriptions of which have been reported in accredited urologic publications. (I am proud to note that, during my tenure as Medical Director of Freedmen's, I served on the five-man committee for planning construction of the existing, first-rate facility, completed in the spring of 1974.*)



**The urological suite of the new Howard University Hospital's surgical wing bears Dr. R. Frank Jones's name. (Ed.)*

The summaries include:

1. My serial contribution to the knowledge of prostatic surgery began in 1934. I introduced water-tight closure of perineal prostatectomies and drained them via an indwelling catheter. This procedure immediately reduced morbidity significantly, mortality to about two percent and hospitalization by 50 percent (4).
2. In 1939 I began a consecutive series of routine one-stage suprapubic prostatectomies. This series, the first reported by an American urologist, abandoned the two-stage operation. (In 1942, when this series was submitted to *Urologic and Cutaneous Review*, it was refused publication. An earlier segment of the series was reported to the National Medical Association in Chicago, and was published in the *Journal of the National Medical Association* (5).
3. My radical operation for removal of all genital organs involved with tuberculosis, applicable where the genital lesions are the only evidence of TB, was submitted to, and refused publication by, a leading urologic journal in 1941. Its publication was deferred until after Dr. William W. Scott, Professor of Urology at Johns Hopkins, reviewed my work and acknowledged its priority in an addendum to his description of a similar technique (6).
4. My interest in the control of gonorrhea caused me to evaluate, in depth, the early claims for penicillin. Using three times the recommended dose of aqueous penicillin in 11 patients infected with acute gonorrhea, I found that all ten who were followed failed to respond clinically and culturally. The dosage was doubled and later quadrupled, and follow-up cultures were extended. I concluded that the rate of failure remained too high to assure safety from communicability (7-9).

5. In regard to lymphogranuloma venereum, I contributed a procedure to evaluate the stricture of the rectum which complicates the disease (10).
6. My interest in the control of nonspecific urologic infection is manifested in the following articles and suggests that I was a pioneer in culture-control of urologic infections:
 - a. One of the first articles on oxytetracycline (Terramycin), a then new antibacterial agent, contained my office experience with the agent (11).
 - b. In my discussion of Dr. Reed Nesbit's paper on Terramycin at a meeting of the AUA, June 1950, in Washington, D.C., I presented graphic details of the clinical benefits of oxytetracycline (12).
 - c. I exhibited at the 1952 convention of the AUA in Atlantic City bacterial growth recovered from the patient's urine, nutrient agar for identification and the degrees of growth inhibition by a variety of antibacterial agents. A series of papers, "Specific Antibacterial Therapy in Urology" followed (13,14).

This scientific testing of bacterial susceptibility to antibiotics continues to the present day.

7. In 1951, while performing a suprapubic prostatectomy on a patient with a very large scrotal inguinal hernia, I dissected the region of the inguinal canal and reduced the hernia. Shortly after, I conferred with Dr. Burke Syphax, Chief of Surgery at Freedmen's, on the practicality of performing a hernioplasty through a midline incision that had originally been developed to perform the one-stage suprapubic prostatectomy. (Exhibited at the 1958 AMA convention, San Francisco; and the 1958 American College of Surgeons convention, Philadelphia.) The exhibit outlined our entire experience of 50 cases from 1951 to 1958. (A very adequate color movie was made of this procedure as it was performed in 1960 on a member of my staff. The film, never titled, is kept on file at the National Institutes of Health.)
8. A true hermaphrodite was diagnosed soon after birth in Freedmen's Hospital. It was converted to a normal female within three months following a series of surgical procedures (15). This is the only case of immediate conversion on record. The case was followed for only three years.
9. A substitute bladder was surgically constructed from a separated segment of the sigmoid (16). The segment, or loop, after being opened along its tenial surface, was tailored to the shape of a pear, and received the ureters in its margins. An indwelling catheter was placed in the substitute bladder, the apex of which was sutured to the urogenital diaphragm.
10. Radical perineal prostatectomy is a probable and acceptable cure for early cancer of the prostate. This finding - since 15 to 20 percent of patients subjected to suprapubic prostatectomy are found to have cancer of the prostate - prompted me to subject such cases to secondary radical prostatectomy. I reported this finding in a symposium on prostatic cancer (with J.C. Kimbrough, Lloyd G. Lewis and Roger Baker) before the 59th Annual Convention of the NMA, August 1954, at Howard University.

11. Dr. Kline A. Price, my office associate, described my surgical approach to phlegmon of the scrotum (18); a bi-section of the scrotum through Camper's, Scarpa's and Colles' fascia down to the Buck's fascia. The necrotic tissue is removed and counter drainage established, if necessary, through the involved fasciae at the lower abdomen. When granulations have developed adequately, all tissues are reapposed.

