

STAT

Color Code

Diverse Clinical Trials. Why aren't we there yet?

Transcript Key:

In this written version of the episode, all words, including speakers, ambient sound, effects, and music, will appear in size 11 black type. **SPEAKER NAMES** are in bold and all caps. Music and other sound descriptions are indicated by [brackets] in regular font.

Speakers:

- **NICHOLAS ST. FLEUR (“NICK”)** is the host of Color Code and a science reporter for STAT, where he often covers the intersection of race and medicine. Based in Long Island, NY, he is in his early 30s.
- **ANGUS CHEN (“ANGUS”)** is a health and cancer reporter at STAT. With the aid of a professional microphone, which he has used in the past as an audio reporter, his voice is warm and clear.
- **ROBERT WINN** is the director of the VCU Massey Cancer Center. Born and raised in a working-class neighborhood in Buffalo, NY, he is in his late 50s.
- **YVONNE BIBBS** is the pastor at Sixth Baptist Church in Richmond, VA.
- **JONATHAN JACKSON** is the founder and director of the CARE Research Center at Massachusetts General Hospital. Now in his mid 30s, he is also an assistant professor in neurology at the Harvard Medical School.

ROBERT WINN (interview clip)

You know, one of the things we're trying to do this for, is that final line is: We're trying to make some local efforts so other people can do the right thing. And frequently what happens is: We're in these offices, behind them chairs, up in them walls, and never in the neighborhood. And yet we try to talk about how we trying to do X, Y, and Z for the neighborhood. Where I came from – you know, I came from a teenage mom, just being straight up – you know, didn't think about being a doc. That was not – I was thinking about working at GM. That was my dream, right? Because they made money, and they had cars.

[Sounds from an electric keyboard enter. A newsy musical phrase glides back and forth across 4 notes. It's the THEME MUSIC for Color Code.]

NICK (narrating)

This is Color Code, a podcast from STAT. I'm Nicholas St. Fleur, a science & health reporter here. And over 8 episodes, I'm taking a look at the hidden and not-so-hidden forces behind our country's stark racial health inequities. Last week, we talked about racist bias in medical algorithms. This week is episode 7, and we're talking about how researchers can diversify clinical trials, including the ones that many algorithms and other medical decisions are based on.

[The MUSIC fades.]

Improving diversity within clinical trials is something that a lot of people in the field are working on. If our medical interventions are going to work on diverse populations of people, they need to be trialed and tested on diverse groups. It seems simple, but you should know by episode 7 of this podcast, that it never quite works out that way. To get deeper into this, we're sharing insights from 2 particular people: The first is Angus Chen, my colleague here at STAT. He's a reporter who's been learning about a researcher in Richmond, Virginia, and how he connects with communities of color.

NICK (interviewing)

So Angus, before we start, tell us a little bit about yourself. You are our cancer reporter, is that correct?

ANGUS

That is correct. Yes, I am STAT's cancer reporter. This series that I've been working on, obviously, has been focusing on health equity in cancer research. It's looking at the ways that researchers are trying to change how they interact with communities of color, the way they recruit from communities of color for research trials, like clinical trials and research studies. And also the way they're, like, trying to change their own institutions, their own academic institutions and structures to make research more accessible, more equitable, more just in cancer.

NICK

You went on a bit of a reporting trip. Tell us, and tell our listeners a bit about what this reporting trip was about. First of all, when did you go on this reporting trip, and where to? And give us all the lowdown!

ANGUS

I went to Richmond, Virginia, around the end of March, and I went specifically to talk to the director of the Massey Cancer Center at Virginia Commonwealth University, or VCU, in Richmond. And his name is Robert Winn. He's a pulmonologist and an oncologist. He'll also be the first Black president of the AACI, the American Association of Cancer Institutes, which is the body that sort of oversees all of these NCI-designated cancer centers.

