Eliminating Health Disparities

Conversations WITH Blacks in America

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ETR Associates
Santa Cruz, California

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Editor: Marcia Quackenbush, MS, MFT, CHES
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Health Disparities Among Blacks in America

Black or African American, the term used in the 2000 U.S. Census, hides a rich diversity of cultural groups of black people with African origins. Blacks, long the nation's largest minority group, have only recently been surpassed in numbers by Latinos. In 2002, 35,824,849, or 12.8% of the population, described themselves as black or African American, either alone or in combination with one or more other races.[1]

About 15 million Africans made the forced voyage to the Americas between 1518, when Spain began transporting captives to the New World, and 1888, when slavery ended in Brazil.[2] Many did not survive the journey across the Atlantic, the infamous "Middle Passage." They were killed by disease or suicide. Only 6% of the survivors, representing a wide variety of tribal and national cultural groups, arrived in North America. Yet, by the time slavery ended in North America, there were more slaves in the United States than all other countries combined.[2,3]

Most African Americans are the descendants of people who were captured from the west coast of Africa, although some are descended from black people who were free in this country since before the Mayflower. In fact, it is held that the first black person came to America as a free man with Columbus.[4] African people were distributed along the routes that the slave ships followed, and their descendants and the descendants of other black migrations, which reach back to antiquity, now come to the United States from many places, including Haiti, the Caribbean, Bermuda, the Dominican Republic,

[1]U.S. Census Bureau. 2003. American Community Survey Change Profile, 2001-2002. From website: www.census.gov/acs/www/Products/Profiles/Chg/2002/0102. Accessed 12/4/03.

[2]Lifson, A. 2002. Voices of the slave trade. *Humanities 23* (March/April): 28-31.

[3]Spector, R. E. 2004. *Cultural diversity in health and illness.* 6th ed. Upper Saddle River, NJ: Prentice Hall.

[4]Palmer, C. A. 1993. Afro-Mexican culture and consciousness during the sixteenth and seventeenth centuries. *In Global dimensions of the African diaspora,* ed. J. Harris, 125-136. Washington, DC: Howard University Press.

the Cape Verdean Islands, Canada, Great Britain, France and Central and South America.[5] These groups are culturally variant with regard to language, customs, family and community relationships, health beliefs and practices, and health problems. Such groups appropriately term themselves according to their country of origin, e.g., Jamaican American, Haitian American, and so forth. It's important to consider these differences.

While the majority reside in the South (54.8% in 2000), black Americans live in every region of the country. New York, Chicago, Detroit, Memphis and Houston are the cities with the largest numbers. Over half live in urban areas beset by the conditions of poverty, such as overcrowding, inadequate housing, poor public education and crime.[6] The number of people living in poverty increased by 1.7 million from 2001 to 2002, from 11.7% to 12.1%, for a total of 34.6 million living below the poverty line. The number of children living in poverty rose from 11.7 million to 12.1 million during this same period. Allowing for the redefinition of racial and ethnic categories in 2002, the percentage of black Americans living in poverty ranged from 23.9% to 24.1%. Both figures are higher than the 22.7% in 2001.[7]

Disparities in Health Outcomes

Health inequities are largely due to discriminatory practices in the larger society that result in unequal access to societal resources, such as education, job security, adequate nutrition and health care. For example, in the United States, lower income is strongly related to disability and premature death. Education, on the other hand, increases the likelihood of good health for the individual and for the children of well-educated mothers.[8] Income ranges vary, not only by gender and age, but also by race/ethnicity,

[5]Palmer, C. A. 2000. Defining and studying the modern African diaspora. *Journal of Negro History* 85: 27-32.

[6]Dalaku, J. 2001. *Poverty in the United States: 2000. U.S. Census Bureau Current Population Reports Series P60-214.* Washington, DC: U.S. Government Printing Office.

[7]U.S. Census Bureau. 2003. *Poverty in the United States: 2002.* Washington, DC.: U.S. Department of Commerce.

[8]Evans, T., M. Whitehead, M. Wirth and H. Epstein. 2001. *Challenging inequities in health: From ethics to action, summary.* New York: Rockefeller Foundation.

and educational opportunity is disproportionately distributed due to social arrangements that decrease the likelihood that some minorities, such as blacks, will receive an adequate public education.

Death rates from heart disease, all cancers, cerebrovascular disease, and a number of other diseases are significantly higher among blacks. The death rate among blacks from HIV/AIDS is more than seven times that of whites, while the homicide rate is six times higher.[9] Blacks have higher rates of hypertension, placing them at greater risk for heart disease, the leading cause of death for both genders and all ethnic groups. Recent studies linking depression and hopelessness with high blood pressure have estimated that blacks are two to three times as likely to develop hypertension, and, at age 25, are twice as likely to have high blood pressure as whites.[10]

Issues for Women

Women of color, especially blacks, comprise the largest number of new HIV infections. This increase is most notable among poor women, whose situation is often complicated by family responsibilities. Black women, who represented only 12% of the U.S. female population in 2001, accounted for an estimated 64% of new HIV infections among all U.S. women. The 2001 AIDS case rate for African-American women (47.8/100,000) was almost 20 times that of white women (2.4/100,000).[11]

[9]Ross, H. 2000. Growing older: Health issues for minorities. *Closing the Gap: A Newsletter of the Office of Minority Health*. Washington, DC: U.S. Department of Health and Human Services. pp. 1-2

Smedley, B. D., A. Y. Stith and A. R. Nelson, eds. 2003. *Unequal treatment: Confronting racial and ethnic disparities*. Washington, DC: National Academies Press.

Umar, K. B. 2003. Disparities persist in infant mortality: Creative approaches work to close the gap. *Closing the Gap: A Newsletter of the Office of Minority Health*. Washington, DC: U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services. 2000. *Healthy people 2010*. Washington, DC.

U.S. Department of Health and Human Services. 2003. *Health, United States, 2003: With chartbook on trends in the Health of Americans*. Washington, DC.

[10]Davidson, K., B. S. Jonas, K. Dixon and Markovitz. 2000. Do depression symptoms predict hypertension incidence in young adults in the CARDIA study? *Archives of Internal Medicine* 160:1495-1500.

[11]Kaiser Family Foundation. 2003. *Women with HIV/AIDS in the United States*. Menlo Park, CA.

In 1999-2000, 50% of black women were obese compared to 30% of non-Hispanic white women. Obesity increased 60% among black women between 1976 and 1980.[12] Black women are more likely to die of breast cancer, in spite of a lower incidence rate and a higher mammography screening rate than white women.

Issues for Men

Black men and other men of color are typically less healthy than any other group. The life expectancy for black men is 7.1 years less than for white men, 7.5 years less than for black women and 12.7 years less than for white women. The prostate cancer mortality rate among black males is more than double that of whites. Black men are at significantly greater risk of death from heart and cerebrovascular disease, homicide and HIV/AIDS.[12] Although they are more prone to chronic disease, black men are less likely to have adequate access to health care. While the health status of middle-class black men is generally better than that of poor black men, for some conditions, such as hypertension, suicide and stress, it is worse.[13]

Black men also are more likely to be affected by poverty, income inequality, low educational status and unemployment, and to experience the detrimental effects of residential segregation and other economic and social problems associated with poor health. Black men are also less likely than white men to see a doctor, even when they are in poor health. Medicaid insures only 6% to 8% of black and Latino males. "Regardless of insurance status, men of color are less likely to receive timely preventive services, and more likely to suffer the consequences of delayed attention, such as limb amputation and radical cancer surgery."[13]

Issues for Children

Despite overall decreases in the infant mortality rate, the infant death rate among blacks has persistently remained at double the white rate for many years. Between

[12]U.S. Department of Health and Human Services. 2003. *Health, United States, 2003: With chartbook on trends in the Health of Americans*. Washington, DC.

[13]Facts of Life. 2003. The forgotten population: Health disparities and minority men. *Facts of life: Issue briefings for health reporters* 8 (5).

1980 and 2000, there was an overall decline of 45.2% in the infant mortality rate; however, the decline for whites (10.9% to 5.7%) was greater than the decline among blacks (22.2% to 14.0%).

Physicians who care for children with leukemia have known since the 1970s that minority children experience disparities in survival rates when compared with white children. University of Minnesota researchers and others found that in the 1990s only 75% of black and Latino children with leukemia exhibited a five-year survival rate as compared with 84% of white children and 81% of Asian children. As a complement to these findings, a study conducted at St. Jude's Children's Research Hospital found that black children who received the best care available at no cost to their families exhibited the same survival rates as white children who received that level of care. However, the disparity in survival rates is the persistent reality.

One explanation is that minority children, who are more likely to live in poverty, do not receive the most consistent medical care. Apparently, black children also are more likely to have a more virulent form of the disease, so genetic differences may affect a child's response to the disease as well as to various drug regimes.[14]

Issues for the Elderly

Many of the health disparities faced by black elders are related to their disproportionate experience of poverty. While 10% of white elderly live in poverty, the rate among blacks is 43%. This is the highest rate of elder poverty for all races.

A 1999 Kaiser Family Foundation study found that almost 25% of black elders have no supplemental health insurance coverage, compared to 10% of whites. More than half the minority Medicare population is black, a group more likely than whites to have serious

[14]Marcotty, J. 2003. Studies show equal access to care helps even the odds for minority kids with leukemia. *Star Tribune*. From website: http://startribune.com/viewers/story.php?template=print_a&st. Accessed 10/30/2003.

health problems and long-term needs and to experience functional limitations and cognitive impairments such as dementia.[15]

Black elders are more likely to suffer diseases prevalent among elderly people, and have a greater likelihood of experiencing complications. For example, blacks have the highest overall risk of chronic kidney disease and develop end-stage renal disease at an earlier age than whites: 55.8 years compared to 62.2 years; and diabetes, the seventh leading cause of death in the United States, affects blacks twice as often as whites.[16]

Although influenza and pneumonia are the fifth leading cause of death for blacks age 65 and over, rates of influenza and pneumococcal immunizations are significantly lower for black adults as compared to whites. Blacks, already more likely to suffer from underlying high-risk conditions, such as diabetes and heart disease, are also more susceptible to invasive pneumococcal infection. Blacks over age 40 are also more likely to develop glaucoma, which often goes unnoticed until vision loss has occurred.[16,17,18]

Environmental Quality

Blacks, other low-income groups and working-class persons are disproportionately subjected to pollution and environmental stressors at home and at work. Even with social class held constant, race has been found to determine elevated public health risks in the distribution of air pollution, contaminated fish consumption, location of municipal landfills and incinerators, abandoned toxic-waste dumps, cleanup of Superfund sites, and lead poisoning in children. Lead poisoning, for example, affects black children disproportionately, with percentages of excessive lead levels far exceeding those of whites at all income levels, and race has been found to be the single most important factor

[15]Kaiser Family Foundation. 1999. *Key facts: Race, ethnicity and medical care*. Menlo Park, CA: Henry J. Kaiser Family Foundation.

[16]Ross, H. 2000. Growing older: Health issues for minorities. *Closing the Gap: A Newsletter of the Office of Minority Health*. Washington, DC: U.S. Department of Health and Human Services. pp. 1-2

[17]Brooks, J. 2000. Immunizations: Not just for the young. *Closing the Gap: A Newsletter of the Office of Minority Health*. Washington, DC: U.S. Department of Health and Human Services.

[18]Common diseases among the elderly. 2000. *Closing the Gap: A Newsletter of the Office of Minority Health*. Washington, DC: U.S. Department of Health and Human Services.

in the location of toxic waste sites. Blacks were most at risk in this area, with three out of five blacks living in communities with abandoned toxic-waste sites.[19]

Access to and Quality of Health Care

The Institute of Medicine reports growing concern over disparities in the quality of health care that minorities receive even at equivalent levels of access. Blacks have been found to be less likely to receive appropriate cardiac medication, coronary artery bypass surgery, peritoneal dialysis, kidney transplantation and analgesia when indicated than their white counterparts. These differences have been associated with greater mortality. Blacks are less likely to have health insurance and more likely to experience difficulty in obtaining health care. They have less choice in where to receive care and are more often found receiving care in emergency rooms.[20]

Addressing the Disparities

Based on a comprehensive survey of peer-reviewed medical literature, an expert panel appointed by Physicians for Human Rights made 24 policy recommendations to address the problem of racial and ethnic disparities in the quality of medical care. The panel advised the federal government to create an Office of Health Disparities within the Department of Health and Human Services Office of Civil Rights to determine if health disparities are the products of discrimination and take appropriate action. The government was also admonished to collect data on race, ethnicity, and primary language in health plans, to ensure analysis of data on racial and ethnic disparities, and to provide resources to agencies addressing racial and ethnic health disparities.

National professional organizations, educational institutions, accrediting bodies and health care provider associations were advised to take appropriate action to ensure that health professionals were educated regarding health disparities and cultural competence,

[19]Bullard, R. D. 2000. *Dumping in Dixie: Race, class, and environmental quality.* Boulder, CO: Westview Press.

[20]Smedley, B. D., A. Y. Stith and A. R. Nelson, eds. 2003. *Unequal treatment: Confronting racial and ethnic disparities.* Washington, DC: National Academies Press.

and that these competencies were evaluated for licensure and individual and institutional credentialing purposes. Research was recommended on patient-provider interactions, provider attitudes and behaviors related to race and ethnicity, health system disparities in care, and interventions to eliminate disparities.[21]

Healthy People 2010, the U.S. Department of Health and Human Services' health objectives for the nation, calls for eliminating health disparities within the decade by concentrating on the six conditions and diseases that have the most glaring and persistent gaps between minority and mainstream health outcomes:

- Infant mortality
- Cancer screening and management
- Cardiovascular disease
- Diabetes
- HIV/AIDS
- Child and adult immunizations

The previous iteration of *Healthy People*, setting forth goals for 2000, called for *reducing* disparities—a goal that was ambitious, but fell short of the current goal of *eliminating* disparities. The rhetorical shift is significant, conveying at once an optimism that disparities can indeed be eliminated, and an urgency and scope different from the more gradual reductions implied in the earlier language. The optimism and urgency inherent in this goal are captured in different ways—all eloquent, passionate and persuasive—by the conversations recorded in this monograph.

[21]Physicians for Human Rights, Panel on Racial and Ethnic Disparities in Medical Care. *The Right to Equal Treatment*. From website: www.phrusa.org/research/domestic/race/race_report/press_release_02.html. Accessed 3/10/04.

Public Health: A Personal Profession

Lenora E. Johnson

Lenora E. Johnson, MPH, CHES, *is the newly named director of the National Cancer Institute's Office on Education and Special Initiatives (OESI). She has been with NCI for two years and is working with colleagues within OESI to provide new direction to and strengthen the science and evidence base within NCI's educational programs and materials. She is also a doctoral candidate in public health at the George Washington School of Public Health and Health Services.*

Previously she directed efforts funded by the Centers for Disease Control and Prevention to support the activities of state health agencies in areas of health promotion and chronic disease prevention. As the program director for the Association for State and Territorial Directors of Health Promotion and Public Health Education, she oversaw several initiatives, including minority health and reducing health disparities, global surveillance of health risk behaviors, broadening states' capacity for social marketing, and capacity building for health promotion.

She has worked at the national and local levels to reach vulnerable populations through the Lombardi Cancer Center in Washington, D.C., the American Association for Health Education, the American Public Health Association, and partnership efforts with community-based organizations.

Several years ago, a few colleagues and I decided to conduct focus groups with African-American public health educators working in and around the District of Columbia. One of the questions we posed related to the separation of professional roles and personal lives. It was interesting that, for us, there was no separation. One of the central themes that emerged from the focus groups was that our work transcends the offices in which many public health practitioners of color spend their days and accompanies us to our homes and communities. Quite honestly, I did not so much choose public health as it chose me, a selection engendered from personal experiences with illness and disease and the ways these experiences played out in my family, my community and communities like mine.

Finding a Calling

While I didn't know it at the time, I think my passion for public health began long ago when I was a junior high school teacher of family health and physical science. A more appropriate course title might have been "family ill health." Much of my teaching focused on trying to help students learn strategies that could prevent them from experiencing the poor health conditions with which they were all too familiar. My experience of teaching adolescents was short lived, however, as the budget cuts of the 1980s resulted in the lay off of 800 teachers in my school district.

After being "pink slipped," I was fortunate to quickly land a position with the American Cancer Society, although the salary was so low that I worked two other jobs in order to earn a respectable wage. Despite the salary, however, the work spoke to me in a way that would turn a job into a professional calling.