As I reflect upon my modest contributions to medicine, to urology and to my medical school during a lifetime of racial discrimination, I can take comfort in the much wider opportunities we helped to forge for the present and future generations of black physicians.

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AUTHOR BIOGRAPHIES



Uzoma Anele, MD

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Uzoma A. Anele received his undergraduate degree in biological sciences from the University of Maryland Baltimore County and medical degree from the University of Maryland. He then completed an NIH/NIDDK-funded, 2-year postdoctoral research training fellowship at the Johns Hopkins Brady Urological Institute as well as the Graduate Training Program in Clinical Investigation at the Bloomberg School of Public Health.

He completed his residency training at Virginia Commonwealth University followed by a clinical fellowship in genitourinary reconstruction at the Cleveland Clinic Glickman Urological and Kidney Institute. He has authored over 50 published manuscripts and book chapters. He is currently an Assistant Professor at the University of Louisville School of Medicine. He serves as the Director of Genitourinary Reconstructive Surgery and Residency Program Director of the urology department at the University of Louisville.



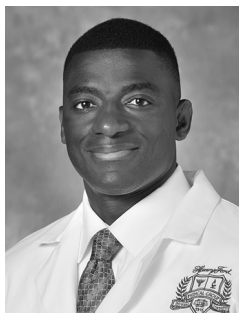
Denise Asafu-Adjei, MD, MPH

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Dr. Denise Asafu-Adjei is a trailblazing urologist, researcher, and health policy champion. She is an Assistant Professor of Urology at Loyola University Chicago Stritch School of Medicine, where she serves as the Director of Male Reproductive Medicine. She is also duly appointed in the Parkinson School of Health Sciences and Public Health.

Dr. Asafu-Adjei completed an Andrology Fellowship at University of California Los Angeles (UCLA) from 2020-2021. She completed her Urology residency at Columbia University Irving Medical Center, the first African-American female graduate of this residency. She received her M.D. from the University of Michigan Medical School. During medical school, she obtained an MPH in Health Policy and Management from the Harvard T.H. Chan School of Public Health. She is a proud alumni of Carnegie Mellon University.

Amongst her involvement locally and nationally in various professional organizations, Dr. Asafu-Adjei is Chair of the Diversity, Equity, and Inclusion Committee of the Sexual Medicine Society of North America and is on the AUA's Inaugural Diversity and Inclusion Committee. She was the 2023 AUA Gallagher Health Policy Scholar, a current member of the AUA's Legislative Affairs Committee, and the Illinois representative to the Health Policy Committee of the AUA's North Central Section.



Humphrey O. Atiemo, MD

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Humphrey O. Atiemo, M.D. is a board-certified urologist in clinical practice for 17 years with specialty certification in Female Pelvic Medicine and Reconstructive Surgery. He has written over 30 peer reviewed manuscripts and is a Clinical Associate Professor at the University of Toledo with a medical practice at Promedica Health. He obtained his undergraduate degree from the University of Maryland as a Benjamin Banneker Scholar and competed as a Division 1 wrestling student athlete.

After graduating with distinction as an Atlantic Coast Conference scholar athlete, he matriculated to the University of Maryland at Baltimore for Medical School and Urology Residency. This was followed by fellowship training at the Cleveland Clinic.

Throughout his academic career, Dr. Atiemo has been a strong advocate of resident education initially serving as an assistant program director at the University of Michigan and then as a program director at Henry Ford Hospital for eight years. Additional career milestones include serving as Chair of the Graduate Medical Education Subcommittee on Diversity, Equity and Inclusion, selection to the AUA Leadership Program, and serving as a member of the American Board of Urology Exam Committee. Dr. Atiemo strives to train future leaders in Urology.

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Dr. Barlow is an Assistant Professor of Urology and Pathology at NYU Grossman School of Medicine. He is a fellowship-trained urologic oncologist with a surgical focus on endoscopic and robotic surgery for bladder and prostate cancer. He is the Director of Diversity, Equity, and Inclusion for the Department of Urology at NYU Langone and serves in several leadership roles and committees within the institution's Office of Diversity Affairs and the Institute for Excellence in Health Equity. A

significant portion of his non-clinical effort is focused on mentorship as a means to support diversity in urology, including the creation of multiple pipeline programs in partnerships with several New York City Public Schools. He also is a founding member and the Director of Research for Urology Unbound, a 501(c)3 non-profit organization dedicated to recruiting, retaining, and promoting underrepresented minority urologists.