And I was really interested in talking to Dr. Winn because I'd heard that he was making a lot of changes in, sort of, the culture and the structures at the Massey Cancer Center to make the research being done there and the care being given from the Massey Cancer Center more equitable, more community focused. And I wanted to learn more about that and how he was doing it.

[Steady, sparse MUSIC with an electric xylophone softly underpins Angus's voice.]

Dr. Winn himself, I mean, he's a Black man. He's from upstate New York originally. He's, like, one of these guys who never imagined he would even go to college or let alone become a

doctor. Like, his original dream when he was growing up was to work at the local GM plant. But, of course, he didn't take that path and instead went around and around and is trying to, you know – is spending his life really trying to make cancer research and cancer care look completely different than the way it has over the last century

NICK

Dr. Winn, as you said – I believe we have a bit of a callback to our first episode here. I think he was either the – I think he might be the advisor for Arnethea Sutton. Is that correct?

ANGUS

Yeah. I mean, so he's not her PI, but he's a mentor to Arnethea Sutton. They know each other well. They worked together quite closely. And, you know, as you know, Arnethea Sutton's research does focus on health inequities and cancer. And this is really their passion, for both Dr. Sutton and Dr. Winn.

NICK

For our Color Code listeners there, you might remember Arnethea from our first episode on medical mistrust, which I think plays a bit of a role here in your reporting, looking at, you know, increasing diversity in clinical trials.

ANGUS

I guess one of the things that the sort of ideas or assumptions I came into this trip with was that mistrust would make a big difference in how people think about research and how people think about certain medical institutions, like the Massey Cancer Center. And I thought history would matter a lot, too, like, people would know the history of VCU, which used to be called the Medical College of Virginia.

And there's a lot of things about the Medical College of Virginia that are pretty messed up. Like, it was one of the places where the first heart transplant in the U.S. was done by taking a heart from a man named Bruce Tucker, a Black man from Richmond, and giving it to a white man without his or his family's consent. Basically doctors at MCV stole this heart and gave it to a white man.

And, you know, it's like one of those things that's celebrated in medicine, like, "Oh, they performed one of the first heart surgeries – heart transplants ever at this place." But it took a long time for that history to be talked about. And as other part of the sort of racist history associated with MCV and, of course, VCU, as it's now called, like the discovery – I think you talked about this with Arnethea Sutton, but the discovery of, you know, Black bones in a well beside the Egyptian Building of VCU.

And so I really wanted to talk to community members to see if that influenced their opinion of VCU. But the interesting thing that I would, like – one of the first things I found out was that it didn't really – for most people, it didn't. And in fact, for most people, they had never heard of this history before. But there was a really interesting reaction that I got when I was discussing this

history with people who hadn't heard of it. And before I even talked to Dr. Winn, I talked to a local pastor named Dr. Yvonne Bibbs. And this was her reaction to hearing those stories.

YVONNE BIBBS

In Richmond, Virginia – I think that's enough said. If you walk down streets downtown Richmond, you'll find that there are many places where the streets were made by slaves. The bricks are still there. And Richmond is the capital of the Confederacy. And Black folk were slaves. You cannot erase history.

ANGUS

So, I mean, this was like, one of the first things that I learned or heard in Richmond that started to change my perspective, which is that maybe some of this history – the details of this history don't matter as much as we think they do. And it's not that they don't matter at all. They do matter. They matter immensely, but not in the way that people, when they're thinking about research, or they're thinking about VCU or MCV, if they're more familiar with that name – that they're thinking, “Oh, I don't want to go there because they experiment on Black people,” or “Oh, I don't want to go there because they stole a heart from a Black man.” They don't, actually – a lot of people don't actually know those stories.

But there is something else. There is this, like, I know – maybe it's like a – I'm not sure how to describe it actually yet, but maybe like a culture or a mindset of protecting yourself, of, like, a healthy skepticism that says, “I don't know everything about this place, but I do know I'm in a country that is a white supremacist country and does not protect me and often actually acts against my interest for the benefit of others.”