At that time there was a common expression that "cancer was color blind." As a patient services coordinator and an area program director, I saw evidence contrary to that notion. While cancer itself may have an equal opportunity aspect to it, I found that the cancer *experience* of people of color was far less hopeful and had a far more deleterious impact than the experiences of others. My work in cancer, at that time, focused on individuals—obtaining services, smoking cessation, financial aid and such. What I

witnessed in the patients we served compelled me to pester loved ones even more to quit smoking, eat more broccoli and fiber, have regular check-ups, and correct all the myths surrounding cancer.

The Move to Public Health

After realizing that I could run smoking cessation programs and help individuals quit till the end of time but not really make a dent in the overall smoking rates, I left the work I loved at ACS to take a position with the American Public Health Association, coordinating a national anti-tobacco campaign aimed at the tobacco industry. Through this different set of eyes, it occurred to me that perhaps the impact of cancer (and other diseases) on people of color derived not just from individual behavior and issues of access, but from targeted marketing to this population by the tobacco industry. While the campaign that I coordinated was multi-faceted, my favorite component included strategies to break the strong hold the tobacco industry had upon communities of color through its support of scholarships, magazine advertising, events sponsorship and many other sophisticated, dependence-driven tactics that presented the industry as the ally of the African-American community.

It was a losing battle. I felt as though I was working to overcome the belief that a foe who feeds you is better than the friend who would see you starve. Public health could not replenish the financial deficits that severing ties with the tobacco industry would create. I realized that I, personally, needed more artillery to address the real challenges before us in public health, particularly the issue of disparities. It was then that I, who loathed school, did what I didn't ever want to do again, and went back to school in pursuit of an MPH.

Those who are thinking of becoming students in public health need only to look around to see the need for African Americans in the field. I believe that until the number of African-American practitioners is proportional to the African-American population, we will not be able to adequately address the elimination of racial and ethnic health disparities. We can speak to each other in ways that reveal more about specific

issues, barriers, beliefs and attitudes. We understand what motivates, enables and reinforces positive behaviors that might yield healthier lifestyles. We are able to identify the attributes within our own cultures that can be valuable in changing health behaviors. Perhaps most important, we're likely to find that we not only study the issues, we live them.

Making the Message Matter

Several years ago, I recall hearing Rev. Lowry of the Southern Christian Leadership Conference attest that "when America gets a cold, black America gets pneumonia." At that time, disparities, which were apparent, needed to be affirmed within our own communities—not simply recognized, but affirmed. Now that there's a strong affirmation of health disparities, there remains a desperate need to support communities in addressing their own health issues in their own fashion. It's been said that one of the greatest practice lessons in health promotion was the empowerment of the gay community to reach its own with effective messages to address the HIV epidemic in its early phases. This lesson, I believe, has not yet been applied to the reduction of health disparities in communities of color.

Once, when out in a public housing community in D.C., a colleague of mine remarked that I was "not like them," referring to the African-American women in the community with whom we'd met and interacted. But in work in community settings, I've always been quite comfortable. Whether I was at a meeting of a community coalition or bringing a health education program to a senior center, if the audience was people of color, I generally felt as though I was chatting with my aunts, uncles or distant cousins. Many see professionals of color as different from the vulnerable populations of color. In truth, we're not different at all. We're not only like them, we *are* them. Again and again, the work of African-American practitioners is a balancing act between our professional challenge of reducing health disparities and our personal desire to help heal our own families.

Over the years, I've come to view translating complex health messages as an art form. It is familiarity with culture and an ability to link strange faces with those of similar relatives or friends that enables those of us in public health education to translate health messages into familiar and appropriate tones. These attributes are difficult to lecture upon or build skills around, and these attributes are what our African-American students can bring to the awesome challenge of eliminating racial and ethnic health disparities. These attributes must, however, be accompanied by a strong knowledge of public health practices, needs assessment, epidemiological diagnosis, theory and its application, program development processes, and sound evaluation design.

The Gift of Mentorship

I would be remiss not to acknowledge the powerful effect of mentorship upon my career and my desire to continue to enhance my professional competencies and skills. I owe so much to those who have taken me under their wings and modeled, taught, encouraged and provided me phenomenal opportunities. Mentors can be instrumental in both practice and preparation. I was fortunate to have had the opportunity to work with and beside a person I would label the preeminent model of public health, Dr. William Foege. He spearheaded my work on anti-tobacco related matters at APHA and led the efforts in domestic health issues at the Carter Center.

I'm forever indebted to those at the Carter Center who provided me the opportunity to participate in dialogues with some of the greatest minds in public health. I've also been blessed to have academic mentors in my field—women who have reached the highest professional levels yet retained the ability and humility to mentor—Drs. Kathleen Miner (Rollins School of Public Health) and Jill Joseph (Children's National Medical Center). Likewise, I am blessed with countless friends and colleagues across the country whose work, partnership and endearing support is invaluable. A close network of African-American colleagues in the field is, has been and will remain without fail my most treasured asset. Being able to relax and "tell it like it is" without judgment, without being assessed and without threat is essential.

It's Worth It

As I continue to pursue the goal of completing my dissertation, I realize that I've never had the pleasure of being a full-time student. My educational pursuits at every level have always been combined with the need to work at least one and often several jobs. I recently had a student intern who lived an hour and a half commute from our offices. He also worked two part time jobs because the internship stipend could not cover his living expenses.

I saw myself in him and recalled how difficult it is only to be able to devote "spare time" to one's studies. I realized that for students of color this is more than likely the case, and that all too often education is not only an investment but also a sacrifice. To those students I say, "Remember, it's not just a professional pursuit—it's personal and it's worth the investment." To those of us who mentor these students, I say the same. Remember that, for them, it's not just a professional goal—it's personal.

I have an uncle who was recently diagnosed with stage 4 cancer of the throat. He is in a cancer center and he is terminal. I also have an aunt, his wife, in the same hospital battling emphysema. This past weekend, my mother's best friend telephoned and we discussed her struggle to determine the best surgical option for her 80-year-old mother who has just been diagnosed with stage 1 breast cancer and lives quite a distance from any treatment center. My 9-year-old nephew just celebrated a year post-cancer treatment. He'd been treated for stage 4 non-Hodgkin's lymphoma. He's now back to his old, overactive, overbearing, loving self. Professional? Personal? It really doesn't matter what you call it. It's our work. It's our lives.

It's About Service

Carol Easley Allen

Carol Easley Allen, PhD, RN, *has been engaged in teaching in graduate and undergraduate programs in community health nursing and in higher education administration for most of her career. She was vice president for academic affairs and dean of the faculty at Atlantic Union College in South Lancaster, Massachusetts, and also served as acting president. Before her present position as professor and chair of the department of nursing at Oakwood College, she was associate dean for academic affairs at The Catholic University of America School of Nursing in Washington, D.C.*

Her interests include the use of philosophical methods in nursing research, and disparities in health outcomes among the poor and ethnic minorities. She studied the effects of poverty through service with Mother Teresa's Missionaries of Charity in Calcutta, India, and in travels to Kenya, Uganda, South Africa and the Philippines. With her husband Dr. Gregory Allen, a minister, she developed and implemented a church-based community needs assessment and intervention model. She's involved in research and training projects related to community-based prevention, diabetes and stroke, and is a frequent speaker at national, state and local professional meetings.

She coauthored the Easley-Storfjell Instruments for Caseload/Workload Analysis in Community Health Nursing, which have been in use since 1978. She served four years on the Executive Board of the American Public Health Association (APHA) with a year as chair, and was president of APHA from November 1999 to November 2000.

Who has inspired your work?

I was initially inspired in terms of public health nursing by my teacher, Darlene Johnson, who is now deceased. My twin sister Cheryl, who is also a nurse and nurse educator, and I had decided that we were going to go into OB nursing when we finished college. That was before we took the course in community health nursing. Darlene Johnson was such a dynamic person herself, and we had a wonderful experience working in southwest, northwest and northeast Washington, D.C., doing public health nursing—from the health department—in the homes. After that there was no question in either of our minds that this was what we wanted to do the rest of our lives. Darlene Johnson was a tremendous inspiration. She was a model of a public health nurse: she was extremely competent; she cared about people; she knew the community and how to work effectively in the community.

Then as I learned and read more about public health nursing, especially in graduate school, Lillian Wald, who's looked upon as the founder of public health nursing in the United States, has always been a tremendous inspiration. She not only started the House on Henry Street but she lived with her clients, in the community with the families. She was such a visionary person. She was involved in everything from school health to occupational health to mother-baby care and infectious disease control. She started milk stations so children and babies could have pasteurized milk. She held fresh air camps in the summer so kids could get out of the city. She was very much an advocate. She was a wealthy woman and well connected socially, so she knew the president and all the important people in the country and she was able to advocate for legislation. The child labor laws that we have in this country today are largely a result of her efforts. She was just a tremendous person.

Mother Teresa has been one of the people whom I've tried to emulate in many ways.

Another person who greatly inspired me was Mother Teresa of Calcutta. Cheryl and I had the opportunity to go to Calcutta some years ago and work with the Sisters of Charity at some of their homes—Kalighat, the Home for Destitute Dying—and some of the orphanages and the leper colony run by the Brothers of Charity. To see that kind

of work being done for people who are extremely poor has been a tremendous inspiration. Mother Teresa has been one of the people whom I've tried to emulate in many ways, her ideas of service and compassionate care. She really wasn't a nurse and they really don't give nursing care per se as we would think of it here in the United States, but compassionate care for the individual is coupled with making sure that people in the community have basic needs satisfied. They feed many people, take care of children who have been abandoned, provide living conditions for lepers who are outcasts in that society.

While I was there they even took in some women who had been incarcerated because they were mentally ill and there was no other place for them to live. When these women got well they were stigmatized, because they'd been in jail. Their families wouldn't take them back, but Mother Teresa's people provided homes for these women. So they care very much for the individual, but they also care for the community. They take the broad view of how they can meet community needs as well.

Nurses I've worked with over the years [have] truly been inspirational in many ways just by doing their day-to-day work.

Those are the people who inspired me in terms of public health nursing and my career. Then there are my colleagues who inspire me every day, people I've met through the American Public Health Association, faculty here on my campus, and other nurses I've worked with over the years who've truly been inspirational in many ways just by doing their day-to-day work.

Were there things about your family's values that guided you and your sister in the direction of nursing?

Not actually. My mother was from a mixed American Indian and black background. She got a lot of her values from her mother who was American Indian. Mom was very noncompetitive. There were five girls, three older sisters and then Cheryl and I, who were late-in-life children. We were never pushed to do anything. We were never pushed to go to college, although Mother and Daddy encouraged us and did a lot of things that made learning and academics attractive. Mother used to read to us all the time, sing and

recite poetry. They helped us with schoolwork if we needed it. They were always very interested but they never said, "You must go to college." But when we wanted to go Mom really moved heaven and earth to make it possible for us, because our father died when we were twelve.

Our mother became a nurse after Cheryl and I had finished the master's program in public health nursing at New York University. In fact, we taught Mother nursing. She was a great-grandmother who had never finished high school, but she went back to take classes, did her GED and entered the Mount Vernon School of Practical Nursing, where Cheryl and I both taught. She practiced nursing very effectively at a senior citizen's center in Riverdale, a small suburb in the Bronx. Then, when we moved to Michigan, she worked with a community health program that did screening and health promotion in the community out of Andrews University. She worked with the woman who directed that program for many years.

There aren't any other nurses in the family so I don't know how my sister and I drifted this way, but we were both interested in community health nursing as a career. We'd done everything together academically, so we both went into community health nursing. We both worked at the health department in Yonkers, New York, after we finished college in Maryland. Then we went back to school together for graduate study in public health at New York University and have both been working in and teaching public health ever since.

It's been said that if we do our work well in public health, we're invisible.

What lessons would you like to share with others?

I would share the notion of caring for people and caring for communities. Public health, many times, is not that well paid, so there has to be some kind of intrinsic motivation to devote yourself to this kind of work. It's been said that if we do our work well in public health, we're invisible. So it's not done for fame or glory, and certainly not for the money. Public health physicians and nurses are some of the lowest paid in their professions. But I think they embrace the notion of a real commitment to health,

to people, to the public's health. In many instances it's a commitment to disadvantaged populations, people who don't have access to or have somehow been discriminated against in the health care system.

Caring for people in the community is one part of it. Concentration on service is another, to see yourself as a person giving service. Whether it's voluntary or paid, you constantly have the idea of service in mind. That's the main concentration, not concentration on a career. I always try to teach my students that nursing and public health are a vocation in the old sense of the word—something you're committed to, that you'd do whether you were paid for it or not. There are many better opportunities in both nursing and medicine to have an illustrious career other than in public health. But the people you work with are so wonderful. I can always tell public health people just by their mind set, their reaction to situations.

Keep your eyes open for problems and opportunities.

Another lesson is to keep current. Keep your eyes open for problems and opportunities. Case finding is a big part of what we do on the practical level, and so I want to develop that mindset in students, to be alert to potential issues for groups of people. What kinds of health promotion or preventive services do people need that are not necessarily part of a program or within the mission of a particular agency or organization? What problems do you see that need to be picked up and cared for? What kinds of things can be done to remedy the situation? You see so many things in the communities and groups of people that you work with. If you just keep your thinking cap on, it'll pop into your mind: this is what the real problem is, and this is how I can make a difference.

For example, we had a Robert Wood Johnson grant to do a lot of small community-based prevention services in and around Huntsville, Alabama. We put breast models in beauty parlors and trained the beauty parlor owners to urge their clients to learn to do breast self-exam and have regular mammograms and clinical medical services regarding breast care. One of the things we learned when we tried to do the same thing with prostate cancer in the barber shops is that black men don't want to talk about these things. I think they're worried about it, and many of them, of course, are at risk.

But it's not something they want to talk about. So we didn't have the success in the barber shops that we had in the beauty parlors.

So what we're trying to do now is to look at how we can reach men. We're thinking of how to build support groups in the church. The church I go to has many men in it who've been to California to Loma Linda University Medical Center to have proton beam therapy because of prostate cancer. So we know there's a large population of people who probably need additional information and support, but the question becomes, How do we best reach these men with the messages they need to hear? It's something we've got to figure out.

What have your life experiences allowed you to accomplish?

Working with the American Public Health Association has been very rewarding for me. I've never considered myself a high-powered person. In fact, when Bill McBeath, who was then the executive director of APHA, called me and said, "Would you be willing to run for the board?" I said, "Are you sure you're talking to the right person?" He said, "Oh yes. You can do it," and encouraged me. It is amazing to me that I was the president of APHA. I would never have envisioned it and it's not something I would have ever aspired to. But when people have a vision for you and are able to communicate it to you and support you in doing it, you're able to do those things. People really have it within their power to create opportunities for other people, give them encouragement and support, and say, "I have this vision for you" that stretches them beyond what they would normally think to do or to aspire to.

People really have it within their power to create opportunities for other people.

Through my work with APHA, I've met wonderful people. I've had tremendous opportunities. I've been given a voice, in a sense, to speak on behalf of some things near and dear to my heart, such as the elimination of disparities, the health of people in prisons, issues of health literacy, advocacy for the poor. I'd never have had that opportunity had I not worked with APHA and been given that kind of visibility.

My husband is a minister, New Testament scholar and chair of our Department of Religion and Theology here at Oakwood. Because of his work, I have another life. He's traveled all over the world for what he's done in his work, particularly when he worked for the world headquarters of the church. Traveling with him has given me tremendous opportunities to look at health care systems in other countries. I've been able to meet people based on doing joint presentations with him on a number of topics, both health related and theological.

We've been able to present jointly on a community health assessment process we created in California. When he was in the pastoral ministry and had been active with several churches we talked with many people on how to do church-based assessment of needs and put in place programs that will meet those needs. Many of the needs were health care related—health promotion, screenings, teaching and that sort of thing—and some were more socially based, such as feeding programs and literacy programs. So that's another side of my life that's related to health and to some of the issues that people face in regard to their health care—poverty, lack of education and lack of literacy.

Right now, I'm partnering with the people at the Rush Presbyterian St. Luke's Stroke Research Center. We have a grant proposal with the National Institutes of Health, the National Institute of Neurological Disease and Stroke, seeking funding to look at whether the lifestyle of people in the Seventh-day Adventist Church, which emphasizes vegetarianism and spirituality, can have a preventive effect against stroke and dementia. My husband and his department are involved with us in that project because we'll actually be doing the study with people in churches.

We've already done two pilots, one in the Chicago area and one here in Huntsville, which showed significant differences based on diet, particularly the intake of fruits and vegetables; lack of smoking; greater emphasis on exercise; as well as the whole social support piece that comes out of church affiliation, and the spirituality piece that has to do with reduction of stress. So we're looking to see if these factors will make a difference in health outcomes related to stroke and dementia. It's interesting that we're

able to combine the efforts of our Nursing Department as well as the Department of Religion and Theology to try to get the total picture—health as well as spirituality.