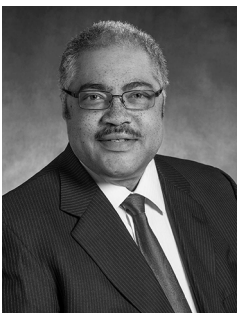
He received his A.B. degree in Biochemical Sciences at Harvard College and his medical degree from Columbia University College of Physicians and Surgeons. He completed his residency training at New York Presbyterian – Columbia and a urologic oncology fellowship at New York Presbyterian – Weill Cornell. Dr. Barlow has published numerous manuscripts and book chapters in urologic oncology, including several studies of intravesical taxane therapy for BCG-unresponsive bladder cancer. He pioneered a method for growing patient-derived bladder tumor cells in three-dimensional organoid culture. He has received awards from the Urology Care Foundation, the American Association for Cancer Research, the American Society of Clinical Oncology, and the New York Academy of Medicine. He currently has a clinical practice divided between NYU Langone and the New York Harbor VA Hospital in Manhattan where he established the region's first VA robotic cystectomy program. Dr. Barlow also serves as a principal investigator for clinical trials in non-muscle-invasive bladder cancer at the VA.



David Bayne, MD, MPH

University of California, San Francisco

Dr. David Bayne, MD, MPH studies the clinical, social and behavioral factors that contribute to kidney stone formation and influence treatment outcomes as UCSF Urology faculty. He attended Harvard for college and medical school and completed his residency in urology at UCSF. He obtained a Master's in Public Health at UC Berkeley during his residency to better understand the social factors associated with the surgical outcomes. He is fellowship trained in Endourology and medical and surgical management of kidney stone disease.



Arthur L. (Bud) Burnett II, MD, MBA

The Johns Hopkins University School of Medicine

Dr. Burnett is the Patrick C. Walsh Distinguished Professor of Urology and Professor, Oncology Center, at the Johns Hopkins University School of Medicine. He is an accomplished urologic surgeon and scientist, recognized for diverse leadership and service roles in urologic healthcare, in areas of research, education, clinical practice and advocacy. Dr. Burnett specializes in sexual medicine, major pelvic reconstruction, voiding dysfunction, prostate cancer, and lower genitourinary tract malignancies. He is considered the world-authority in the science and medicine of male sexual dysfunction, and among his many academic contributions he made original scientific discoveries in the science of penile erection that paved the way

for the development of oral medications to treat erectile dysfunction and was the lead urologic surgeon in the first-ever penis and anterior pelvis transplant surgery. He has written more than 400 original peer-reviewed articles, 50 book chapters and 3 books, along with numerous editorials and publications related to his biomedical research and clinical activities. He also founded and directs a non-profit humanitarian organization called UroMissionsWorks Incorporated.

He received his AB degree in Biology from Princeton University and MD and MBA degrees from Johns Hopkins University. He performed his post-graduate training in general surgery, urology and genitourinary reconstructive surgery at the Johns Hopkins Hospital and was awarded an American Foundation for Urologic Disease new investigator scholarship. He is an alumni member of the Alpha Omega Alpha Honor Medical Society and Fellow of the American College of Surgeons. Among various awards, Dr. Burnett received the Urology Care Foundation Distinguished Mentor Award in 2016, the Distinguished Contribution Award from the American Urological Association in 2018, the Ferdinand C. Valentine Medal from The New York Academy of Medicine in 2020, and the Hugh Hampton Young Award from the American Urological Association in 2022.



Christi M. Butler, MD

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Dr. Christi Butler is a urologic surgeon who specializes in urinary system reconstruction at the University of California San Francisco. Her primary focus is on gender-affirming care and genital reconstruction, including feminizing vaginoplasty and vulvoplasty, masculinizing metoidioplasty and urethral lengthening procedures. She is also trained in placing prosthetic implants after phalloplasty procedures.

In research, Butler's interests center on clinical outcomes (how patients feel and function after treatments) for transgender and gender-diverse people. Specifically, she looks at motivations for seeking surgery and techniques impacting aesthetic and functional outcomes. During her fellowship, she was part of research initiatives to begin collaborative registries that would track outcomes data and facilitate the study of factors impacting decisions about surgery. She is also interested in better understanding the impact of hormone exposure on certain hormone-sensitive cancers, such as prostate, breast and endometrial cancers. An overarching goal of her studies is to expand knowledge in the field of transgender care.

Butler earned her medical degree from the Warren Alpert Medical School of Brown University. She completed a residency in urology at UCSF and a fellowship in genital and urinary reconstruction, with a focus in gender-affirming care, at Oregon Health & Science University.