And that sense, I think, is really pervasive and doesn't necessarily mean that someone's thinking about it in the context of, like, the Tuskegee syphilis experiment.

NICK

Tell me a bit about, you know, when you first met Dr. Winn.

ANGUS

So part of the trip that I had planned was to coincide with something that Robert Winn calls “the district walk.” And he basically goes to neighborhoods that are often cancer hotspots, or they're often low-income communities of color. And he sets up, like, a community meeting, like, sort of a town hall to talk to people who live there and say, “Hey, this is who I am. You know, this is actually how you can reach me or reach members of my staff. And here's what I'm offering you. And I'm also, like, your” – like, I remember when we first got to one of these sites, he leaned into me. He said, like, “Hey, like the most important reason why I'm here is to listen. Like, I'm here so I can – I want to hear from people who live here and hear what, you know, what they need and how I can do better for them in terms of access or health or even more than that, just like for the neighborhood.”

NICK

It sounds to me like this is kind of like a “walkalong” kind of thing.

ANGUS

Yeah. I did two of these district walks with Robert Winn. The first one was in a neighborhood that was sort of to the east, the east side of Richmond, just outside of Richmond. And we drove over to a spot. So it was a kind of, like, playground area, and there were a few people waiting there, who lived in the neighborhood, and a state representative or a state councilor was there as well. She showed up to talk and listen as well. What Robert Winn does is he kind of gives a stump speech. He, like, talks about all these things. He talks about cancer. He talks about the cancer inequities that affect the Black community. And then he opens up to people, just for conversation.

People ask him questions like, “Hey, can you tell me, like, if my children are going to get cancer? Because I had cancer. And my parents had cancer. And, you know, my aunts and uncles – they had cancer.”

And then he’ll just answer their questions. He’ll talk about, like, sort of germline mutations, like mutations that might be passed down from parent to child that increase your risk of cancer, and what kind of things they might be able to do about that. And then at the end of this conversation, he and his staff will give their contact information to people who are at that meeting, the residents of this neighborhood. And they’ll say, like, “Hey, if you have any more questions, you can call me, or you can email me.”

And at the end of this sort of “town hall” part, he usually will walk around a little bit around the neighborhood. But it’s not more of talking to people. Often, the people at the town hall, they just go home at that point.

During that little walkaround – at least what I saw – the county manager was at this last meeting, this last district walk, and it was more of Dr. Winn talking with these local officials and saying, “Hey, can we do this, or can we try to do this? Can we sort of start something here that’s going to hopefully change health equities in this area or change cancer inequities in this area?”

NICK

How does that play into this bigger picture idea of, you know, diversity in clinical trials, trying to increase diversity in clinical trials, if you want to tell us a bit about that?

ANGUS

So, Robert Winn often uses this phrase “high tech and high touch,” which is – basically, what he means by this is that there’s a lot of high-tech stuff happening in cancer research right now. We have AI. We’ve got precision medicine. We’ve got, like, immunotherapies, right, targeted therapies – all this super exciting stuff that’s done a lot to save people’s lives and improve outcomes.

But what's missing, what's been missing for so much in science and in cancer science in particular, I think, is this “high-touch” element, sort of this “personal-touch” element and when Dr. – so Dr. Winn's idea was that if he shows up personally and tells people what he's about and shows them who he is, he can show them that he is trustworthy. And as a representative of the Massey Cancer Center, the cancer center is trustworthy and help people realize that he's actually there as a resource for them. He's not there to take anything from them. He's not there to just use their data or, you know, “make money” off of them, even, although, of course, we know that hospitals are a business. But he's trying to give this – create this image and create this relationship that says, “I'm not here about – I'm not – that's not what I'm about, right? Like, I'm about, sort of, being a service for you.”