What are the most important issues related to health disparities for African Americans and other blacks in this country?

First of all, there are a whole set of contextual issues that aren't health issues per se, but certainly have a tremendous impact on the health of black people. I'm talking about issues such as poverty and discrimination, both within the system in general and within the health care delivery system—we're seeing more and more of that coming out in the research—as well as lack of education, unemployment, lack of health insurance and access to care—all those contextual issues that surround health.

When you start to look at specific health issues, prominent among them are chronic illnesses such as diabetes, which has a tremendous impact on our community, particularly the complications of type 2 diabetes including end stage renal disease, visual problems and amputations, as well as various types of cancer that seem to be more common in blacks. All those things are influenced by the contextual issues. For example, even though we have a lower rate of breast cancer, we have a higher rate of mortality based on problems with when care is sought and how it is delivered. Asthma among children, infant mortality, HIV/AIDS and other infectious diseases are particularly a problem for African Americans and other blacks in this country. Some of this is due to problems of access and support for health care. Some of it has to do with cultural issues, perhaps a fatalism in how people think about seeking care, or fear of the medical and health care delivery system. Contextual issues are implicated in all of these things.

There are a whole set of contextual issues that…have a tremendous impact on the health of black people.

As we're getting more information about genetic influences on chronic illness, some of this is pointed up even more. People need to be able to trust genetic testing and screening and what will happen with the information derived from those tests and screenings. The community looks back on the bad things that happened when sickle

cell screening first started. People lost their jobs, lost their insurance, because there wasn't a clear understanding of what it meant to have the trait versus having the disease. So along with these new opportunities for understanding, we still need to look at what it means for a particular community to participate in genetic screening and how they can do so with full trust that their best interests are being taken to heart. These are some of the issues that are really important as far as our community is concerned.

There are contextual issues, and then there are individual practitioners. What advice would you have for people who are working one on one with patients?

I think you start with building cultural competence. It boils down to respect.

I think you start with building cultural competence. It boils down to respect. Do you actually respect the people, the families for whom you are providing care? Does that respect lead you to understand and learn about the cultural issues they are confronting? People need to be sensitized and they need to learn specific things. Not that you stereotype, because I don't believe there's any such thing as the African-American family or the Latino family or the Asian-American family the way it is presented in textbooks. I think those profiles can give you some basic information, but then you've got to really be with the people and talk with them to come to understand their perspective, their world view and how they process reality so that you can be respectful as you work with them.

And respect means different things in different cultures. In the Asian culture it may mean receiving objects from a person with both hands. In the Middle Eastern community it may mean not crossing your legs and showing someone the sole of your foot. In many black cultures in the United States it has to do with how people are addressed. Many people whom I would never call by their first names are addressed that way by health care providers young enough to be their great-grandchildren. The provider says, "Hello, Annie" or "Sally," and it's not, it's "Mrs. Someone." If you want to use the first name, you at least have to grace it with "Aunt" or "Mother." Simple things like that make a difference,

showing respect for people in the ways they perceive respect. This whole area of cultural competence is growing. You learn more and more as you live. Providers need to be sensitive enough to start to learn and put what they learn into practice.

I'm working now in an area that the group I'm in calls Clear Health Communication. We've started a partnership of organizations—I'm the American Public Health Association representative—and we've talked about the stigma that's attached to that term *health literacy*. But whatever you call it, we know that lack of health literacy is the cause of billions of dollars of excess cost in health care—complications, people taking wrong medications, and various other problems. It's submerged in terms of its visibility, but clear health communication is really important. It affects the entire country generally, but certainly affects many ethnic minorities in particular.

Often people cannot read or clearly comprehend or act on the health care information they receive from providers. So one of the things that's important in dealing with any population, but certainly with ethnic populations and those who are older, is to be acutely aware of the fact that people may not be able to understand the health messages that are given, particularly if these messages are given in writing that's at too high a reading level or contain jargon people can't understand. Providers often really haven't gotten confirmation from people that they know what they're supposed to do in relation to their care.

If people don't understand the message, we haven't done anything by giving it, no matter how eloquent we might have been.

I've been working on this issue for several years, ever since I was at Catholic University back in 1997-98 and became interested in the topic. I've tried to press it ever since. We need good ways to rapidly assess a person's health literacy and then be able to gear our health message in such a way that he or she will understand it. If people don't understand the message, we haven't done anything by giving it, no matter how eloquent we might have been. That to me is something that health providers on the ground need to think about all the time. Are people understanding?

The "Ask Me Three" campaign teaches three simple questions people can ask their providers that will help the message get across to them more clearly: What is my main problem? What do I need to do? and Why is it important for me to do this? That's essentially it—those three basic questions. If people can ask those questions, in the long run it cuts down on the time the provider needs to spend with them to communicate what they need to know.

People in practice also need to think about advocacy. They can look beyond the person sitting in front of them or the family they're dealing with to the larger contextual issues on which providers can give some specific input in a larger arena. Can they speak out about poverty? Can they speak out about environmental injustice in the black community? This is a big issue—how waste dumps are situated, especially toxic waste dumps, based on where people are on the socioeconomic scale and their race. If I'm a practitioner, I'm going to be seeing the effects of some of these things. How can I raise my voice and shift from a purely clinical perspective to looking at the larger picture and what I can do to help?

What suggestions do you have for people about mentorship?

A person mentors all the time. You can mentor people on a formal or informal basis. Some people you just spend time with and help. They're not formally your mentees, but, in fact, you're playing that role, trying to use your experience to help them move along. I mentor a lot of people informally, and I have one person I mentor formally. George Ashley, the new department chair of the Department of Social Work, was assigned to me, so we have regular meetings to sit down and talk about things.

Deal honestly with the people you're trying to mentor.

What I try to do in terms of mentorship, and what I would encourage others to do first of all, is be open and transparent. Deal honestly with the people you're trying to mentor. They can learn from your mistakes as well as your successes. Admit to poor choices you've made. Say, "This is where I went astray and this is what I should have done in hindsight." You may prevent others from making the same error.

You also need to make yourself available. In nursing we talk about the notion of authentic presence—not just being present physically but being present spiritually, providing space to be with a person at the deepest level, to offer yourself in terms of time, which includes quantity as well as quality. It takes time to mentor people, so you have to be willing to voluntarily offer up this amount of time, this amount of effort, this amount of emotional presence to be with a person and really enter into what she or he is trying to do, the issues, problems and questions this person is confronting. You concentrate on that person's needs and forget about your own self and your needs at that point. It's a lot like the nurse-patient relationship. It's unequal in that you give a lot more than you expect to receive, but, in the long run, you actually receive a lot. You learn from the person as he or she learns from you. It's a sacrifice on one hand, but on the other it's not. The rewards in terms of relationship are tremendous.

You can be there and be willing to use other contacts you have on the other person's behalf. There may be issues and problems that you're not able to deal with, but you know people who can help. You connect people to the network you have, which not only helps and encourages them, but helps them see that they in turn have a responsibility to give to others. You groom them to become mentors themselves, both in terms of the formal content and the mindset that it's a professional or personal responsibility to help others in the same way that you've been helped.

What is the philosophical model of nursing?

Three of us at New York University asked a question in our doctoral classes: could we do philosophical research in nursing? The research at New York University was very theoretical; they produce theoreticians and build theory. We had read articles by Dickoff and James, two nurse theorists at Yale, who had talked about the need for more philosophical study in nursing. So we went to Florence Downs who was the head of the doctoral program and asked if we could do philosophical research. She said, "Yes, but I can't help you do it. You'll have to go to the philosophy department and I'll support

you." So we did—my sister Cheryl, Judy Baigis Smith, who wrote a book called *The Idea of Health* based on her research, and myself.

I did my doctoral dissertation on the concept of holism, the pragmatic consequences for health and the profession. In nursing, we never just take care of the physical, we take care of the whole person—the spiritual, the social, the psychological, the emotional. We take care of the whole person, the whole family and, in fact, the whole community. So the idea of holism is very prevalent in nursing. In my doctoral dissertation, I looked at how nurses came to that idea and what it's meant to us in terms of practice, in terms of research, and in terms of education. Looking at things from a philosophical standpoint is an anomaly in nursing research, because it's very clinical in most cases. It's usually either qualitative or quantitative. Philosophical research—basically looking at ideas and concepts—is not empirical research at all. Since then, my whole interest has been, how do ideas and concepts actually make a difference in how we practice?

In nursing, we never just take care of the physical, we take care of the whole person.

Holism is not just pie in the sky. It's made differences throughout history in terms of how nurses practiced. It makes a difference in how everyone has practiced. That's why I've always been concerned with looking at the contextual issues, because a lot of the time the contextual issues we encounter reflect how people think in the society, their world views. It may not seem that connected when you first look at it, but how people feel about people of other races has a direct impact on how health care is delivered in this country. Basic assumptions many times are so implicit that we don't ever bring them to the fore. We're not even really in touch with our assumptions, but those assumptions have a tremendous impact on health and health care and how it's delivered.

I think spirituality also has to do with the holistic notion of what nurses do. It has a root in the religious bent of my life. I'm married to a minister. I've worked for various religious institutions. I've taught at three different Seventh-day Adventist institutions as an educational administrator: Oakwood, where I am now; Atlantic Union College, where I was academic vice-president and acting president for a while; and Andrews

University, where I taught when I first left New York. I've also taught at The Catholic University of America where they put a tremendous emphasis on spirituality and what it means to be in a faith-based situation as far as education is concerned.

Assumptions have a tremendous impact on health and health care and how it's delivered.

So I've always had that spiritual bent, and it continues in working with my husband on many of the things we've done together that have to do with spirituality or theological issues. We make a lot of presentations on topics such as sexuality from a scriptural standpoint, trying to help students understand why they should be responsible in their sexual behavior from a spiritual perspective. It all ties in in a holistic way for me.

What is your passion and vision for the future?

I'm passionate about health care for disadvantaged populations—the poor, those who are in prison, international populations of people who are lacking in health as well as human rights—all those public health things. Environmental issues are tremendously important for minorities here in this country, as well as people abroad, regardless of their ethnicity. Environmental issues are implicated in a lot of the health care problems that we see. I think that the more information we get and the greater our knowledge base becomes, the more we will see that environmental issues are at the root of many of the issues we confront. Dealing with the environment is extremely important. That's one of the things I teach.

Another thing I've always been interested in, but much more of late, is genetics and chronic disease predisposition. In the past, we only thought of exotic diseases as being genetically linked or related. Now, if you talk about any disease—heart disease, cancer, breast cancer (a particular problem in our community), diabetes, anything—there's a genetic component we've been able to identify since we've been able to map the human genome. I took an 18-week continuing education course through the Genetics Institute at the Cincinnati Children's Hospital Medical Center online. I learned more in those 18 weeks than I think I've ever learned in my life. It was fantastic.

What was pointed out was that, with the mapping of the human genome and all these things we've been able to learn from it, there's a new role for health care providers and for nurses to play in terms of helping people come to grips with this information—what it means and what the screenings mean. So much so that it's being said that eventually the need for this kind of service is going to overwhelm the existing genetics counselors and geneticists available in our health care delivery system. So a new role is being proposed for nursing. This new nurse would be a mid-level practitioner who works with families and individuals to answer questions and make appropriate referrals. This is an exciting new aspect of health care.

My vision for the health care delivery system is universal health care and social justice. I don't know if we'll ever achieve it, but this is my hope. I would really love to see universal coverage. But I'd also like to see social justice and human rights provisions strengthened in our society and around the world. After 9-11 there have been too many instances of the abrogation of human rights. It's frightening to me to see some of the things that have happened based on the fear that 9-11 engendered. It's a red flag. We've always got to keep this idea uppermost: social justice and human rights are just as much a part of health care as any of the other contextual issues. If we lose those things, we've lost something tremendous in our country and in our world.

My vision for the health care delivery system is universal health care and social justice.

A Question of Culture

Collins O. Airhihenbuwa

Collins O. Airhihenbuwa, MPH, PhD, *is professor of behavioral health in the College of Health and Human Development at the Pennsylvania State University, where he teaches in the areas of international health, ethnic minority health and health promotion evaluation. He has served as a consultant to the World Health Organization (WHO) and the United Nations Development Program. He is the 1998 Scholar of the Year of the American Association for Health Education, was named 2001 Symbol of Hope by the* American Journal of Health Promotion, *and is 2004/2005 president of the Society for Public Health Education.*

He is the author of Health and Culture: Beyond the Western Paradigm, *and has authored and coauthored numerous publications in the areas of culture and health behaviors, global health issues, HIV/AIDS, and ethnicity and health belief systems. He has been a keynote speaker and presenter at many national and international conferences and health education trainings, and has received fellowships and grants from the University of Tennessee at Knoxville, the National Institutes of Health and the Joint United Nations Program on HIV/AIDS. He has been on the editorial board of the* Journal of Health Education *and currently serves on the editorial boards of* Health Promotion Practice, AIDS Education and Prevention *and the* Journal of Health Communication.

Who has inspired your work?

The inspiration came from many places. I learned very important things from my parents, who are not lettered in the sense that they didn't go to a formal school, but in matters of values they are very well educated. The values I learned from very early childhood, from my parents and in my family, have stayed with me. As I began to study, it became very clear to me that some of these values from my family were not reflected in what I learned in school. This isn't something that comes out immediately—it's something you begin to realize over time as you interact with others.

The other inspiration came from my Edo culture in Nigeria. In school, most of my inspiration came from the literary field, the work of someone such as Chinua Achebe, author of *Things Fall Apart*, who talks about the Igbo culture and the conflict that resulted with the introduction of Christian missionary ideology. I was also influenced by the work of Wole Soyinka, the Nobel Prize winner for literature in 1986. These authors were trying to raise the question of how our cultural values were being left out of the work that we do. I also did a lot of reading about how our culture is expressed or not expressed through our training in school. These experiences taught me that we need to pay very close attention to make sure our values are reflected in our work, or in what we learn in school. It is not necessarily a matter of comparing our values with Western cultural values. It is simply saying that this is our culture and this is the way it is. It doesn't have to be a model of comparison. This really resonated with me.

We need to pay very close attention to make sure our values are reflected in our work, or in what we learn in school.

So, the inspiration came first from my family and then from the humanities, the literary world, and subsequently from reading more contemporaries, more of the work that comes out of cultural studies, philosophy, history of consciousness. Those types of writings allow us to examine behavior and humanity from a very realistic perspective, knowing that there's really no universal solution or universal truth.

When people ask me where I was educated I say in Nigeria, at home, because that's where I learned the values that allow me to understand why people relate the way they do. My primary and secondary education was in Nigeria. Then I came to this country and did my undergraduate training at the Tennessee State University, a historically black school where a lot of shared values were present. We read the work of Ralph Ellison, James Baldwin. So I began to see some of the retained values, the similarity between the African value and the African-American value—a combination of the African value and the American value. This transition was quite positive for me in that I came into a school that actually promoted positive aspects of African culture through the writing and work of scholars in the field.

What lessons do you have to share with others?

I was 20 years old when I came to the United States in 1977. I came from a place that was nice and warm to a place where it was snowing. As we were landing in London, people were pulling out big overcoats to put on over their three-piece suits. It was unimaginable to me that it could get so cold that someone would need a heavier coat on top of a three-piece suit! Another shocking thing was when I watched people outside speaking and it looked like they had smoke coming out of their mouths. I had never seen the condensation of breath in cold air. These were very memorable experiences in terms of the initial shock of leaving one environment and arriving in another, although by the time I arrived in New York the London cold had shocked my system so much that the New York cold didn't feel that bad.

When you first come into a new country, there's an initial embracing of what is visibly absent in your own country.

I think when you first come into a new country, there's an initial embracing of what is visibly absent in your own country. This depends to some extent on your stage of maturation when you arrive in the new culture, but I embraced what was clearly a more advanced infrastructure—the buildings and roads, and the ease with which one can get phone service. Of course, the novelty fades in time. Then you start to get disappointed. It's as

if once the surface values are gone, you start going to those deeper issues of relationship and connectedness. You feel this value was very important in your growing up, but you can't seem to see it now.

So what often happens is that initially you go through a phase where you embrace almost everything as wonderful. Then you go through a stage when you start to discount what is there—the experience is not as rich as it was in your homeland because you are missing those deeper values. Then you move to a stage in which you begin to appreciate the value of culture—not as a comparison of what is good or what is bad, or which is better—but trying to understand the different systems and different ways of being. Then, finally, you reach a stage where you can cross the cultural border and be able to function in both. When you move between two cultures or have lived in one culture for a long period of time and now live in another, you learn to appreciate both.

There's a lot you can draw from a culture once you get past the stage of disappointment with what one culture has and the other doesn't. The challenge is getting to that point.

It's not always about cultural barriers, it's about cultural strength.