Alexia Charlot, BS

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Alexia Charlot is a third-year medical student at Morehouse School of Medicine. She was born in Virginia but spent her childhood traveling the world with her mother who spent 20 years in the Navy. She earned her Bachelor of Science degree in Psychology from Armstrong Atlantic State University in Savannah, Georgia. She chose to receive her medical education at Morehouse because of their mission to achieve health equity through promoting the primary health care needs of underserved populations. Beyond her academic pursuits, Alexia is a nature enthusiast with a passion for outdoor activities. Hiking, kayaking, camping—she finds solace and joy in exploring the great outdoors.



Pamela W. Coleman, MD

Howard University College of Medicine

Dr. Pamela W. Coleman is Associate Professor of Surgery and Interim Chief of Urology at Howard University Hospital (HUH) in Washington, DC. She holds board certification in both Urology and Female Pelvic Medicine Reconstructive Surgery.

Her leadership positions include Secretary of the Medical Dental staff, Chair of the Practitioner Peer Review committee, Director of the Men Take Ten Prostate Cancer Screening Program, Board Member of the Mid-Atlantic American Urological Association (MA AUA), member of the AUA Diversity, Equity, and Inclusion Committee, HUH Director of the MA AUA Pre-Medicine Enrichment (PEP) program, speaker at the R. Frank Jones Urological Society on Pipeline programs in Urology, founding member of Society of Women in Urology, member of the National Medical Association, Member of the American Urogynecologic Society (AUGS) Education Committee, and Clerkship Director for urogynecology, in both medicine and surgery resident rotations. Dr. Coleman heads the Physician Champion Committee for prevention catheter-associated urinary tract infections (CAUTI) at HUH. She was presented the Department of Surgery Star Performer Faculty Award and twice received the HUH Patient Care award.

Dr. Coleman is involved in clinical trials evaluating urinary urgency incontinence, and an investigator on grant studying genetic factors in prostate and renal cancer.

Dr. Coleman is best known for her teaching style of ‘flipping the classroom’ to actively involve student participation in learning. She is a mentor, preceptor, and instructor for many students. She has distinguished herself by assisting underrepresented students enter pipeline programs to achieve their goals towards becoming a urological surgeon.



Tracy Downs, MD

UVA Health

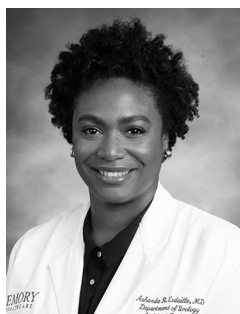
Tracy M. Downs, MD, FACS, is a board-certified urologist specializing in the surgical treatment of urologic cancers, with a sub-specialty focus in the treatment of both prostate and bladder cancer. He also has extensive experience in taking care of patients with general urology health concerns and overseeing clinical trials.

In addition to providing patient care, Dr. Downs joined UVA in 2021 to serve as UVA's first Chief Diversity & Community Engagement Officer. In this role, Dr. Downs serves as UVA Health's leading voice on diversity, equity and inclusion and as an advocate for related initiatives across the health system and the local community.

Dr. Downs comes to UVA Health from the University of Wisconsin School of Medicine and Public Health, where he was Associate Dean for Diversity and Multicultural Affairs and Professor of Urologic Oncology. At UW, Dr. Downs played an instrumental role in overseeing the recruitment of and medical education support programs for individuals from ethnically diverse backgrounds underrepresented in medicine. He also served as Faculty Director of the Cancer Health Disparities Initiative at UW's Carbone Comprehensive Cancer Center.

Dr. Downs earned his medical degree from the University of California San Diego, completed his residency at Brigham & Women's Hospital in Boston, and completed a fellowship at the University of California at San Francisco. He earned his undergraduate degree from California Lutheran University.

Dr. Downs was born in Portsmouth, Virginia while his dad was serving in the U.S. Navy. He grew up in San Diego, California where he enjoyed playing baseball and football and BMX dirt bike racing. His life has been positively impacted by his family, and especially his mother and grandmother. Dr. Downs pursued a medical degree because of his interest in health and science, but most of all so he could use this knowledge to help take good care of people from various backgrounds.



Ashanda R. Esdaille, MD

*Emory University School of Medicine/Atlanta VA
Medical Center*

Dr. Ashanda R. Esdaille is an Atlanta native, a Phi Beta Kappa alumna of Spelman College and she received her medical degree from Morehouse School of Medicine. Following her medical degree, she completed her Urology residency at SUNY Downstate Health Sciences University in Brooklyn, NY

where she was inducted into the Alpha Omega Alpha Honor Medical Society as a chief resident. She is an Assistant Professor in the Department of Urology in Emory University School of Medicine with a clinical appointment at the Atlanta Veteran's Affairs Medical Center. Her clinical focus is on genitourinary malignancies particularly prostate and kidney cancer, while her research focuses on prostate cancer disparities.