He also talks to them, to his audience in a way that's just, like, very natural. I think he definitely tries to be as down to earth or just as much of himself as he can be. And, like, less like, “Oh, I'm like a fancy doctor who's a director of a cancer center.”

I think I want to play you a clip of him talking that I think really demonstrates, like, you know, how he relates to crowds and audiences and other people and communities.

ROBERT WINN (interview clip)

There's – hopefully y'all have me back because sometimes I can wear people out. That's what my grandmother told me. She said, “Boy, you wear people out. You just wear people out.” But hopefully I don't. Because what I want to do is make this the first connection. And by the way, we ain't doing nothing right if all we doing is just take care of your cancer.

So here's the other thing I want to try to do. Right here: “Where's your pipeline program for young people?” I just had a group of 4th and 5th graders yesterday on Sunday actually showing up and like, “Yo, this is how this – this is what this could be.”

They'll say, “Well, aren't you a doctor? You a cancer doctor. How come you sound –”

I sound exactly like I sound because I'm actually proud of the people I come from. Period.

NICK (commenting on the clip)

Oh, that's interesting, like, in terms of him feeling he doesn't need to, like, code switch when he's, you know, just in his everyday life. That's very powerful, honestly.

ANGUS

It is. And, you know, the other thing is he doesn't even do it in academic settings. I ran into Dr. Winn at every cancer research conference this year possible, pretty much. And I talked to him there. I listen to him talk, give lectures to other researchers and scientists, and he still talks the same. He doesn't feel like he needs to code switch. He doesn't want to code switch, even. He's just like, “This is who I am. This is what I'm representing.”

He's like, "It's not just about cancer. Like, we, as the Massey Cancer Center – we want to be a resource for more than that." He talked about sort of finding ways to bring jobs to this community from the Massey Cancer Center, find ways to bring better grocery stores to these communities as well. It's sort of this really big-picture talk that says, "Hey, you know, I know I'm a cancer center. And ultimately this, for me, this all does connect back to cancer. But that's life. Like, cancer is life. We want to make sure that you're living as healthily as possible."

NICK

Whenever I speak to people about, or experts in this area about how to get more, you know, people of color in clinical trials, or how to help diversify clinical trials, they always talk about, you know, "You need to be where the people are." The big case with, you know, COVID vaccines is that you shouldn't have to wait until there's, like, a global pandemic for the community to know who, you know, who these local researchers are, who these folks are. And it sounds very much so, like, he's, you know, not only doing that effort, but **has** been doing that effort, you know? The people in the community, it sounds like they know him. It sounds like this isn't his first, you know, walkalong. So tell us a bit about how this walkalong – how it directly relates towards clinical research and clinical trials.

[MUSIC notes from a synth march in the background.]

ANGUS

I guess when you're just looking at this, and you think, "Well, what does this have to do with research?" Because he's just talking to people. They're just getting to know him. But he's not like there, being like, "Hey, sign up for this trial. Sign up for that trial" or something, right?

But I think – I mean, what we know about who joins research and how they join research often has to do with the networks and the connections that they already have in their community. So one of the reasons why so many research studies and clinical trials in cancer have been so overwhelmingly white is because the academic research centers, where this research is being performed, have a patient population – they have a catchment, even – that is primarily white and more affluent, and it's primarily a population that has a greater level of baseline trust in the medical system, and at baseline often have better sort of personal historic – in their personal history – better interactions with clinicians as well. And all of that we know from research translates into people being more willing to participate in clinical trials and participate in research. And there's more to it than just trust. I suppose it's also access, like whether or not people can make it to wherever they need to be to take part in a clinical trial; whether or not they have the time to do it, if they have resources to do it. Often clinical trials are required to have health insurance, even if some of these barriers are solved in some way. There's, like, a solution to them for the trial. People aren't always aware of them, and they aren't always able to have a strong enough or a trusting enough relationship with the investigators to feel like they can ask for help on some of these access issues.