I say this in my writing: it's not always about cultural barriers, it's about cultural strength. Every society has a culture. It's a question of trying to understand what is positive, what is negative, and what is unique about this culture. Those who have the privilege of functioning in two different cultures are able to draw strength from both cultures, know the barriers one needs to overcome in both, and know how to cherish the unique aspects of both.

For me, in the Edo culture, there's a really strong value of sharing, of connectedness, of defining family not simply at a level of blood relatives but very broadly. The nuclear family is not the center. It's not the defining point, not the point of departure. We must learn the language that allows us to define relationship, to define meaning, so that we know how to put cultural elements into perspective. Here in the U.S., for example, there is the strong value to help, a desire to lend a helping hand. It probably appears more pronounced here in this individualized culture because that same value of wanting to help in Nigerian cultures often starts within the bigger family unit. There, it's taken for

granted that you are supposed to lend a helping hand. The family member in the Edo culture may be somebody who would be considered a stranger here in the U.S. That same desire to help is there in both cultures, but it has a different meaning because of the parameters that define families in each culture.

Another example is the importance of food and agriculture. Often when you get a group of people together, that is one of the things that defines what they hold on to and cherish. What is really the food that defines the culture, as opposed to the commercialized foods that seem to imply a definition? For example, there is a lot in American culture that has nothing to do with fast food, but the impact of fast food on contemporary America is so profound, it's hard not to think about American culture without thinking of fast food. How can we understand the value of the culture outside of fast food, even as we see the commercialization of consumption producing the type of food that proliferates here?

What have your life experiences allowed you to accomplish?

They say that the more people you know, the more life you live. I'm really a "people person" in the sense that I cherish interacting with people, learning new ways of thinking about the same issues, sharing my views with them and trying to be open so they can share their views with me. I've been privileged to travel to many different countries in Latin America, Asia, Africa and Europe.

They say that the more people you know, the more life you live.

When we talk about Western culture my European colleagues will often remind me that the French way of thinking is very different from the American way of thinking or the British way of thinking. For example, if we look at the issue of consumption, the French will take longer to consume things, whether it's food, alcohol or cigarettes. Studies show that the consumption of a cigarette is faster in the U.S. than France. These are the ways culture produces relationships and influences the ways we behave. So, for the French, having dinner for three hours is very normal. That is not what you would find in the U.S., where we tend to engage in consumption at a faster rate. These are the

things I've learned interacting with people—that culture is not about good or bad. It's really about trying to understand what shapes the way we think.

Cultures that have not seen a colonial invasion tend to function very differently.

I've been able to do work in France, Thailand and Ethiopia. This has helped me understand that, when we look at the richness of a culture, it's really not about whether or not the people have buying power or money. It's about how they function within the culture, independent of the actual resources they have. Ethiopia has a very rich culture.

What is also interesting is that cultures that have not seen a colonial invasion tend to function very differently. In the colonized cultures, the traditional values were not only destroyed, but were kept out of the school curriculum because they were seen as retrogressive, as not leading to progress. What was put in their place were those things the colonizers thought would lead to progress. In a place like Ethiopia, the traditional language and writing have been very much maintained. Those sorts of things were not allowed to go on in cultures that were under colonialism.

The cultures of different ethnicities, or of different countries, become very vivid as you interact and meet with people. You see and appreciate the wealth of their culture. You also see the influence of interaction with the outside world and how this has affected some of these values' ability or inability to surface.

When you come from a different country, you can see how some of the concepts you've learned, the ideas, are actually a form of the culture. For example, there is the Western philosophy of Descartes, "I think therefore I am." In African culture, on the other hand, there's the notion of Ubuntu, "I am because we are." In such a culture, the definition of the person only has meaning within the context of the group—the group is the unit of concern that defines or gives meaning to the personal identity, whereas "I think therefore I am" talks about the individual almost as an island, as a discrete thinking entity.

These are all ways of trying to understand cultures, without saying one is better than another, but by simply respecting each culture for its strengths and uniqueness. Visiting

many places and doing work in many cultures can bring this more to life than anything that might go on in the classroom.

What are the most important issues related to health disparities for blacks who've come to this country in more recent years—those from the Caribbean, Latin America or Africa, for example?

It's just now coming out in the public health literature that the social environment, the institutions, the context, very much influence health outcomes. Decisions we make about health are not just a matter of individual rational volition. They are conditioned by one's environment, by the context. When you control for factors such as socioeconomic status there are studies that show low birth weight baby figures for an African cohort are very similar to the white cohort in the U.S. Whereas for the African Americans—blacks here in this country—low birth weight rates are greater. Some people argue that these are genetically based differences. But the whole construction of race is essentially based on pigmentation, not on genetics. Genetically, blacks are more different from each other than they are similar.

So the health issues among groups of blacks are different because the social context influences behavior. Where people grew up, what is happening in that particular time, the history that led up to the present—these things influence how they define the meaning of health and what happens to them physically.

Decisions we make about health are not just a matter of individual rational volition.

African-Americans cannot forget the legacy of slavery. I've written that slavery is part of African-American experience, not a part of African-American culture. We have to make a distinction between experience and culture. Slavery is important because of the historical legacy of what that status meant, in terms of how people were used in research and in medical studies, for example, and the level of suspicion blacks now have around that. Even before the Tuskegee syphilis study, those sorts of studies were done. Food behavior is another critical example. When you learn to eat a certain way as a child or as a young person, it will follow you throughout your

life. For example, if you didn't grow up drinking soft drinks, that's a behavior you'd have to learn to acquire and adapt to in your adult life.

Certain kinds of foods were eaten during slavery for survival, and people became accustomed to those foods. So that style of diet has persisted over time till today. You can look at the African tradition in terms of foods that have existed over time and how that diet has persisted. In the Caribbean, it's the same thing. Yet, in terms of the specific foods, there's such a diverse representation. Your experience in Barbados will be different from your experience in Guyana, or in Trinidad-Tobago, or in Jamaica. Barbados is a small island, with a higher literacy rate than we have in the U.S., but there are also high rates of obesity, heart disease and diabetes. So you can't really talk about the link between literacy and health among blacks when you have Barbadians in the mix.

The contemporary culture in terms of what children value really depends on where they grow up.

Even among Africans and Caribbeans coming to the U.S. and African Americans, the contemporary culture in terms of what children value really depends on where they grow up. Increasingly more of the younger generation of people of African descent say they are African, but were really born and grew up here. I may run into somebody when I'm teaching a class or giving a lecture who says, "Oh, you're from Benin City, Nigeria. So am I." When I ask when he or she came over, the answer is, "I was born here in the U.S. I've never actually been there." The identity is there through their parents' lineage, but they may not have experienced other values in terms of food behavior, practices, connectedness and the broader family network. They may not have received the experiences or the values that are translated through the parents' language. They may not even speak the language. For all practical purposes their experience is more similar to an African American who is born here.

So identity may depend on the generation and whether or not a person has spent some time growing up in a different environment, say in Nigeria, Ghana, Guyana, Trinidad or Jamaica. I think in my generation people came here to go to school and intended to go back, but circumstances change and you end up staying. It's very different

when you've had that as part of your experience. For the younger generation, there's a desire to have that affinity through parental lineage, but their experience doesn't necessarily allow them to fully become part of the culture of their parents.

So, in terms of health outcomes, the younger generation of blacks who were born here may be more likely to have health outcomes similar to somebody whose family has been here for many generations. A lot may depend on the environmental context. The difference might be whether or not their parents prepare food at home in traditional ways. Traditional food preparation appears to have some protective health mechanisms, even though it might not be intended for that purpose. They might not fry food, for example, which would express more of the traditional values they brought from their home. That difference could influence the health outcome for a younger generation.

Traditional food preparation appears to have some protective health mechanisms.

What can health providers do to address health disparities?

If I have one piece of advice for health providers, it's to go out of their way to seek experience in a different environment—it doesn't even have to be in another country—that puts them in the role of an outsider for a period of time. When clinicians and other providers visit another country where they really have to function as an outsider, it deeply influences the way they relate to the people with whom they interact. It's not simply a matter of, this person is different, how can I show I respect him or her? They will actually begin to understand how information in that culture might be processed quite differently from the way people process information in their home culture.

For example, it quickly becomes clear that a decision to adopt a particular health behavior often doesn't occur at the individual level. Clinicians may have to consider the relationship with a spouse, or the role of the wife and the husband in the broader context of the family. Unfortunately a lot of the behavioral models we study in school tend to place heavy emphasis on the individual's ability to make decisions. But this can only happen when the environment supports and nurtures that type of behavior. The

emphasis on individuality is really a middle-class value, because the lower class has no choice. They have to seek support from others. And the upper class has always understood the importance of group identity, which is why they don't like anyone in their group to go outside of the group to marry. The notion of the individual as an "island" is very much a middle-class value.

So when practitioners have that opportunity to visit another culture as an outsider and learn how ideas or decisions are processed in that system, they are better able to understand the notion of multiple truths, rather than a universal truth—to understand that there are different ways people relate to each other and make decisions. That is why immigrants who come to the U.S. often are disappointed when they interact with clinicians. They find that something they are being told or asked to do doesn't make sense, because for them it doesn't work that way. A decision about one's health may be more of a collective decision, depending on what their experiences are. So the meeting of the minds where service delivery can really be improved is when the provider is able to respond to and understand the things that may influence a client's decision. There are going to be different ways of thinking, of relating, not based on things we've learned from the social psychological model. It isn't solely about rational volition.

A decision to adopt a particular health behavior often doesn't occur at the individual level.

What suggestions do you have about mentoring others?

I advise the people I work with very early on to go beyond familiar territory in learning. For example, if you are studying public health or health education, be sure to read something in the areas of genetics, neuroscience, the humanities. Read any novel and begin to think about how it may relate to or express a particular view or culture. Then let's talk about it, because when I read I'm going to learn new information. I want them to read and tell me what they've learned. My mentorship model is very interactive, usually one on one, although sometimes I also speak on the group level.

I often talk about the differences in culture. One thing that is quite different between Europeans or Africans and Americans is the issue of social space. We all have what we could call a private space, the circle you draw around yourself, but it's a question of how wide or small that circle is. One of the complaints African students used to have was that when they took a class and interacted with American students, everyone was buddy-buddy friends. But, afterward, the American students wouldn't act like close friends. I would explain to them that the private space in America is very close to the body, which means you can come quite near to interact and establish what might be perceived as closeness, but you have not really penetrated the private circle around the individual. If this African student were in a class in France or in Nigeria, that sort of very friendly social interaction wouldn't take place because the private circle around the person is further away from the body—people don't act like buddies before real friendship is established. If one or two persons did break through the private circle, they would remain friends for a very long time.

The African students come from a society where there are quite a few people in the personal circle where the interaction is taking place. They experience this in the American classroom and think they're breaking through to true friendship. The rest of the class, the Americans from this culture, were in that circle too but know that that experience didn't necessarily translate to friendship. There have to be other indications beyond that classroom interaction that show a person has broken through the private circle for the Americans to become really good friends. That tends to create a tension or a misunderstanding. But it's really, again, a cultural expression that is neither good nor bad, it's just the way that people interact.

As students who come from another country begin to interact, they'll come to understand why things happen the way they do.

So, in my mentor relationships, part of my goal is to explain the differences in cultures. As students who come from another country begin to interact, they'll come to understand why things happen the way they do, why this relationship they think has been established hasn't really been established. I also have a number of students who come in and say, "Every

time I saw this professor he would tell me, 'You are doing well,' but in the end, I got a C. How could I have been doing well when I got a C?" So I explain that this type of greeting and exchange in America is a ritual, so somebody saying you're doing well doesn't necessarily translate into, "You're getting an A." The students are from a culture where hearing praise from a professor means you are on top of your game, because in their experience the professor is more likely to say, "You're having a problem in this class" or "You're flunking" or "You've submitted poor work. Don't give me this junk. When you're serious come back to see me." Conversation in American culture is much more indirectly worded, almost a way of not being completely open with one's judgement.

Most of the people I mentor are involved in international health or minority health work and I try to prepare them to work in different cultures. I spend a great deal of time mentoring long distance, internationally and with people I interact with at conferences. We have a mentorship program where we send U.S. ethnic minorities to South Africa, Senegal and France. Those individuals become my protégés by extension, because they stay in touch with me and ask for advice and direction about how they should proceed in their career. That's something that I very much enjoy doing. It also gives me an opportunity to pass something on to those who are coming and who may do it better than we are doing.

What is your passion and vision for the future?

I'm very passionate about addressing what I see as the beauty of culture, the complexity of culture, and, on the other hand, the simplicity of culture. I also don't really worry so much about the answer. I worry about how the question is posed, because it's the question that determines the answer. I think we're missing the opportunity to raise important questions about culture and context and what makes people make the decisions they do. Structure in society, structure in the environment and how people relate all affect how they make health decisions.

I'm very passionate about addressing what I see as the beauty of culture, the complexity of culture.

The language we use in our work may actually limit the opportunity for those we train to examine communities. If we talk about "community diagnosis" we are going to look for problems. When you *assess*, you look for assets and liabilities. When you *diagnose*, you look for problems. Some language that's appropriate in a clinical setting does not really work for communities. It sets students up to look for problems, and, if you look hard enough for a problem, you are going to find one.

In terms of the future, I think success is going to be largely dependent on the degree to which we understand how the social context influences individual behavior. That is what my work is about in terms of the Developmental Dependency Model. Individual volition doesn't really explain or help us understand the broader problems. There is an ethical issue there on the part of the profession, and also an issue of what race and ethnicity means. The work that I did for the United Nations is programmed along this same line—we have to include the broader issues of policy, social economics, culture, gender relations and spirituality to really understand what are the exemplary programs, what are the best practices, what makes HIV/AIDS programs work.

I think our success is going to hinge on our ability to understand that there are no universal truths—there are multiple truths. There is no single solution—there are multiple solutions. For us to be able to involve African Americans, who are very suspicious of the medical profession based on the legacy of atrocities visited on their population, we're going to have to look at this broader issue of context, to learn how to identify not just what is wrong, but what is right, what is positive about a culture, what is unique about a culture. My message always is, if you go to a community to do a program and you cannot find something positive, you don't really have any business being there. You should get out because you've become a part of the problem.

There are no universal truths—there are multiple truths.

Identifying what is positive about any community is the starting point. When we've done that we won't have to identify the negative, because they'll let us know themselves. People will say, "We don't want you to leave here thinking that everything is positive when we have these negative issues, too." Which is the way it should be. You know you can

address whatever shortcomings there are in a community once the people begin to identify these themselves. As in psychoanalysis, that is the ultimate goal—to get the patient to identify the problem or even come up with a strategy for how to overcome it. If you just start telling people at the outset everything that is wrong, you may never be able to understand the strengths they have, the positive things they could capitalize on to help bring about a resolution to the issues.

The future lies in our ability to involve the voices that have been left out of the conversation up until now.

As we talk about eliminating disparities, we must begin to seriously invest in ways of having the voices of these groups represented at the center of the conversation. We need to begin with training programs in schools of public health, programs in health education and health behavior. If we don't do this, we are not going to be able to eliminate health disparities, because eliminating health disparities is not an issue of identifying what is not there and bringing it in. It's about understanding why there *is* a disparity. In what ways does the social structure create a disparity in a certain area that is then translated into health behavior? I think the future lies in our ability to involve the voices that have been left out of the conversation up until now.

Pieces of the Puzzle

Byllye Y. Avery

Byllye Y. Avery *was heralded as the "Guardian of Public Health" by* American Health *magazine, an apt description for the visionary behind the Avery Institute for Social Change, an organization that promotes community approaches and supports community and scholar activists in defining health issues from the community's perspective, and targets social justice and equity issues in health care, particularly for women of color. She also co-founded the Black Women's Health Project some 20 years ago, as well as the Gainesville Women's Health Center and Birthplace in Gainesville, Florida.*

Ms. Avery is currently a clinical professor in the Heilbrunn Department of Population and Family Health at the Mailman School of Public Health at Columbia University. She is the recipient of the Dorothy L. Height Lifetime Achievement Award and the President's Citation of the American Public Health Association, and a leadership award from the University of Florida's School of Medicine. In 2003, she received the Lifetime Television Trailblazer Award.

The Avery Institute emerged from her two-year stay as a visiting fellow at the Harvard School of Public Health's Department of Health and Social Behavior after she was awarded the MacArthur Foundation Fellowship for Social Contribution. This recognition honored her years of work developing programs to improve the health and self-esteem of black women.

Who has inspired your work?