She completed her Society of Urologic Oncology fellowship at the University of Wisconsin School of Medicine and Public Health in July 2022. During fellowship, she developed her current research program: to identify the association between structural inequity and prostate tumor immunobiology for Black men. She acquired the AUA Research Scholar Award during her first year of fellowship, which aimed to characterize the immune infiltrate in men with advanced prostate cancer. Her interests also include clinical trial development and increasing minority enrollment in genitourinary cancer clinical studies.

Towards the end of her first year in fellowship, she was accepted to the AACR/ASCO Methods in Clinical Cancer Research Workshop to develop a phase II trial aimed at evaluating the efficacy of neoadjuvant immunohormonal therapy setting in patients with advanced or oligometastatic prostate cancer. Understanding the inherent barriers to minority enrollment in clinical trials, she secured the Robert A. Winn Diversity in Clinical Trials Career Development Award, a 2-year grant focused on improving diversity in clinical trials from both a provider and patient perspective. With this program, she further expanded her knowledge in clinical trial design and development and in addressing the barriers to minority participation and recruitment.

Dr. Esdaille has a firm commitment to continue her research efforts in prostate cancer from both a translational and clinical perspective; she has a long-term goal of furthering the medical community's understanding of racial differences in tumor microenvironments, how these environments may be influenced by structural inequity, and whether these differences, in part, account for the disparate oncologic outcomes. Lastly, Dr. Esdaille serves as a medical student mentor for the R. Frank Jones Black Urological Society, research committee member for Urology Unbound and serves on the scientific committee for the Consortium on Disparities of Urologic Conditions.



Christine Ibilbor, MD, MSc

University of Virginia

Christine Ibilbor MD, MSc, is a fellowship-trained urologic oncologist who specializes in robotic surgery. Her research interests include bladder cancer survivorship and perioperative exercise, as well as racial disparities in prostate cancer treatment and clinical trial enrollment. She cares for patients at Emily Couric Clinical Cancer Center, at the UVA Urology Clinic at the Fontaine Research Park, and at UVA Culpeper Medical Center.

Born and raised in Georgia, Dr. Ibilibor attended medical school at the Medical College of Georgia in Augusta. She then completed her urology residency training at Texas Tech University Health Sciences Center in Lubbock, Texas and a fellowship in urologic oncology at University of Texas at San Antonio.

Dr. Ibilibor has always had a passion for anatomy and physiology, and feels it is a privilege to be able to treat patients surgically.



Linda L. McIntire, MD

MyMichigan Health

Linda L. McIntire, MD is a native of Detroit, MI. She is a graduate of Michigan State University (MSU) with a Bachelor of Science in physiology. At MSU, she became a member of Delta Sigma Theta, Sorority, Inc. She graduated from Wayne State University School of Medicine. Dr. McIntire is the first and only Black woman graduate of Wayne State School of Medicine to become board certified in Urology. She completed a general surgery internship at Mayo Clinic, Rochester, MN and a Urology residency at Henry Ford Health System in 2004.

After spending time in private practice, she spent over a decade caring for veterans' urological needs at both the Hampton VAMC and Aleda E. Lutz VAMC. She is currently employed at MyMichigan Health in Midland, Michigan.

She was honored to be a part of the first-ever American Urological Society (AUA) Taskforce on Diversity and Inclusion and currently serves on the AUA Diversity and Inclusion committee. She is Past-President of the R. Frank Jones Urological Society (RFJUS). As President of RFJUS, Dr. McIntire also served as an editor for the Journal of the National Medical Association.

Through her roles with RFJUS and the AUA, Dr. McIntire created "PROSPECT." "PROSPECT" is a summer medical student fellowship for URiM students at four academic urology programs. Dr. McIntire will continue in her second year as director of the Diversity and Inclusion Course at the AUA International conference. In 2023, Dr. McIntire debuted a novel plenary session for urologists at the AUA international conference called "Cultural Complications". "Cultural Complications" is a patient case basis plenary session that teaches urologists how to recognize and address health care barriers for select patient groups. In addition, Dr. McIntire serves as a board member on the Hamilton Community Health Network, a federally qualified health clinic that services the needs of patients in Genesee and Lapeer counties.



Brian Keith McNeil, MD, MBA

SUNY Downstate Health Sciences University

Brian Keith McNeil, MD, MBA, FACS is the Associate Dean for Clinical Affairs and Vice Chair of the Department of Urology at SUNY Downstate Health Sciences University. He completed a clinical fellowship in urologic-oncology at the Memorial Sloan Kettering Cancer Center following research fellowships in urologic-oncology at both the National Institutes of Health/National Cancer Institute and James Buchanan Brady Urological Institute at Johns Hopkins Hospital.