NICK

So it sounds to me what's special about this kind of walkalong or walk through the neighborhood is that it's **not** special. He just does this all the time. They do this all the time. And that's the point of it, to the point that the community knows you, and you built those relationships. So when you do need to, you know, kind of lean on those relationships, they're already there. They're already established. You've built that trust.

ANGUS

It's also about the relationship existing in the first place. If you ask communities of color if they want to participate in research, they pretty much resoundingly say, "Yes." People actually want to participate in research because they are altruistic. People are, I mean – I suppose this is maybe a philosophical point, but a lot of people are altruistic. They want to take part in research because they believe it will benefit other people. Maybe it will benefit themselves in some way or their family in some way too. But if those relationships don't exist, that question never gets asked, right? And it never gets asked in a respectful way.

When I followed up with people who were at that district walk, I talked to a woman named Teresa Burrell, and I asked her what it meant for her to actually see Dr. Winn show up in her neighborhood, and talk to them, and listen to them, and explain what he's really about, and what he wants to do. This is what she said.

TERESSA BURRELL (interview clip)

What it means to me is saying that we're being heard as a community. What it means to me is saying someone's thinking about us. Someone's caring about us. And, you know, we do exist.

ANGUS

The other thing she said – and pretty much everyone I talked to who was there at that meeting said – they'd never seen anything like this before, where a doctor or the director of a local powerful institution came and sat down with them.

NICK

What do you hope the people who are listening to this come away with when we talk to her in regards to what Dr. Robert Winn has done, how that applies towards increasing diversity in clinical trials? What is the take-home message from this walkalong, from your reporting trip, from all the work that Dr. Winn is doing?

[Light, percussive MUSIC colors Angus's narration.]

ANGUS

I think it's fascinating what he's doing. And he's obviously putting a lot of effort and a lot of work into this type of community engagement and outreach. He really believes it's going to make a difference when people think about research, when people think about clinicians and their relationships with their clinicians. And down that line, he really believes it's going to change the way that research participation looks.

But it's not everything. It actually depends on a lot of stuff, and whether or not he's going to be successful also – like, I know during this whole time we've been talking about all this stuff that he's doing – I actually don't know how successful it is right now because you actually have – you're going to have to look at like whether or not it's actually affecting the enrollments of the research that's happening at the Massey Cancer Center. You kind of have to look at like, you know, the health outcomes in this region: Are those changing? And that, of course, is something that's going to take years to see. And finally, like, are there any concrete changes in the communities that Massey Cancer Center or Dr. Robert Winn have been involved in that, you know, are making positive changes?

I mean, that's, like, a huge follow-up effort. But it's obviously really important because we want to know whether or not these efforts are worth it, whether or not they are, you know, a model that can be used to change the relationship that communities have with researchers and research, not just in Richmond, but many other places in the country where the same problems exist, where people don't – often committees of color aren't asked to participate in research, or they don't participate in research because there's something wrong, not because there's something wrong with the communities, but because there's something about the research that is preventing them from doing it. There's something about the way the researchers are interacting with the community that is preventing them or stopping them from being part of the science.

And so I think really the takeaway is: 1) The goal has to be there. The goal of changing that relationship needs to be really front and center. If researchers want to have any hope at all of making sure that their trials, and what the participation looks like in the trials, is equitable and is diverse. And people in the community do respond to this doctor, Robert Winn. And they say, “You know what? I didn't know about him before. I used to not want to go to VCU, but after meeting him, my perspective is changing.”

NICK

Angus, thank you so much for your reporting, and thank you so much for your time.

ANGUS

Oh, it's great to be here.

[Lively, upbeat MUSIC marks the end of the conversation with Angus.]

NICK (narrating)

After hearing about Dr. Winn and his efforts to connect with the local community around VCU, I wanted to get the bigger picture. So I turned to one of my go-to sources: a guy named Dr. Jonathan Jackson.