I think I became motivated by seeing the poor health conditions of people in the black community and by being aware of how little we know about how to take care of our bodies. When my husband Wesley had a massive heart attack and died at age 33 it really propelled me into thinking about health. He was four months away from his PhD, an honor student who had all the makings of a very successful person. He had high blood pressure and we didn't know it. We certainly hadn't been told about health conditions in a way that made us think it was serious or anything we needed to think about. This was in the early 1970s, before the nation, the whole medical community, was really aware of the relationship between blood pressure and cardiovascular diseases.

A lot of my motivation also came from being involved in the women's health movement. That was where I got started, where I took my passion for working around health. I was one of those crazy women in the street saying that we needed to know more about our bodies. We needed to have access to our medical records. We needed to be active participants rather than passive receivers. I did 10 or 15 years of work in women's health, helping to found an abortion clinic and a birthing center. Those facilities were really based on the idea of understanding what it meant to become a knowledgeable consumer and what it meant to have explicit care, that is, care that had us in mind first. We made sure that the women we served in our facilities had as much information as they wanted and needed, and we created places that we could come to for our care—it was good enough for us.

We created places that we could come to for our care.

I always felt that the work that I was doing was really special work and that I got picked to do it—that there was sort of a bond between me and the Creator. I had a certain part to do and the Creator of the universe had another part to do. I've been pretty lucky so far that most of the things I've wanted or needed came, not too early but just in the moments that I needed them. The resources were open to me almost as if from some Divine intervention. We would need something, and before I'd know it someone would tell me about someone who could help me get from point

A to point B, which led the way. So I've always felt that the work was not only activist work and empowering, but was also very spiritual work.

What lessons do you have to share with others?

First, I really love working with people. We all have special gifts, and when we bring all of our gifts together, we're able to make the changes we have to make. Every one of us has a piece of this gigantic puzzle. If we all get our pieces to connect together, we have a unified whole. People will say, "I didn't hear about any of this work you were doing until now." I say, "Well, this is your time to be here. It wasn't your time to be here then. It's your time now." Nine times out of ten, that person will bring the piece that fits into the puzzle at that particular time.

I've always felt that the work was not only activist work and empowering, but was also very spiritual work.

One of my most valuable lessons in this area was learning to engage with the affected population. I felt very strongly that we were faced with seemingly insurmountable health issues and statistics that were so bad—what can you do to help change that? So we went to black women, to the affected population. If you can go to whatever population you're working with and ask the people who are being affected most, What do you think we need to do about this? That population has certainly thought about their situation a lot because they're in it. When you're in misery you commiserate over how miserable you are. It's about all you can to do, so you spend a lot of time thinking about it.

So when we come together with each other in a group setting and are able to talk about what's happened to us, that talking provides an opportunity to analyze what's happened. And when we do that group analysis and develop that kind of group process, we're able to come up with some workable solutions that are often very different from those that people who sit outside ourselves propose.

Second, when we think about what we need in life to accomplish things, nine times out of ten the resources are really all around us. We just need to take time to open our eyes

Workable solutions are often very different from those that people who sit outside ourselves propose.

and see them. Sometimes it means looking at old things with new eyes. What different kind of perspective do I need to look at this? I really believe the Creator provides us with all of the pieces, the resources, that we need. Part of our journey and our learning is to figure out how we get to those resources. It's sort of like being on a treasure hunt—one thing leads to another that leads to another.

The third thing I've learned, is there are many people who feel strongly about health and about what's happened to us, not only as African-American people in the United States, but, on a larger scale, what's happened to us as a whole nation of people. We live in this very wealthy country that has so much disparity going on, so many "have not's" when there are people who have so much excess. We have to figure out how to bring people together and teach them that we are our brothers' and sisters' keepers. We have to realize that we own very few things in life and get back to what's really important.

When I first started I remember somebody telling me, "You can't get black people interested in this. They don't care about their health." I thought, Why would someone make a ridiculous statement like that? I know people aren't ready to die, so of course they care about their health. Just because you haven't figured out a way to reach them doesn't mean that they don't care. Go in with the assumption that people *do* care, that they *do* want information, that they *are* concerned. That's a different way of sharing and educating and helping people ignite their process of empowerment so they can then make the life changes they need to make.

The big lesson is that we have to work effectively to lift the standard of care for people who live on the bottom. Because, if you think about the foundation of anything, the blocks that hold up the whole system are the ones on the bottom. You can change the blocks in the middle, raise them up, and you can keep raising the ones on the top, but raising the ones on the bottom is the only way you raise up the whole thing. We have a high standard of living here in the United States, probably higher than anywhere in the world, but I wouldn't say it's the best quality, because I think a lot of countries have

a better quality of life. We could do more to make sure that there were no hungry children, and to make sure that every child had a house to live in. As I ride around in these large cities, I see all of the boarded up places and people sleeping on the streets, and it doesn't make sense. How can we allow that to happen? How can we not see each other as human and deserving to have the basic things—somewhere to live, clothes to put on your back, food, and, I would also say, access to health care. I don't know how so many people can live without those four things.

We have to work effectively to lift the standard of care for people who live on the bottom.

What have your life experiences allowed you to accomplish?

I always feel I haven't done nearly enough, that there's so much to be done. We've just snipped the surface and started the process. But I had this serendipitous thing of being involved in the women's health movement. I noticed the absence of black women. There were so few of us, and this bothered me. It made me think, What am I doing here? I also think that I don't get placed in situations unless it's for a reason, and I have to learn what that reason is.

One of the things I learned over the years of working primarily with white women around women's health issues was that a lot of the issues white women articulated were also important to African-American women, but not in the same order. There were different priorities. The white women were really working on reproductive health and access to abortion, to good birthing, all things that black women certainly need and are interested in. But when we started talking to black women we found out different things about what was important.

Back in 1983, black women declared violence the number one health issue. That was before the CDC or anybody else started thinking about "social" issues as being health issues. But, clearly, if you're threatened by violence, it's very difficult to get anything else done. So don't talk to me about Pap smears, don't talk to me about breast exams when my mind is preoccupied with how I'm going to survive. If you think about it, it really shows the impact where people sit in the social strata has on how they think about their health.

One thing I've done that was important was to raise the question of the role of culture and ethnicity as it relates to health. How does our culture dictate how we think about health? That rang true with lots of women. The Native-American women started to organize after we did, and the Latino women and the Asian women. Now we know that all of our cultural, ethnic groups have different perceptions about health and different ways of being around health. That's certainly become a big component of how we do prevention, as well as treatment strategies.

All of our cultural, ethnic groups have different perceptions about health and different ways of being around health.

Can you talk specifically about health disparities as they relate to black women?

Let me talk first about health disparities as they relate to African Americans in general. It's very hard to think about the past of African Americans without going into the devastating institution of slavery. If you think about slavery and health, and think about just how that institution set up the culture of African Americans, it has a strong relationship to what we do. People were brought here from Africa, eating what they had eaten in Africa, and I doubt it was food high in fat, or high in sugar. When we got here we got everything left over from the old masters' tables, not only the scraps left at the end of the meal, but the scraps from before it was prepared—pig chitterlings, hog maws, whatever. Well, people are adaptable. They're survivors. They want to live. So they learned how to cook this stuff, and it became a part of the culture. It'll take a long time for some of those eating habits left over from slavery to be gotten rid of.

I was just thinking the other day about how we did grocery lists when I was a little girl. My mother's grocery list would start off with flour, sugar, meal, grits, lard, and so on. Now, almost 50 or 60 years later, I certainly wouldn't have those things on the list every week. Some of those things I might have on there only once a year. I think I buy a 2-pound box of sugar maybe once a year, as opposed to how my family used to buy 5 and 10 pounds of sugar at least twice a month. So you can see we are making some dietary

changes. But we still see a lot of people eating the old foods that said "love." And eating them too regularly. Hence, we have the powerful problem of obesity.

That really is a problem that contributes to a lot of health disparities—the lack of good, nutritious food. You have to look back to how this came about to realize that these disparities will not go away with just two or three advertising campaigns that say, "Eat low fat, cut out the sugar, etc." It's going to take time. We not only have to make a behavioral change, we have to make a head change. Then we've got to get stronger, get our bodies so they function well.

We not only have to make a behavioral change, we have to make a head change.

There are some things that are real disparities for black women—think about the fact that the black infant mortality rate is double that of whites. That really talks about the wellness of women. Infant mortality isn't a medical issue, it's a social issue. The social things that black women need to have healthy babies and healthy lives are not in place for them. Most of the women aren't healthy when they get pregnant.

So, we have unhealthy women giving birth to unhealthy kids who often live unhealthy lives. The thing about infant mortality that is so frightening is that you can't just say it's poor people. It's middle class people. It's upper-class people. It's really across the board, which makes me think that we have got to continue to work on all of those things seen or unseen—genetics or factors passed on through deprivation, such as not growing up to have a fully healthy body due to lack of the right vitamins.

HIV/AIDS among black women has a lot to do with power, our relationships around sexuality, who's in charge, our need to be loved, our willingness to give up pretty much anything to say that we have a relationship, our need to not be alone, our lack of confidence in our own ability to be in charge of our lives. This is a very serious issue. Another issue—I don't know if this is actually a disparity, I think it happens in all populations across all racial groups—is incest and child sexual abuse, which plays out later in our adult lives in our sexual relationships with men. That's a big one—sexism—and how it negatively affects our health.

If you look at any of the diseases related to obesity—diabetes, cardiovascular diseases—there are a disproportionate number of black women. When I speak and I ask women, "How many of you here have heart problems?" about half of the people in the room raise their hands. "How many have had bypasses, or a stroke?" It's an incredible number. It's frightening, and has a lot to do with how we eat. The obesity battle is won and lost in the kitchen. We need to turn it around—not by becoming obsessed about weight and moving into anorexia and bulimia and eating disorders, I'm not suggesting that at all—but we need to start paying more attention and understand that our hearts are carrying around a lot more weight than was intended and it causes a stress on the body.

The obesity battle is won and lost in the kitchen.

Another issue is breast cancer. It tends to strike African-American women at younger ages than white women, and we tend to get a more aggressive form of it. We've got sisters who are working real hard with the Department of Defense Breast Cancer Research Program through a fund specifically to research why this happens. That really is an issue. They say you don't need to get a mammogram until you're 40 or so, but black women in their early 30s are getting breast cancer. These women think they should have mammograms early on, but they're told it won't do them much good because their breasts are too dense then. So what do you do? There are some things on the horizon that may be able to answer that question through the research being done now.

These are some of the health problems that disproportionately affect black women. We used to talk a lot about teenage pregnancy, but I think with the HIV prevention and good teen pregnancy prevention programs we've had in place—until the current administration—that young people are learning more about how to take care of their bodies. They're also understanding that it's hard enough living this life when you're walking down the road with a good pair of walking shoes, so it's almost impossible to be walking barefoot in flip flops. It's best for everyone to start thinking more about getting themselves prepared.

There's also the issue of depression and psychological distress. I'm not talking about the mentally ill. This is the plain old walking-around-in-the-street distress, where you

are still able to work your job, take care of your family, do every little thing, but you've got things on your mind that are bothering you. There's really nowhere for these women to go, because they're not mentally ill, but they do need someone to talk to, someone to share with. We don't have enough safe places where people can go to work out some of the stuff they have on their minds.

Then you also have the issue of actual depression, women who are depressed, who live in very depressive situations. Our whole mental health care situation is certainly not up to standard. A black woman goes in for help, and they give her pills and send her back home to the same situation that got her there in the first place. There's really very little being done for black women who are depressed. And you have to think about what happens to children who are reared by mothers who are depressed, still in the home, still trying to operate the family. It makes it quite difficult.

What can health providers do to address health disparities?

One of the first things is to be honest with people. It's not that practitioners are dishonest, it's more that they commit sins of omission. A lot of practitioners make decisions about patients' care—what they should have, what they will respond to, what they will do, etc.—without giving the patients all the information or outlining their options.

It's not that practitioners are dishonest, it's more that they commit sins of omission.

When I was younger, I took my children to the dentist regularly. Their daddy always used to tell me, "You've got to take these kids to the dentist because I've got soft teeth." So one day I was going to pick them up from the dentist's office and on my way I stopped off for something to eat. While I was eating, I bit down on a tooth that hurt. So I thought, I should ask the dentist about this when I pick the kids up. He told me that I needed to have two teeth pulled immediately because they were both infected. It was a surprise to me, but I didn't question him—he was my dentist. I allowed him to pull my teeth. Later on, I was talking to a friend and she said, "Why did you allow him to pull your teeth?" I said, "What choice did I have? He said

the teeth were bad and needed to come out." She said, "If they're bad you don't have to have them taken out. You can have a root canal." I was 35 years old and I hadn't heard of a root canal. No one I knew had ever had a root canal. The dentist never mentioned to me that I had that option.

When I went back to see him I asked, "Why didn't you tell me I could have a root canal?" He said, "Well, that would cost about $750 and I didn't think you could afford it." I said, "But you don't know what I could afford." In fact, I ended up with a partial plate that cost much more than that. Providers make assumptions. But people need to be given all the information so they can make their own decisions. Part of the disparities problem is that black people can't get adequate care, even if we show up at the hospital or doctor's office with the same symptoms as someone else, because of the attitude of the providers.

Black people can't get adequate care… because of the attitude of the providers.

What we as consumers have to do is to become knowledgeable. If I'd known what I know now, I would probably have come home from the dentist and done some research to find out what my options were. We have to become more knowledgeable about what's happening with our bodies, and today we have many avenues for that. The Internet gives you more information than you ever want to know about anything. We can't just leave it up to other people to do that for us.

So, I would say that practitioners need to be honest, and they also need to become more astute and more in tune with what people need. They need to do work around revising our health care system so that people can be presented with all the options, and so that decisions are not always based around money and ability to pay.

It's also important for patients to be good stewards and to think about our office visit before we go. What are the questions I want to ask? We need to write them down and/or take someone with us who'll make sure we don't forget what those questions are. A lot of us still have shame and guilt around illness. We need to know that we don't serve a God that would be punishing us by making us ill, so there's no reason to feel shame or guilt. That really gets in the way.

We have to become involved, not only in our health care delivery, our access to care, but also at the policy level. We have to care. That's why I say to people, "In this election, think about who is going to best give you what you need for your health care." For me, that's one of our top issues—what are we going to do about getting care. Because it really doesn't feel good to be living in the most powerful county in the world that has all of this medical technology if it's not available to me. As far as I'm concerned, if I need it and can't get it, we don't have it.

We have to become involved, not only in our health care delivery, our access to care, but also at the policy level.

Do you have any comments about mentorship?

Mentoring is an interesting process. It's not a one-way street. Sometimes when people come to you they bring you gifts, but it's under the guise of "I need you to give me a gift." So you really wonder who's doing the gift giving. When people look for mentors they don't look so much at what's on the outside but at what they see on the inside. I think that's the gift of it. They've got the desire, they're committed, they're talented, but they want somebody to bounce things off, to guide them, or to say, "I went down that path and this is what happened to me."

When I started building the National Black Women's Health Project, I remember Luz Alvarez-Martinez, a Latina woman, started coming around all the time, and then Charon Asotoyer, a Native-American woman, was always around. Luz founded the National Latina Health Organization and Charon is the founder of Native American Women's Health Education Resource Center. I wouldn't say I've been a mentor to them in the traditional sense, but I tried to share with them the doors that were opened to me. We weren't stuck in the same places. Some things I had a good handle on. Other things they had a better handle on. But we knew that we all needed to hold hands together.

I serve as a sort of springboard to several people now who will call and say, "I want to run this by you" or "I need help with this." It's not anything formal, but I know where

they are and they know where I am. It's a good thing, because it provides wonderful learning for the person doing the mentoring as well as the person being mentored.

What is your vision and your hope for the future?

I'd like to see us have a national health plan in which all people knew that from the moment they were born until the time they died they would have access to basic health care and not have to worry about money. When I say health care I mean preventive care as well as medical care when needed. It's the only thing that makes sense to me if we're going to live in what we call a progressive and just world.

I'd like to see us take charge of our communities and make them places that promote health and well-being more. I'd like to see us realize that we have made our lives so busy and so stressful that it's very hard to be healthy. We rush from one place to another. We're constantly rushing. To go where? To do what? We're overcapitalized. We certainly don't need three VCRs, eight TVs, four cars—all of the excess that we have. It makes us continue to work hard to keep getting more. We don't really take time to relax, to be happy. I sense that there are a lot of people in the United State of America who are very unhappy—their lives are going by and they're not living in them.

I'd love for us to be able to improve our quality of life so that people wouldn't have to make the decision between staying home with their children—both men and women—or going to work because they have no choice. People shouldn't be penalized for their children's illnesses. It's ridiculous that you have a working mother with four children who gets ten sick days a year. Well, she needs ten days for each one of them because they get sick. You get penalized if you've got a sick child and you don't have an understanding boss. It's like we forget about each other as humans.