Similar to the “Doughnut City” concept, previously used to describe booming economic centers surrounded by concentrated pockets of poverty, some patient groups have access to state-of-the-art treatments while other more vulnerable populations lack access to standard of care therapy. This is an issue in most fields of health care. Brian’s focus is care in medically underserved communities, a dilemma international in scope, which he strongly believes we must “think globally and act locally” to address.

Brian was raised in Philadelphia, Pennsylvania. He is a graduate of Morehouse College, the University of Pittsburgh School of Medicine and the New York University Stern School of Business. He is a Fellow of the American College of Surgeons, Fellow of the New York Academy of Medicine and 2023 Presidential Leadership Scholar.



Yaw A. Nyame, MD, MS, MBA

Fred Hutchison Cancer Center, University of Washington

Yaw Nyame, MD, MS, MBA is a urologic oncologist with a research interest in health equity and quality in urologic cancer care delivery. His research practice focuses on using patient-centered approaches to build patient, community, and research collaborations to develop and sustain multi-level interventions and studies to eliminate health disparities in prostate cancer and other urologic malignancies. His research team uses this patient-centered foundation to engage in translational health services, molecular and clinical research in prostate cancer, with a focus in addressing inequities among Black and African-descent prostate cancer patients. His research also focuses on evaluating the efficacy and harms of early detection, with a focus in high-risk populations.

He attended medical school at the Feinberg School of Medicine at Northwestern University and business school at the Kellogg School of Management at Northwestern University, graduating in 2012. Prior to medical school, he completed a master’s in health services and administration at the School of Public Health at the George Washington University. He completed his urology residency training at the Glick-

man Urological and Kidney Institute at the Cleveland Clinic and an SUO fellowship at the University of Washington, where he joined the faculty upon the completion of his training.



John Phillips, MD

New York Medical College

Dr. Phillips is originally from the New York area and is currently the Program Director and Executive Vice-Chairman of the Department of Urology at Westchester Medical Center, New York Medical College. His interest in history began in 1973 with his self-published treatise on the US Presidents, subsequently lost by his 3rd grade teacher, but conceived at that time as an homage to the then-current Chief-Executive who had visited

the Tarrytowns during a campaign stop. Undeterred, Dr. Phillips became President of the Nathan Smith Club, Yale Medical School's History of Medicine interest group where his research included the history of decompression sickness or the 'Bends'. Under John P. Fulton, Yale had become a center of expertise on the subject during the 1930s and 1940s and provided much of the physiologic studies required for the US Air Force's foray into high altitude flight. Dr. Phillips' work on Yale and other notable advances in decompression sickness was later published in "The Bends: Compressed Air in the History of Science, Diving, and Engineering" (Yale University Press, 1998) and can be purchased on Amazon or downloaded on Kindle.

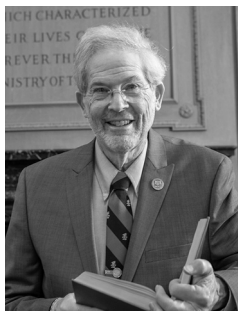
Dr. Phillips became subsequently interested in the AUA's History Forum as a fellow in Urologic Oncology at the National Cancer Institute under Marston Linehan (AUA Gold Cystoscope awardee 1992). Dr. Phillips revisited his earlier 1973 work on the US Presidents with a focus on the prevalence of urologic disorders in the Executive Branch which was presented at the 1999 History Forum meeting. He continued his career in urologic oncology with the rise of robotic surgery in 2001, first under Harris Nagler (former Chair of both the Ethics and the Judicial Committees of the AUA) at Beth Israel Medical Center, New York and then as Chief of Robotic Surgery at Westchester Medical Center under Mohammad Choudhury (AUA Gold Headed Cane awardee 2022).

Dr. Phillips served in the 2007-2008 AUA Leadership Program class where he was privileged to learn about the AUA and how to make a difference with Robert Siemens (now *The Journal of Urology*® Editor-in-Chief), Jean Joseph (Chairman, University of Rochester Department of Urology), Badrinath Konety, now the CEO of University of Minnesota Physicians, and other incredibly talented individuals.