JONATHAN JACKSON (interview clip)

Yes, my name is Dr. Jonathan Jackson, and do you want my full Mass. General Hospital because they give everybody, like, 9 titles?

NICK (narrating)

He's the director of the Community Access, Recruitment and Engagement (CARE) Research Center at Massachusetts General Hospital and Harvard Medical School. And we've talked a ton about this topic. I know he's got a lot to say.

NICK (interviewing)

Are you tired of talking about diversity in clinical trials?

JONATHAN JACKSON

You know, so I am a scientist, which means that I have a higher threshold for talking about my work than most people. I think I'm tired of having the conversation of: "Is this interesting; is this worthwhile; should we care about this?"

I mean, of course we should. But starting to see, you know, the first fruits of all of those efforts and all of those conversations and all of that planning, that becomes exciting because it means we, as scientists, get to ask new questions about this whole diversity lark and how it intersects with clinical trials and clinical research. So I'm actually not sick of it yet. I'm doing pretty good because I think there's a lot of new stuff coming down the pipeline in this area.

NICK (narrating)

Just last month, in May of 2022, a committee that Jonathan had briefly served on from the National Academies of Sciences, Engineering, and Medicine released a comprehensive report on the impact that the lack of diversity in clinical trials has on health outcomes. The report called on the FDA to hold researchers and their institutions more accountable for recruiting diverse participants. But how do they actually find those participants and get them to sign up? Angus told me how Robert Winn is doing it by trying to build trust in the community.

JONATHAN JACKSON (interview clip)

A lot of researchers, if you ask them, they'll say, "Oh, trust. You know, those people don't trust us." And there's a huge conversation to be had around that. You know, number one, it's not about, you know, you as a clinician or you as a researcher, you don't deserve trust inherently. You've got to be trustworthy. And there's a lot of people, who have written much more cogently and eloquently on that topic than I have. But it turns out that there are probably like 10 other reasons why people can't get involved in research.

NICK

Often, people from historically marginalized communities are simply not asked to participate in the trials, or they don't know who to ask if they have their own interest, which shows just how important Dr. Winn's work is.

JONATHAN JACKSON (interview clip)

We, as researchers – we keep bankers' hours. If you aren't willing to come in between 8 a.m. and 3 p.m. on a weekday, then, you know, you don't have a chance. And so you have to be able

to be willing to be doing this sometimes, you know, every week for up to 2 years. And it really, really adds up over time.

NICK

People have to go to work. They have to take their kids to school. They have to live their lives.

JONATHAN JACKSON (interview clip)

If you are not, at the same time, white, male, overeducated – so you have to have a master's or a doctoral degree – and living in an urban center on the East or West Coast of the United States – if you're not all of those things at the same time and rich, then you are underrepresented in clinical trials, in clinical research, which means that when the FDA, the Food and Drug Administration, when they approve some sort of therapy, we don't know how it works in someone who looks like you, or someone who has the background that you have.

NICK (interviewing)

So let's talk a little bit about a researcher or a clinical trialist, who's listening to this. What would your advice kind of be for them if they want to make sure that their clinical trials are diverse?

JONATHAN JACKSON (interview clip)

If you have white people as a reference group in your dataset, you're doing it wrong, and you're being racist. Please stop. And so I know I'm going to get a lot of hate mail for that, but it's true. There are lots and lots of things that you can do. So number one: The best thing that you can do is have a really well-defined, what I'm going to call, a “sampling frame.” So if you think of your larger catchment area: all the people that could do your research study define a “sampling frame.” So instead of the people who maybe could do your research study, try to figure out who actually **will** do your research study based on your selection criteria, based on the fact that you're going to keep bankers' hours, you know, based on the fact that individuals from your health system are the ones who are going to be most likely to participate, and really try to drill down who's going to participate. If you don't have a diversified representative population from that sampling frame, that means that you are going to have to try new things in order to recruit that population that is broadly representative or diverse. The number two thing that I would say is: Most people are going to worry about trust. But before you can worry about trust, you need to worry about awareness. If people have never heard of you, the trust is not your problem. You're going to have to do some advertising and to have to do some some talking, some conversation.