I want to live in a world where we look around at each other and realize that we are all human beings and we all deserve respect, we all deserve dignity, and we all deserve to have a place where we can live a peaceful and joyful life. That's what I think would make a good world.

Getting Rid of the Rat

Carl C. Bell

Carl C. Bell, MD, *is president and CEO of Community Mental Health Council and Foundation, Inc.; clinical professor of psychiatry and public health at University of Illinois, Chicago; principal investigator of Using CHAMP to Prevent Youth HIV Risk in a South African Township (NIMH R01-MH-01-004); and co-principal investigator of the Chicago African-American Youth Health Behavior Project and Informed Consent in Urban AIDS and Mental Health Research Project.*

He is the editor of Psychiatric Perspectives on Violence: Understanding Causes and Issues in Prevention and Treatment, *author of* Poor and Underserved: Reflections on Community Mental Health and Wellness, *and has published over 200 articles on mental health. He is a member and former chairman of the National Medical Association's section on psychiatry, a fellow of the American College of Psychiatrists and the American Psychiatric Association (APA), and a founding member and past board chairman of the National Commission on Correctional Health Care.*

He received the E.Y. Williams Distinguished Senior Clinical Scholar Award from the National Medical Association in 1992 and the APA President's Commendation in 1997. He was appointed to the Violence Against Women Advisory Council from 1995-2000, and participated in the White House's Strategy Session on Children, Violence and Responsibility, the working group for the Surgeon General's Report on Mental Health: Culture, Race and Ethnicity, and the planning board for the Report on Youth Violence.

Who has inspired your work?

I went to a black medical school, Meharry Medical College, whose motto was "serving God by serving the people." Their whole ethic was built around that, and that very much conditioned me and focused me professionally to be a public health kind of guy. One of the prime stories at Meharry was that if a child came in with a rat bite and you treated the child as you were supposed to, you would be a good doctor. But if 50 children from the community came in with rat bites and you stayed in your office and treated rat bites, you should be disbarred because you were not going out into the community and getting rid of the rat. So that was always a huge paradigm for me.

People who inspired me include geometry teachers, grammar school science teachers—Mr. Bowman and Mr. Binns—and the biochemistry teacher at Meharry, Henry Moses. I had an uncle, Bert Pratt, who was a lieutenant commander in the Army who inspired me. I've had tons of inspiration: John F. Kennedy's Profiles in Courage, Albert Schweitzer and his public health mission. David Satcher is real clear about public health. He went to Congress for money to study Ebola virus and they said, "What does that have to do with us? That's over there. It's their problem, not ours." He told them, "Germs don't need a passport." The National Medical Association has been pushing for national health insurance since the 1940s. In fact, it was their push that got us Medicare. So I've got a lot of models.

What lessons do you have to share with others, especially with regard to the connection between mental and physical health?

There are behavioral vaccines out there that people don't get.

Do you wait until someone has polio and is in an iron lung before you treat him? You can, but wouldn't it be better to get the vaccine? There are behavioral vaccines out there that people don't get.

Something we know now is that children who were repeatedly, chronically traumatized not only have twelve times the rate of suicide, ten times the rate of depression, ten times

the rate of substance abuse—all the things we would expect—but they also have two and four times the amount of cancer, heart disease and chronic obstructive pulmonary disease, because stressed-out kids engage in behaviors such as overeating, drinking or using substances that give them physical health risks. But we've not yet been able to make that connection in our public policy or in our understanding of public health in terms of physical medicine.

In treating patients for thirty years, it became very clear that any number of them had been traumatized—sexually or physically abused—and I was seeing the end result in their behaviors—high-risk behaviors, substance abuse, depression. But I never quite connected it to the physical health piece, mostly because people came to me for psychiatric issues. I would check their physical health status, but psychiatry was my focus.

Back in 1982, the Community Mental Health Council did the first work on children exposed to violence. Prior to our work, that wasn't on anyone's radar screen. Lenore Terr had examined the 1976 Chowchilla bus kidnapping, and Robert Pynoos had studied a 1980s sniper attack at a school in Los Angeles, but no one was taking a look at the common everyday violence children were being exposed to. We did this study in our area and found that 25% of the kids had seen a shooting or a stabbing, which I already knew from clinical experience through seeing a lot of kids and a lot of adults who'd talked about their childhood experiences. There's got to be this connection between early childhood trauma and wellness and mental health.

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When most people say "mental health" they're thinking of mental illness. But, in my book, mentally healthy means "well." If you don't do the things that will help you live a long, healthy life—don't watch your weight, don't exercise—then, in my mind, you have a mental illness. That takes us outside of the DSM-IV—the diagnostic manual for psychiatry—and people who live on the DSM-IV planet are very uncomfortable with that. But in order to affect people's issues around wellness, you have to go outside the practice of medicine. You have to go into politics, social policy, housing and education.

Those of us who practice medicine don't have the skill sets that allow us to influence those domains. So we're just not there, and it bugs the hell out of me.

Because I run a large comprehensive mental health center, I'm in a position to take lessons from good science and research and move them into the field. For example, there's a very complex biopsychosocial model called the Triadic Theory of Influence that Brian Flay and John Petraitus developed. It has all of the measures and domains from Fishbein, Digman, Bandura—all of the people in psychology who've discovered what causes people to do what they do. It's got five tiers and three streams and it's serious science. I've distilled it down to seven basic field principles around health behavior change: (1) rebuild the village, (2) provide access to health, (3) do activities that are going to allow people to bond and connect to one another, (4) improve people's social skills, (5) give people activities that increase self-respect and self-esteem, (6) reestablish the adult protective shield, and (7) minimize trauma. And we've applied these principles to help make a difference.

The Chicago Board of Education's Cradles to Classrooms program identified all pregnant teens and teens with babies in the Chicago public high schools. There were approximately 500 per class. The program gave these teen moms child care, health care, tutoring, mentoring, whatever they needed to raise healthy babies, and last year 500 girls with babies graduated from Chicago public schools. If you go back to before the program started, of those 500 teen moms in the senior class only 250 would have graduated. Usually these kids would start having babies at 14 or 15 and by the time they'd get to be 17 or 18 they'd have two or three. But, after the program, only five who graduated had more than one baby and half were on their way to college.

Another example from the Chicago public schools was when they wanted to start a mentoring program, because all the resiliency studies say that if there's a positive adult in your life you'll grow up to be OK. But for a school of about 500 kids they'd found three mentors. So I said, "Rebuild the village. Let's go to the black churches and see who's there." So we found three large black churches within about half a mile of school, and now all of a sudden we've got 1,500 mentors for those 500 kids. We connect the dots. We rebuild the hoods. We link the church to the schools. We recreate the social fabric.

Urbanization is destroying social fabric and the adult protective shield. It's destroying the sense of connectiveness.

Urbanization is destroying social fabric and the adult protective shield.

Felton Tony Earls out of Harvard did a study in Chicago where he looked at 49 poor black neighborhoods and whether residents felt comfortable talking to somebody else's kid about antisocial behavior. He found that in communities where residents felt connected to their neighbors and, as a result, were willing to say something to a neighbor's child about that child's behavior, you had very low rates of violence, because there was social fabric, there was connectedness, there was an adult protective shield. There was somebody teaching social skills and encouraging kids to respect themselves. The HIV prevention research we're doing in South Africa and the HIV prevention research we did at Robert Taylor Homes, a housing project of the Chicago Housing Authority, are documenting that the strategies we're using work. The National Institute of Mental Health is funding the research.

I'm able to do community psychiatry for real, and so we do a lot of service. We do education and research, all on top of a good management leadership system that has its roots deeply in the community, so we know that what we're doing is what the community wants us to do and we have their support. I've got two MBAs working in our program to do the business. That's a strategy that people in mental health and wellness haven't utilized to their advantage at all. Not to mention the whole marketing piece.

Scientists are adverse to pitching their products and, as a result, no one knows about them. They sit on somebody's shelf, while, in the meantime, people are selling toothpaste like nobody's business. Sure, toothpaste is a good thing. But why not sell behavior change? Scientists feel cheap when they sell their stuff. But, on the other side, the people trying to disenfranchise the underserved sell their propaganda all the time. They destroy and fragment the health care safety net. They don't recognize that sooner or later whatever plague is in the poor community is going to come into the rich community. Trying to have a paradigm shift in the country away from deficit model care to protective factor strategies that cultivate resistance is very difficult. But it's called, "Get rid of the rat."

What have your life experiences allowed you to accomplish?

The first national impact I had was in about 1980 when I did some of the first work on the misdiagnosis of African Americans with bipolar disease who were being diagnosed as schizophrenic. All of a sudden people figured out that they'd been misdiagnosing blacks all this time.

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I remember one woman who was 34, a college graduate. Her first psychotic episode she's running around the street, talking a mile a minute, thinking she's Jesus, calling all over the world, hearing voices. They put her on 50mg of Haldol, long-acting shots, once a week and called her chronic schizophrenic. Yet everything here except the hallucinations indicates bipolar, manic illness. I asked, "Where did you get chronic undifferentiated schizophrenia?" They said, "Well, she's black. She's in the public care system." But the Haldol messed her up. She wouldn't take her medication, and, as a result, she'd have bipolar episodes. I'm not even thinking about the tardive dyskinesia that African Americans are more likely to get as a result of being on neuroleptics that they don't need to be on. Finally, I got her on lithium and she was fine. Other patients also were being misdiagnosed as schizophrenic. They'd be put on large doses of neuroleptics and bounce in and out of the hospital like a rubber ball. When I finally got them on lithium, they went on to have a life again.

Part of it had to do with the myth that black people didn't get affective disorder. Part of it had to do with how the public mental health system is structured. In the public mental health system, you've got two weeks. If you're trying to get a history from an acute psychotic, all you're going to get is incoherence. And most people think that's schizophrenia, but it's not necessarily. Then by the time the person's verbal and able to give you a coherent history that would allow you to do a decent diagnosis, you're sending that person out of the hospital. The problem is that you're sending these people out with a diagnosis of chronic undifferentiated schizophrenia. Then when they go to the clinic and see Joe Blow the psychiatrist and he sees chronic undifferentiated schizophrenia on the chart he keeps doing what was being done in the hospital.

When I was at this clinic at Jackson Park Hospital, I started seeing all these people who might not be schizophrenic. That's what led me to write and publish the article, which then got other people interested. Now, if you read DSM-IV, it says if the patient's African American, be aware that he or she is more likely to be misdiagnosed as being schizophrenic, so make sure you're doing a good evaluation.

Another thing I did back in 1980 was write about racism and narcissism. Now it's come full circle, and we're having conversations about whether racism should be considered a psychiatric disorder. Most people say, "It's learned behavior. Why would you medicalize a social problem?" Well, that's one aspect of it, but no one has ever asked paranoid patients about their racism or feelings against some other group, although this is a very common feature of paranoia. You'd think the patients who are projecting the idea of "all those bad people out there," would be perfectly primed to have racism as a medical symptom. Clinically people talk about it, but no one has ever asked the question in research.

I've also proposed looking at racism as a relational disorder.

I've also proposed looking at racism as a relational disorder. What if you've got a white guy who's pro-white and anti-black, and you've got a black guy who's pro-black but *not* anti-white? They're going to have a relational problem. If they're working together and one supervises the other, it might ultimately result in a lawsuit. No one's studied this. So here I come pushing the possibility of applying some honest-to-goodness science to this question.

I already mentioned the study on children exposed to violence we did in the early eighties. About 2 or 3 years ago, Attorney General Janet Reno's deputy, Eric Holder, had a meeting called "Safe from the Start," and the federal government released something like $20 or $40 million for research dealing with children exposed to violence. I started all that in 1983. It took 20 years of jumping up and down and screaming and talking about all the violence that the children were being exposed to for it to finally take root and have this large systemic impact.

I also did some stuff in 1984 on sleep paralysis, which is in some ways a culture-bound syndrome for African Americans. Before that, you'd see absolutely no culture-bound syndromes for African Americans. It was like we didn't even exist, didn't have a culture. I discovered this phenomenon of isolated sleep paralysis, and I put it in the *Journal of the National Medical Association,* and nobody cared. Then these two psychologists did a review of the literature on anxiety disorder and African Americans, and they found my sleep paralysis studies. It turns out there's some evidence that sleep paralysis is related to panic disorder. So they published this—there were about five studies on anxiety disorders and African Americans and I'd done three of them—and then everybody got interested. Some people replicated my work and found the same thing—African Americans have more sleep paralysis than European Americans. We're trying to figure out what this is, because it does seem to be related to panic. So now there are about five people all over the country investigating sleep paralysis and the black culture-bound syndrome. It was even in the Surgeon General's Report on Culture, Race and Ethnicity.

I've put issues on the country's research agenda about five times. I'm this Mickey-Mouse community psychiatrist who discovered this stuff in the real world and put it out there, and then the "real" scientists take hold of it. I'm now being funded by NIMH, but before I was just a hack in the community trying to satisfy my curiosity about stuff. I was doing empirical data collection, which happened to be accurate, but the science behind it wasn't of NIMH quality. I sometimes think I had more influence when I was a community psychiatrist, a research hack, as compared to now being an RO1-funded NIMH, got-a-gold-key-to-the-bathroom science researcher. It takes much longer to do good science than to simply see something that's real and then yell and scream and tell everybody about it. For example, this HIV prevention work that I've been doing for seven years is more solid and evidence based, but it takes longer. Before, I would have the inspiration, I would see the pattern, and then I'd just go do the work. Now I see the pattern, I've got the inspiration, but I have to prove scientifically what I'm seeing in 95% of the people I see.

It takes much longer to do good science than to simply see something that's real and then yell and scream and tell everybody about it.

I'm not at the Academy where I see ten people a day, I'm in the community where I see 35. Most researchers have a convenience sample because they might have five patients. I've got 400. So I've very much got my finger on the pulse, and my surveillance is much wider sweeping. As a clinician, you see stuff, but most clinicians aren't in the research world. I was once treating all these alcoholics. They couldn't sleep, so I'd give them an antidepressant. At that time, it was doxepin. They'd come back and say, "With this medicine, I'm feeling better. I'm sleeping better, and my stomach isn't as upset as it used to be. I don't have diarrhea, I don't have stomach pains." Ten years later there's a publication out of the University of Michigan stating that this medication is good for irritable bowel. And I'm saying, "All you had to do was treat 100 alcoholics a year and you'd have seen that ten years ago."

What are the most important issues related to health disparities for African Americans and other blacks in this country?

There's a lack of research, a monocultural ethnocentrism.

Racism is a big one, as is lack of access to health care. If you compare the health care infrastructure on the south side of Chicago—residential rehab, psychiatric emergency services, psychiatrists per capita—to the north side, it's two different worlds. Part of it is economics. Part of it is the notion that health care is a privilege as opposed to a right. And part of it is that there's a lack of research, a monocultural ethnocentrism.

Now that I've tried, I understand that it's hard to do good research on poor black people, because they're always moving around. It's easy to do research on middle-class white males, because you can always find them. But if you're poor and you're black, you have to keep finding these ecological niches to survive in. There aren't enough African-American health professionals who have an interest in this. There are some decent white health care professionals who understand ecology and the fact that germs don't need a passport, but, for the most part, my sense is that many white people believe they can build this protective bubble between themselves and the people with the plague, so they don't have to worry about getting the plague. That's why inmates don't get good health

care. That's why poor people don't get good health care. It amazes me that the established medical community doesn't see the ecology of this. People think they're safe and they're *not* safe. I remember when Mexican Americans were sniffing glue, and I started studying glue sniffing. Someone said, "Bell, what are you doing? Those are Mexicans. What's that got to do with black people?" Well, I believed it was going to migrate, like all illness, behavioral or physical, does, and that sooner or later black people would be sniffing glue. And, lo and behold, it's happening.

There's a lack of vision, a lack of clarity, a lack of being open to the things life teaches you about ecology and interdependence. We have a scarcity mentality in health care instead of an abundance mentality. We think the money's going to run out, that there's not enough to go around. Plus the politics involved make it even more difficult to address.

We have a scarcity mentality in health care instead of an abundance mentality.

How does violence contribute to health disparities?

Tony Earls' work at Harvard found that poor black communities where there was social fabric didn't have those high rates of violence. They had rates like everywhere else. In 1984, when I was yelling about the public health aspects of violence, along with Prothro-Stith at Harvard and a lot of other people, I was very concerned that it might backfire, and that counting the homicide statistics would frighten people and make them want to lock up 12-year-old children. And that *was* part of the outcome. Yet, at the same time, there were people who bought into the notion that violence was a public health issue and that, therefore, it could be prevented.