Dr. Phillips has served on the board of editors of the Canadian Journal of Urology and *The Journal of Urology*® where he noted the poor acceptance rate of history of urology articles, often due to the perceived lower impact factors that history articles may generate. With Akhil Saji, now a fellow at the University of Southern California

under Inderbir Gill, he co-created the International Journal of Urologic History which may be downloaded twice yearly at www.ijuh.org. Unlike open access journals, IJUH is free for authors and subscribers, and the journal is focused on publishing high quality, peer-reviewed manuscripts on the history, art, and culture of urology. IJUH authors are easily found on GoogleScholar and may be listed on PubMed as soon as July 2025.

Dr. Phillips' other interests include translational research, and he is a 2019 awardee of a New York State ECRIP grant for the development of a nanoparticle-based approach to the treatment of bladder cancer. Dr. Phillips is a proud father and grandfather and is hoping to row in an all-urology quad in the 2025 Head of the Charles. Two seats need to be filled so any interested and able port or starboard female rowers should e-mail him at john_phillips@nymc.edu.



Ronald Rabinowitz, MD

University of Rochester Medical Center

Ronald Rabinowitz, MD, is Professor of Urology and Pediatrics, Chief of the Division of Pediatric Urology at the University of Rochester, and Historian for the American Urological Association.

Born and raised in Pittsburgh, Dr. Rabinowitz earned his medical degree from the University of Pittsburgh. He completed his urology residency at the Hospitals of the University Health Center of Pittsburgh, including a year at the Children's Hospital of Pittsburgh. This was followed by a fellowship in pediatric urology at the Hospital for Sick Children, Toronto. He served two years on active duty in the United States Air Force as a pediatric and general surgeon.

Dr. Rabinowitz is an internationally renowned expert in pediatric urology and urologic history. He has served organized urology in numerous capacities for more than four decades. As a member of the AUA Board of Directors (2001-2005), he served as a member of the History sub-committee of the Strategic Long Range Planning Committee that was tasked with designing a role for the William P. Didusch Center for Urologic History in the new headquarters building. In this capacity, he recommended and participated in planning to spread the museum's displays throughout the building, as one sees today.

Nationally, Dr. Rabinowitz has served the Northeastern Section AUA as Secretary, President, and Historian; the American Academy of Pediatrics Section on Urology as Chair; and the American Board of Urology on the written examination committee and as an oral examiner.

The American Urological Association has honored Dr. Rabinowitz with a Distinguished Service Award in 2013, the Lifetime Achievement Award in 2021, and the William P. Didusch Art and History Award in 2023.

Dr. Rabinowitz has continued to lecture and publish on topics related to urologic history. He has authored or co-authored over 250 scientific publications and textbook chapters (many pertaining to urologic history), edited a textbook on pediatric urology, and served on history publication committees. Ron has remained committed to the preservation of urologic history and the William P. Didusch Center for Urologic History.



Kymora Scotland MD, PhD

University of California Los Angeles

Dr. Scotland is an Assistant Professor and Chief of Endourology Research at UCLA. She earned her medical degree from Weill Cornell Medical College of Cornell University and her doctorate at the Tri-Institutional Cornell/Rockefeller/Sloan Kettering MD-PhD Program. She then completed her urology residency at Thomas Jefferson University and an endourology fellowship at the University of British Columbia. Dr. Scotland has been the recipient of awards including the Urology Care Foundation Research Scholar Award 2017, Western Section-AUA's Young Urologist of the Year 2022, and AUA Rising Star Award 2023.

Dr. Scotland's clinical interests include the treatment of kidney stones, benign prostatic hyperplasia, and upper tract urothelial carcinoma. Her basic research at UCLA investigates stone pathogenesis and stone-associated infection with an ultimate focus on developing innovative solutions to the care of kidney stone patients. Dr. Scotland has a particular interest in biomineralization and the role it may play in kidney stone formation and is currently undertaking collaborative projects to investigate this.

Additional collaborative work includes projects in the fields of patient education and shared decision-making, global surgical training and mentorship. As Chair of the World Endo Committee of the Endourological Society, she has established fellowships for the teaching of endourology at the regional level and developed the Urograve platform for equipment exchange. She has recently expanded her efforts to reach more urologists as part of the international Executive Committee of the Endourology Academy, an online platform that provides a structured format for the learning of skills in endourology.