[A tense SYNTH hammers within earshot.]

NICK (narrating)

It takes sustained effort to form a relationship with local communities, in a way that Dr. Winn does. But Jonathan also believes that that type of work could lead to more inclusive research.

JONATHAN JACKSON (interview clip)

If you can find a way to design these trials from a very human-centric perspective, then what you're going to find is that folks are going to respond. They're going to participate, not just in this

study, but in the next 10 studies that you're going to try to design and advertise within this community.

NICK

Essentially, researchers need to recognize that creating diverse clinical trials is complex, and there are no shortcuts. Lots of folk think that all they need to find Black participants for studies is go to a Black church. But that's not enough.

JONATHAN JACKSON (interview clip)

It's really important to recognize that there is diversity within diversity. And just because somebody has a Brown face, doesn't mean that you'll find them at the one church that you're going to go to on a Sunday.

NICK

But he's got more ambitious hopes for the future of research as well.

JONATHAN JACKSON (interview clip)

You know, if we think about science, and we think about what the colonial model is, science is it – like, science is the most colonial thing that I think we're currently doing right now as a society, and we got to get rid of that because it's not sustainable. It's not helpful. We have taken it as far as it can go. And we need to come up with a new playbook here. Usually it's a small number of very, very powerful people, who have no sort of transparency or accountability, who are collecting data on vast populations, who don't necessarily get to directly benefit from that. They just get, you know, the privilege of participation. That's – that is like, you know, that's colonialism. So the idea is that under decolonized science, it doesn't stop the science that people are already doing. It just adds context. And it just adds structures and support. It makes the science that you're doing easier, and it means that you don't have to work as hard to make sure that your science can reach each and everyone. You just need to be able to step aside and let someone else do that job if you're not willing to.

NICK (interviewing)

At what point would you stop being, you know, asked to speak on these issues and such?

JONATHAN JACKSON

Oh, boy.

NICK

What metric needs to be reached?

JONATHAN JACKSON

“What metric needs to be reached?” That's a great question. I would actually love to be out of a job. I would love – I'm a scientist, so I would love nothing more than to be just, like, stuck in a corner with a large dataset and a fast computer and just left alone for easily decades at a time. If you're asking me when I'll be happy with the work that I'm doing, it's when we can redistribute

these systems of organization and power so that everybody gets a chance to participate, and everybody gets a chance to benefit. And we're just so far away from that right now.

NICK (narrating)

As I had mentioned, Jonathan and I have spoken about diversity in clinical trials many, many times. And I remember once before we were set to take the stage at the STAT Breakthrough Summit earlier this year, he just said to me, "Hey, I'm just gonna go out there, and I'm just gonna share my truth."

I feel like that sums up how a lot of researchers in this field are feeling. They're gonna share the truth, and they're not gonna tiptoe around this issue anymore. Diversity in clinical trials is important. Diversity in clinical trials should be the baseline. And they're gonna make sure it's taken with the same amount of seriousness that it deserves.

[Full, uplifting music, complete with a keyboard, percussion, and more, rises. THEME MUSIC closes the episode and takes us to the credits.]

Thank you for listening and being part of our Color Code community.

Our team here at STAT is Alissa Ambrose, Hyacinth Empinado, Theresa Gaffney, Crystal Milner, and me, Nick St. Fleur. Kevin Seaman is our engineer, and Tino Delamerced is our intern. Our theme music is by Bryan Joel.

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After every episode, we'll have a bunch of photos and some more reading related to the episode's topic at STATnews.com, so please: go check it out! We'll have our final episode in two weeks.

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[THEME MUSIC ends on a final note.]