Surgeon General Satcher's youth violence report clearly outlines things that could be done to prevent violence. The problem is that the public won't do it, partly because violence fuels the criminal justice complex and that's a lot of jobs. When we did an intervention in Bloomington and reduced the number of black children going into foster care, I got attacked like you wouldn't believe. We'd done something good—we reduced the number of children going into foster care by 62%—but that had taken money out of

the people's pockets who were providing services to all those kids. It didn't make sense, but that's the reality, and I'm OK with that. You've just got to fight, and I like to fight.

Are there ways you mentor or share your experience?

I've had four African-American think tanks that have given me a lot of help with the work I've done. They started in 1982. I participate in the American Psychiatric Association's Minority Mentor Fellowship and also do some mentoring work with the American Academy of Child Psychiatry. The Community Mental Health Council used to have residents from University of Illinois, University of Chicago, Northwestern and Chicago Medical School. We've got a psychology internship program here because part of our thing is education, to train people to do the work. I go to high schools and talk to students. I've got nine psychiatrists at the Council who I'm bringing along. I'm on the staff at the University of Illinois so I also reach people there. I'm always training people, because I'm not going to be around forever. I also used to teach martial arts.

I don't know if people in my business really get trained in how to do leadership. I learned a lot about that through martial arts training—how to lead, how to mentor, how to teach. You've got to have some fire. You've got to have some passion. You've got to have some vision. You've got to be clear about what you're talking about. You've got to articulate what you're trying to do and what you see—for example, the connection between trauma and poor physical health that I'm currently pushing. Some people are getting it. I'm on the Chicago Board of Health and the commissioner gets it. And the mayor gets it. And the CEO of Chicago public schools gets it. You've got to lead and influence people, while at the same time advocating that they lead and influence themselves.

There has to be a shared vision, and people have to have input into the vision.

I know business from running one. We rely a lot on Peter Senge, who talks about interdependency, mental models, cooperative learning and personal mastery. Something's got to be in it for the person who's being taught or led. There has to be a shared vision, and people have to have input into the vision. The people you mentor can teach you as

well as you teaching them. You've got to have the right theoretical underpinnings driving the work. And you've got to understand the ecology and the interdependence of the work you're doing, and of life itself. In the same way they're strategic in planning their methodology and statistical analyses, psychiatrists and researchers need to sit down and be strategic about how to move their demonstration project into real life to help real people.

What is your passion and vision for the future?

What's my passion? Saving lives. Sometimes I wonder, "How the hell did I get here? Who had the bad judgment to let me in this room, because I'm going to blow it up, and we're going to try to figure out what's real. We don't need to be in this box. Let's break the box! Let's try to be creative and fix it! Let's have some fun!" I have three criteria: saving some lives; making some money; having some fun. Sometimes, two out of three ain't bad—as long as you have the "saving some lives" part because that's what I'm here to do. That's my mission.

I really want to study other cultures' resistance-cultivating strategies. The problem is that the cultural imperialism of European and European-American forces have so decimated cultures that some don't know how they made their people strong. They've lost the connection. Their strategies can help Europeans and European Americans, but there's this monocultural ethnocentrism that says that anything non-white couldn't possibly have value, so we don't have to bother studying it.

For me, my own health care, my own well-being, is directly connected to the person on the planet who's got the worst health care.

I've got some high-leverage opportunities. I get to influence national and state efforts. And I'm doing international work too. I was talking the other day about how I felt like a warrior, healer, priest because that's been my path. For me, my own health care, my own well-being, is directly connected to the person on the planet who's got the worst health care. It used to be the person in the city with the worst health care, then it expanded to the state, then it expanded to the nation, and now I'm in South Africa.

David Satcher had me go to this conference to connect HIV researchers in the U.S. with South African researchers. Their science is weak because they don't have the technology or the methodology. On the last day, they were going around the room and everyone was saying, "Oh, this was such a wonderful meeting. I'm going to miss everybody. I'm going to miss South Africa." And they got to me and I said, "I hope I never see any of you again. I don't want to come back here. It's too easy to die here. The problems are overwhelming." I mean, I could be killed in Chicago, I don't have to go to South Africa. I asked a public health nurse there about the rate of syphilis. "Oh, it's only 11%." What the hell do you mean it's "only" 11%? What's that about? She couldn't tell me about TB because they're treating people with tuberculosis like I did thirty years ago. I wanted to get out. I didn't want to go back.

When I was back in Chicago telling Redd and Suggs, my two vice-presidents, about it, I said, "I can't help those people." And they said, "Bell, that doesn't sound like you. It sounds like a good fight, an insurmountable challenge. It's got 'you' all over it." I said, "I don't care, I'm not going back." Then they said, "Well, Bell, are people dying?" I said, "Damn, well, yeah." So I'm going back. If it wasn't my spiritual imperative, I wouldn't need to be there. But people are dying, so how can I not be there? If I can help, I can't turn my back. If you have a gift and you don't use it, God will kick your ass. And I've had my ass kicked by God before, and I don't need God kicking my ass any more. So I use my gift. I'm going to South Africa to do HIV prevention research. And it's going great. I haven't won, but I'm winning. You deal with traumatic helplessness by having people engage in learned helpfulness. As long as you're doing that, you may not win but you didn't just do nothing. I'm a fighter. I'm crystal clear about that.

If you have a gift and you don't use it, God will kick your ass.

A Healing Perspective

James L. Kyle II

James L. Kyle II, MD, *is vice-president, California market, for Schaller Anderson of California in Orange. He serves on the board of Catholic Healthcare West and Oakwood College. He is the pastor of the Breath of Life Seventh-day Adventist Church in Westchester.*

A graduate of the UCLA School of Medicine Andrews Theological Seminary and Loma Linda University, he has attained an impressive record of national and international service. He has served on five hospital staffs, as an internist and medical advisor, and as medical officer and operations director for numerous businesses and community organizations. He was president and CEO of Sharp Health Plan, one of Southern California's most innovative health care systems, and has been a field director, pastor and director of ministries with inner city and international charitable organizations.

His numerous awards include two Doctor of the Year awards, the Recognition Award from the National Association of Medical Minority Educators and a Certificate of Merit from the Los Angeles Board of Police Commissioners and the Los Angeles Human Relations Committee. As a captain in the U.S. Army Reserve, he received the Award for Operations for his work in the Federal Republic of Yugoslavia. He has served as chair of the Venice/Oakwood Community Coalition Against Gang Violence and is the founder and board chair of Operation H.O.P.E.

Who has inspired your work?

I started my college career as a premed major, but in my sophomore year I switched to theology. One early influence in my life was a man named Lorenzo Paytee, a minister and also a teacher in my high school and elementary school, who was associate pastor of my church. He was one of my early mentors in terms of creating in me an ethic of service to other people. My own father died when I was 10, so my relationship to this pastor became a very important relationship to me.

I graduated from college as a minister and my first assignment was working as Pastor Paytee's associate in a community center that he was operating in Watts. We were working in poverty programs to help kids learn to read and trying to eliminate the other issues surrounding poverty, such as ignorance, lack of food and lack of job opportunities. I later took over the center when Pastor Paytee became ill and took a leave of absence. I continued that kind of work and went to Andrews Theological Seminary where I completed my ministerial training, then worked in religious broadcasting.

I saw the deplorable health care conditions and it started me thinking about what was going on with minorities in this country.

While I was on Palau, an island in the Pacific, doing evangelism, I made a decision to start thinking about expanding my work and my career. I saw the deplorable health care conditions and it started me thinking about what was going on with minorities in this country, in terms of what was happening in access to health care. That's when I made my decision, around 1980, to go back into medicine.

I graduated from medical school and residency at UCLA, and had some wonderful mentors there, but two people really helped shape the rest of my career. One was a gentleman named Paul Simms who worked in a local health department in San Diego where I went to practice after I graduated. I learned from his work and how he was thinking about population health and improving the health status of larger groups of people. The other was Dr. Terry Kane who was working at that time for Sharp Health Care and gave me my first opportunity to move into health care management.

Those three individuals—Pastor Paytee, Paul Simms and Terry Kane—have had some of the biggest influence on what I'm trying to accomplish with my career. I work in organizations, be they in the public or private sector, that can focus not just on treating the individual patient but on creating equitable systems of care and care delivery to populations of people. That way we can begin to address some of the larger issues related to community health, access to care and health disparities.

You continue to be active both as a physician and as a pastor.

I pastor a church of about 200 people. This is my seventh year pastoring this congregation as well as trying to continue my medical career. It's been very gratifying, but is certainly very taxing at times.

What lessons would you like to share with others?

When I look at our profession I see two groups of physicians out there. There are physicians who still believe in something, in a mission, a purpose for what they do; and there are those who assume that the privileges of our career are only about money and power and position. If people have chosen this profession just as a means to procure money, they've really made a mistake. Number one, the economics don't support that being a wise choice, and number two, we really don't need those kinds of providers in our profession.

We need a spiritual reformation within American health care.

We need, I think, a spiritual reformation within American health care that deemphasizes the importance of wealth and fame and begins to stress the importance of sacrifice, service and continued commitment to excellence. Wherever God needs us as individuals, wherever we find ourselves, we can be of tremendous service, but we have to maintain an ethic that says, "People are more important than things, and principle is more important than profit."

Can you say more about how spirituality applies to health care professionals?

Within medicine and epidemiology, public health, whatever segment we're working in, what we do rarely cures disease. But we all have the opportunity to bring healing. I distinguish healing from a cure. Healing is a process that allows individuals to feel hope, to feel courage for tomorrow, and to engage in the work of healing themselves, of growing stronger, of becoming empowered.

Even when people have a disease for which medicine knows no cure, they can enter into a healing relationship with their provider, if that provider is connected spiritually and knows how to apply what I would call the healing arts of hope and encouragement, such as touch that says, "I care about you and you are somebody." Even as an epidemiologist, it's not enough just to generate the data. From a healing perspective, one must figure out how to interpret the data and then make suggestions to the community or to policy makers about how we can bring an atmosphere of healing and restoration to a community.

I think a spiritual connection for providers is absolutely essential. I view medicine as a form of ministry. I'm a Christian, so if I look at the life of Jesus, I recognize that he probably spent far more time healing people and helping others than he did preaching sermons. I think that would be a model that the modern church could learn from. That model also makes perfect sense for health care professionals whether we are nurses, doctors, technicians or hospital administrators. What happens in the course of our work that heals the community? If we can focus on that, I think we will actually make a stronger country and a healthier population.

What have your life experiences allowed you to accomplish?

I don't sit around trying to measure those things, but I do think about the activities I've been involved in. When I was a junior in medical school at UCLA—don't ask me what made me think I had time to do this while being a medical student—I organized a

homeless feeding program called Operation H.O.P.E. It was based out of a local church in the Los Angeles area that I was attending as a member. We began going down to Skid Row and taking hot food and setting up tables, and we began feeding the homeless and doing intervention counseling, what we call streetside counseling, for the families. We'd collect money and find housing, especially for the mothers and children. We'd try to get them connected with social services.

I ran that program for almost three years and we fed about 1,500 people a week. It was all voluntary—we had no public support, just private donations and gifts. I turned it over to one of our associates when I had to start my second year of residency, and it carried on for another few years. That was an accomplishment I felt especially good about—that we were able to touch the lives of so many people.

I enjoyed the time I spent in the San Diego community, not only in private practice, but working with community organizations. We created a program while I was at Sharp Health Care called the Sharp Mediversity where we connected with Lincoln High School and started mentoring youngsters. We'd take 50 young people and provide a stipend to pay them for their services to the hospitals. They were assigned to various departments of the hospital where they could be mentored by people who worked in health care and also be encouraged to stay in school and stay focused in their lives. We hoped to attract them into medical professions down the road but that wasn't a prerequisite for joining the program. We also went on campus with lectures for the classes. That program, I believe, is still going on today. It started back in 1994. That's the kind of program I was proud to be associated with.

What are the most important issues related to health disparities for African Americans and other blacks in this country?

If you look at the 2003 Institute of Medicine report it's clear that racism is still alive and well in America. The milieu that makes health care disparities a reality in this country cannot yet be disassociated from racism. Racism is not the only reason, however. Economics and our current health care model also play a role.

Let me give you an example. If you look back to the turn of the century, in 1900 there were probably 100 black-owned hospitals in this country. If you look today to see how many of those hospitals still survive, you'd be hard pressed to find half a dozen still in existence. That's partly an outgrowth of the changing landscape of health care and health care reimbursement, which makes it harder for any small institution to survive if it's not connected to a hospital system. But other things happened as well.

It's clear that racism is still alive and well in America.

African Americans came to this country first as slaves, then lived through the Jim Crow laws and all of the segregation in the south and the rest of the country. At the close of the Civil War we were able to own our own businesses. There was a flourishing of black entrepreneurism in the south that continued through the north, the west and the east in terms of black-owned business, black-owned stores. And, therefore, we patronized our own hospitals and physicians.

With the advent of desegregation and the Civil Rights Movement, although we gained much that we didn't have before in terms of our being able to have access to the wider community and the wider society, we also began to lose some of what we *did* have, namely the patronage of strong African-American owned and operated institutions. Those institutions were essentially abandoned as people wanted to get access to other services, be it Nordstrom or some private hospital in the suburbs. African Americans stopped patronizing their own institutions. So what we find now is that we don't have solid, strong institutions in every city that can serve our community.

Most of the institutions that serve minority communities tend to be publicly operated by either the county or city government. They tend to be underfunded. You have long lines and access is always a challenge. All these things contribute to the ongoing health care disparities. Not to mention the fact that, even if you as a minority can leave your community and find health care in another community, the racism in the background of health care disparities, which has been very well documented, may mean that providers may not understand your cultural milieu and may not fully appreciate your

symptom complex. An African American presenting with chest pain, is much less likely to get the diagnostic and therapeutic cardiac modalities that someone who is white will. African Americans are less likely to get the same treatment for cancer. They are less likely to be in a transplant program, or to get a transplant if they are in a transplant program. The list goes on and on.

One of the important lessons we must learn as a community is that we have to take control and responsibility for our own health status, which means we need to increase programs that talk to African Americans about the role of diet, the role of exercise, the role of moderation in lifestyle—things that people can do to improve their own health and well-being. We need to make our people smarter medical consumers so that they will begin to ask questions when they're in the doctor's office, seek second opinions when surgery is recommended, and learn how to get what they need from the health care system, whether it's a PPO or HMO or whatever the system may be, so they can have much better health care outcomes over the long run.

We have to take control and responsibility for our own health status.

What advice do you have for clinical practitioners working with African-American patients?

What really needs to happen at a bare minimum is that providers need to have more respect for the intelligence of their patient population, for their patients' desire to be well and be disease free, for their patients' willingness to trust and cooperate with the medical regimen if they understand that regimen and it's in their best interest. We can't assume that people who are black either don't want better health or don't need expensive interventions. Our lives have to be seen as just as valuable as anyone else's life.

We have to offer patients, irrespective of color, the best that our medical science has to offer. Sometimes we have to also keep in mind that what is best is not always what is more, it's what's most appropriate—the most appropriate amount of medication, the most appropriate surgery, the most appropriate treatment to bring about maximal outcomes for the patient.

If we get back to outcomes-driven medicine and management, framed by protocols and best practice across the country, and if we standardize our approach to all patients (keeping in mind the cultural nuances for any given population), we'll go a long way toward eliminating disparities. But when doctors are allowed to practice without the discipline of guidelines, without the discipline of outcome measurement, physicians sometimes wittingly or unwittingly allow bias to determine how they approach a given patient with a given set of symptoms. I think that one of the things that's going to help our profession overall is to move toward a more outcomes-based medical practice that looks at how well a population is improving in health status as a measure of the effectiveness of the medical system, an intervention or an individual provider.

We have to offer patients, irrespective of color, the best that our medical science has to offer.

What recommendations do you have to help mentorship efforts?

Mentorship has to begin very early in life, with elementary school children. They need to be able to see medical professionals—doctors, nurses and others—and demystify the road to get there. Frequently kids grow up feeling, "If I have to spend four years in college and four years in medical school and then residency, I'll be too old to have a life, so I want to find something else to do," and they want to drop out. I think we have to show our kids that these careers are possible for them; that they are necessary for them to have; that they can serve a broader purpose for our community. We've got to mentor them around the basics of mathematics and reading and physics and chemistry in the early years of school so we can foster an interest.

For example, Drew University had a program that went on for years called the Saturday Science Academy. The university did outreach to youngsters in the community, brought them in on weekends and helped them understand what was happening in medicine and science. The kids got to wear little white coats when we went on rounds. It was a wonderful program to inspire kids to see a bigger future for themselves.

We have to show our kids that these careers are possible.

If kids only see crime or lawlessness, violence and hopelessness around them, it's hard for them to have hope. We've got to allow children to see that there is another world and that they can enter health care professions and serve with distinction and honor. And that they will be, for the most part, well compensated for doing so. They won't be rich but they'll be comfortable. They'll be able to care for their families in these professions.