Efe Chantal Ghanney Simons, MD

University of Michigan

Efe Chantal Ghanney Simons is a clinical fellow in the Urology department in the division of Neuro-urology and Pelvic Reconstructive (NPR) surgery. She grew up in Ghana and came to the US to attend Yale University where she double majored in Chemistry and French then pursued medical education at the Icahn School of Medicine at Mount Sinai in New York. While at Sinai, she created several global health projects, including an international palliative care research project, that took place in her home country of Ghana and the African Research Academies for Women, a fully funded research internship for college women in African universities. Chantal completed her urologic surgery training at the University of California, Los Angeles (UCLA). During her residency research year, she had plans to pursue global health work in Ghana, Senegal and Uganda focusing on surgical education and quality improvement of international surgical work however due to the pandemic, she pivoted from a global stage to focus on pressing local needs to promote diversity, equity and inclusion (DEI) in the urology workforce and in medical education. At the University of Michigan, in addition to her clinical fellowship, she is pursuing a Masters in Health Professions Education (MHPE) permitting her to continue her collection of research projects that critically examine every step of the succession from medical student to practicing physician to determine the factors that positively and negatively influence the decision to choose urology, access to the field of medicine at large but urology in particular, and career advancement for Under-Represented in Medicine (URiM) individuals. These studies provide the historical and current context, produce data from ongoing baseline assessment of racial-ethnic diversity in urology, and provide recommendations for best recruitment and retention practices.



Randy Vince, MD

University Hospitals of Cleveland

Dr. Randy Vince Jr. recently began a new position at University Hospitals and Case Western Reserve University as an Assistant Professor of Urology and the Director of Minority Men's Health. He was born and raised in Baltimore, Maryland, and as the oldest of four siblings, he developed a passion for athletics. Dr. Vince attended Towson University, where he was a Varsity Letterman in Football. At Towson University, he double majored in MB3 (Molecular biology, Biochemistry, and Bioinformatics) and Chemistry. He later attended Louisiana State University Health Sciences Center in Shreveport, where he earned his M.D. and subsequently completed a Virginia Commonwealth University (VCU) Health Systems residency. He developed a passion for Urologic Oncology after his grandmother's passing in medical school. While at the University of Michigan, he earned a master's degree in computational medicine and bioinformatics. He has a keen interest in using precision medicine to combat the concept of racial biology and evaluate the intersectionality of environmental exposures and gene expression on tumor biology.

Dr. Vince actively participates in research and community outreach events to promote health equity and eliminate healthcare disparities. He has a personal philosophy that he applies to his career and life, leadership through service, and he is extremely excited to serve the people of Northeast Ohio and beyond.



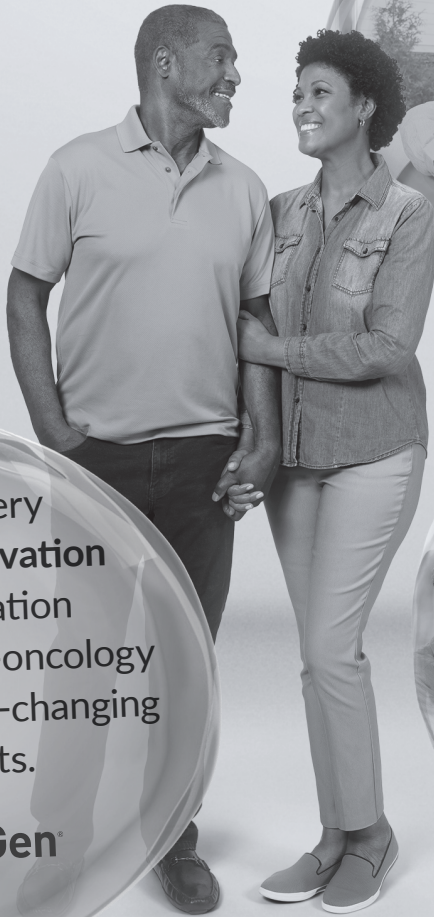
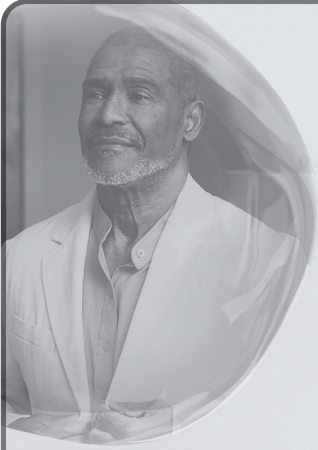
Shenelle N. Wilson, MD

Metro Atlanta Urology and Pelvic Health Center

Dr. Shenelle N. Wilson is the Founder and CEO of Urology Unbound, a nonprofit organization dedicated to the recruitment, retention, and advancement of underrepresented minority urologists. In 2021, she was honored with the Southeast Section Young Urologist of the Year Award in recognition of her commitment to the progress of both current and future underrepresented minority urologists.

Dr. Wilson is fellowship-trained in Female Pelvic Medicine and Reconstructive Surgery and runs her own practice in Georgia, the Metro Atlanta Urology and Pelvic Health Center where she focuses on the diagnosis and treatment of voiding and sexual dysfunction in adults. In her free time, Dr. Wilson enjoys international and domestic travel and a variety of outdoor activities.

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