As they say in Chicago, you've got to vote early and you've got to vote often. So mentorship must start early with kids and be consistent. We need a union of the hospitals, medical schools and the churches in our communities all working together to establish a culture of excellence that drives our kids to want to achieve more for themselves and rewards them for their efforts along those lines.

Are you in a position to mentor others?

I still do some mentoring. I work with other health care professionals to mentor the children in our local congregation. We just started a program in our church called SOS (Save Our Sons) that is working with the young men of single parents, and have another program that's working with the young women of single parents, teaching them how to grow. We try to encourage mentorship. It's just a way of life.

I have a number of premedical students I spend time talking to on the phone. About twice a year I go to programs at UCLA and at Loma Linda University where I speak with medical students either in public assembly or give them some one-on-one counseling. So I still try to stay involved in mentoring as much as I can.

What is the role of the church or of spirituality in the African-American culture as an aspect of preventive health care?

What we've known in the black community all along is that there's a major connection between faith and healing. People have to believe that they can get well in order to get well. So the connection I see for African Americans is pastor and physician working

together to say to a patient, "You can live better. You can live longer. You can overcome disease and not feel victimized by your own behaviors."

When it comes to preventive medicine, you have to give a spiritual ethic to a community that says, "Your body is a temple of God." You want people to feel an obligation to treat the body better than we typically do, to respect this gift that's been given to us—the gift of life and our bodies. You tie the notion of the body as a temple to living a lifestyle of temperance. This idea suggests that I'm not free to treat my body any way I like. I'm not free to smoke or use cocaine or drink with impunity because I have a responsibility to my God, as well as to my family and community, to preserve the useful years that could be lost due to illness or disease.

You want people to feel an obligation… to respect this gift —the gift of life and our bodies.

When you look at the devastation that alcohol or crack cocaine has had on our community everyone can readily say, "Well, OK, I see that's bad." But what about the devastation that high cholesterol and obesity have caused in our community in terms of heart disease and cancer in African Americans? These diseases are preventable. And, if they are preventable to some measure, then we have an obligation to prevent them in our own bodies.

Does that kind of message work for people who are not actively spiritual?

I think it can. There are a lot of people who are not actively spiritual who for different reasons come to an epiphany that it's their life and their body and they owe it to themselves to take better care of it. Sometimes it comes because they've seen the devastation in the lives of family members or close friends who didn't take care of their health. Unfortunately, it seems to be a lesson that's much easier to learn in our fifth or sixth decade of life than it is in the second or third. We can most benefit from taking good care of the body when we're young and healthy. But many people tend to ignore it until they start getting ill later in life. Then they say, "I wish I'd lived better twenty years ago," and they're trying to play catch-up in terms of their health.

I think the message can be packaged in such a way that even the nonspiritual can see the wisdom in it. It's a logical argument, even if you remove the aspect of spirituality, that living better today means living longer tomorrow, and living better tomorrow. Some research done about 15 or 20 years ago at Tufts University suggested that people who ate well, who did weight lifting or resistance exercises for their muscles, and who maintained a healthy body weight actually were able to shorten the period at the end of life during which they were completely incapacitated or disabled—the "disability zone." People who take poor care of themselves may find themselves disabled and unable to care for themselves or work for many, many years. People who take better care of themselves, this research suggested, were able to shorten the duration of their disability from years to perhaps months or even weeks. So there are scientific as well as spiritual reasons for why people should do this.

Living better today means living longer tomorrow.

On the other hand, I believe it's fairly difficult for people without spiritual motivation to change their lives. People have the best of intentions—from January 1st through the 30th many gyms are filled to capacity with all those New Year's resolutions: "I'm going to lose weight this year." People flock to the gyms, but you can't find them there by March or April. So the ability to sustain that desire to improve one's life is supported more by a spiritual foundation than a scientific one. Reasons for making changes tend to last longer in people's lives when they are living well and living better because they feel they owe it to their God to do so.

I would also like to say that the time has come to stop apologizing for the spirituality of the human species. We are a spiritual people. I think it was Kierkegaard, the nineteenth century theologian, who talked about the God-shaped hole in every man's heart. There's a part of us that does not function to full capacity in the absence of spirituality in our lives. I think that rather than being apologetic for spirituality, I'm far more up-front and enthusiastic about saying to people, "You've got to have a connection to God in order to live a full and meaningful life." It's the method used in 12-step programs that work with people with addictions. It's a basic reality of living. Obviously

if someone doesn't believe that God exists, he or she will have a hard time embracing that. But I believe those people don't actually represent the majority of people on the planet.

What is your passion and vision for the future?

I think we're going to have to arrive at some sort of national health care program that provides access to insurance to people of all colors and every economic status, so that everybody has basic access to health care in this country. The growing ranks of the uninsured and the impact it has on all our lives in terms of their being prevented from getting routine medical care, check-ups and vaccinations is a tragedy that shouldn't exist in this country.

But I don't believe that access alone will be enough. I think my long-term hope would be to see a reformation in the hearts of men and women that would suggest that God is God and that all people are created equal, and that therefore we must care for people as we care for ourselves. I have to tell you, I doubt if we'll ever see that day in this country, but I don't believe we should ever give up that hope in terms of how we operate and in our efforts to encourage others to live for an ethic beyond themselves, to achieve not only better lives for their own benefit, but also for the benefit of others. That requires a selflessness that's uncommon in our society, but it's the ethic that built this country from its very beginnings, and it will be the only thing that will ensure our nation's continued existence and prosperity.

The time has come to stop apologizing for the spirituality of the human species.

A Mission to Make a Difference

David Satcher

David Satcher, MD, PhD, *was the 16th Surgeon General of the United States. He is only the second person in history to have held the positions of Surgeon General and Assistant Secretary for Health simultaneously. He is currently the director of the new National Center for Primary Care at the Morehouse School of Medicine in Atlanta, Georgia.*

He has served as director of the Centers for Disease Control and Prevention, president of Meharry Medical College in Nashville, Tennessee; and a professor at Morehouse School of Medicine, UCLA School of Medicine and Public Health, and the King-Drew Medical Center in Los Angeles, where he directed the King-Drew Sickle Cell Research Center for six years.

A former Robert Wood Johnson Clinical Scholar and Macy Faculty Fellow, he is the recipient of over 30 honorary degrees and numerous distinguished honors, including top awards from the National Medical Association, the American Medical Association, the American College of Physicians, the American Academy of Family Physicians, the American Academy for the Advancement of Science, the National Association of Mental Illness, the New York Academy of Medicine and Ebony *magazine. He is a fellow of the American Academy of Family Physicians, American College of Preventive Medicine and American College of Physicians.*

Who has inspired your work?

It started with my parents. Neither of them finished elementary school, but they were committed to seeing that their children had opportunities they didn't. In addition, I was very ill when I was young. I almost died of whopping cough and pneumonia at age two. There was one black physician in the Anniston, Alabama, area. Somehow my dad convinced Dr. Jackson to come out to the farm on his day off because there was no place for us in the hospital—people died at home. Dr. Jackson spent almost all day there, and when he left he told my parents that he didn't expect me to live out the week. But he showed them what to do to increase my chances—keeping my chest clear, keeping my fever down—and they must have done it well.

By the time I was six, I was telling people that I was going to be a doctor, just like Dr. Jackson.

My mother told me that story almost every day, and, by the time I was five, I was talking about how much I wanted to meet Dr. Jackson, because I never had met him. So they promised me that for my sixth birthday they were going to take me to town—going to town was a big thing—to meet Dr. Jackson. But he died of a stroke that year, so I never met him. By the time I was six, I was telling people that I was going to be a doctor, just like Dr. Jackson. I had no idea what that was about, but somehow that's what I felt. That vision has driven me through the years.

As a black family, we didn't have access to care. We didn't have access to much of anything. I actually didn't grow up thinking of us as poor because we were out there on the farm. Our parents were loving parents. We just thought that was the way it was supposed to be. We didn't think a lot about there being no place for us in the hospital or the fact that you couldn't go into a restaurant.

It had always been like that up until about the early 1950s when I was in junior high school, and then I started to think about human rights. And, of course, Martin Luther King came to Montgomery to pastor Dexter Avenue Baptist Church at that time, and my brother was at Alabama State. So when Dr. King led the successful Montgomery

bus boycott I heard about that and read about it, and the idea that there was something you could do, that you could change things and even do it nonviolently became a part of me and a part of my passion. When I got to Morehouse College in Atlanta I was quite involved in the Civil Rights Movement, the sit-in movements especially.

What lessons would you like to share with others?

The first is how important it is to really follow your dreams. Even though I didn't know how I was going to do it, I believed as strongly as I could that I was going to be a doctor. Nobody in my family had even finished high school at the time when I started saying that, so I had no idea what it meant, what it would take, but I believed it. I followed it. It influenced everything I did. It influenced what I said yes to, what I said no to, whether it was drugs or violence or whatever. That vision of what I wanted to do and what I was going to be drove me on. I think it's really important to tell young people to follow their dreams and not give up because those dreams seem unrealistic, to stay the course, even when things don't go well. There will be times when things won't go well and they'll get discouraged, but it's important to stay the course.

It's really important to tell young people to follow their dreams and not give up because those dreams seem unrealistic.

It's also important to connect with other people who have a commitment similar to yours. I've been fortunate as I've come along the way to have had relationships with people who cared a lot. I often tell the story of my high school teacher, Mrs. Jairrels, who figured out that somehow, without working hard, I was doing better than most of the other students and started really putting pressure on me. I was in the C group because I would leave school to go work in the foundry. Most of us who left school went to work in the fields, but I got a job in the foundry because I wanted to go to college and I had to make the money. But when she found out that I could do good work, she started giving me extra work. She wouldn't accept that fact that I made the highest grade. She still would say, "I want you to go to the library and write this report."

I've been fortunate to meet people all along the way who said, "You can do better. I'm going to make sure you do the best you can." That continued at Morehouse. I went there without any money. I had a scholarship for tuition. They said, "You've got to keep a B average and we'll make sure you get work and room and board." So I got jobs in the library, in the laboratory, waiting tables, and I was able to make it through. I graduated with high honors and was student body president my senior year. It was a supportive environment. They didn't care where you came from at Morehouse. They tried to make the point that you were *somebody* and you were expected to be a leader.

At Morehouse, they tried to make the point that you were somebody *and you were expected to be a leader.*

There was a man by the name of Benjamin Elijah Mays who was president of the college at that time. We had chapel six days a week, and every Tuesday morning Mays would speak to the students. I got a lot of my inspiration from him. He was always challenging us to be leaders, to make a difference. It was a supportive, nurturing environment for my dream.

What have your life experiences allowed you to accomplish?

I graduated from medical school at the top of my class at Case Western and won top awards in research and patient care. It's meant that I've had a lot of opportunities. I went to Rochester and trained in community medicine and pediatrics. When I'd been there for two years of the four year program, I heard that they were going to be opening a hospital out in Watts, because the people there had to catch three buses to get to the county hospital. I was doing well in my residency program—they were talking about making me a chief resident—but I decided I wanted to be part of that new hospital development. It was seeming like the longer I stayed in medical school and training, the further away I got from rural Alabama and working with people. So, when I heard about what was happening out in Watts, I said, "Wow, if I could go there and be a part of developing that hospital it would be a really great experience." That was the kind of thing that drove me into medicine in the first place.

So I left. I took quite a risk. People at Rochester said, "You've done a great job here. If you stay, you'll probably be chief resident and maybe one day the department chair, whereas if you go out there, nobody will ever hear of David Satcher again." But I went, and had a chance to be involved in developing the Martin Luther King, Jr., Hospital and the medical school.

I think it's what launched me into a leadership role, because there were so few people out there with my kind of background, with both an MD and a PhD. I knew about research, and they needed that. I wrote the first NIH proposals and we were funded as a National Sickle Cell Disease Research Center, which not only funded me for research, which I knew how to do by that time, but also made me the administrator of the center. That was my first leadership role in academia and it went on from there. I spent two years at UCLA as a Robert Wood Johnson Clinical Scholar, finished residency training, was department chair and interim dean at Drew, and negotiated the agreement with UCLA that led to the medical school there.

If something's consistent with your commitment, sometimes you have to take risks.

I've been able to do a lot of things. Some of them involved taking risks. I think if something's consistent with your commitment, sometimes you have to take risks. Every time I get an offer or an opportunity, the first thing I ask myself is, "How does this relate to why I went into medicine in the first place?" I have my own mission in life and whenever anybody offers me a new job or a new opportunity, the first question I ask is whether it's consistent with what I'm committed to doing in medicine and public health. Will I be able to make a difference?

What are the most important issues related to health disparities for African Americans and other blacks in this country?

We're defining more issues every day, because when we set that goal of eliminating disparities in health we identified the problems and the gaps. The next challenge is what are the points of attack if you're going to change these things? What's leading to these disparities? That requires much more work and research.

It's very clear now that access is a major issue. Hispanics and African Americans have very poor access to health care in this country. They are more likely to be uninsured, more likely to be underinsured, more likely to live in underserved communities, and, of course, are under-represented in the health professions. All of those things mean that they have inadequate access.

We also know that there are some quality issues. The Institute of Medicine's report last year documented something I've been saying since 1973 about the fact that minorities don't get the same quality of care even when they go to the same physicians and have the same insurance and same socioeconomic status.

Minorities don't get the same quality of care even when they go to the same physicians and have the same insurance and same socioeconomic status.

Environmental issues are another area of concern. African-American and Hispanic children are more likely to be exposed to toxins such as lead and to be poisoned by these toxins. That's a problem. Environmental issues also relate to safety and activity. We're dealing with this epidemic of overweight and obesity that I identify in the Surgeon General's Report as a national issue. Now we know it's a global issue. Environment is important. People live in places where there are no walking trails, no parks, no safe places to get out and walk or play. Parents worry about their children going outdoors, so they're not going to be as physically active. Environment also influences diets. In the inner city it's not easy to find a supermarket close by with fruits and vegetables, and even if you do, those foods are going to cost more than if you were out in the suburbs. So there are a lot of environmental issues people struggle with that contribute to disparities in health.

In our National Center for Primary Care at Morehouse School of Medicine, the program is set up to try to deal with all of those areas, not just developing new drugs in the laboratory. How can we improve access and how can we work with communities to improve access to care? How can we work with physicians to make them more culturally competent so that even when white physicians take care of African-American and Hispanic patients they're more sensitive to cultural differences? Culture might have

Culture counts in the way people experience an illness.

an impact on the illness and also on how a person responds to treatment. When I did that Surgeon General's Report on Mental Health: Culture, Race and Ethnicity I looked at that very critically. The language we used summed it up: culture counts in the way people experience an illness. It also counts in the way professionals diagnose and treat a patient's illness, and we documented that. Professionals often make the wrong diagnosis because they don't understand the culture.

What can clinical practitioners working one-on-one with patients do to address and help eliminate health disparities?

Each of us has, first and foremost, a doctor-patient relationship, and we need to take that seriously in terms of prevention, by counseling patients about ways to stay healthy, by identifying and diagnosing problems early. The earlier you diagnose diabetes, the more likely you're going to be able to control it and prevent complications. It's the same with other acute or chronic illnesses. So the first thing is to eliminate disparities one patient at a time.

The second thing is to connect with patients' families and communities. Practicing in a community, you have an opportunity to learn about the family from which the patient comes and what might be going on. For example, you may see a child with elevated lead levels, and because of that you've identified a problem in the home. Working with social workers, you can sometimes change the whole community because you've identified that one child who was suffering from lead poisoning.

Back in the 1960s when the whole concept of primary care was first defined, I was still a medical student. One of the components of that definition was community leadership. I believe that physicians have a responsibility to provide leadership. Go speak to the school board about how important it is to have physical education in grades K through 12. Go speak to the school board or the principal about good nutrition and the fact that the school can make a difference in whether children become overweight or obese. Seventy to eighty percent of children who are overweight or obese are going to be obese adults.

I think physicians sometimes underestimate the difference they can make by just working at the community level in terms of educating people and influencing policy.

Physicians have a responsibility to provide leadership.

Do you have any comments about mentorship? You're so involved in teaching, are you able to include mentorship in that?

Well, yes and no. I just finished speaking at a conference and somebody came up to me and said, "I'm looking for a mentor." Because of the nature of my schedule now, I don't often say yes to individuals like that. I know I don't have time to do a good job because I'm going all over the country all the time speaking as former Surgeon General. So I tell people I wouldn't be good one on one, but, over the years, I've developed mentoring relationships with people and some of those have lasted a lifetime.

I'm proud of Helene Gayle, for example, who's now leading the Gates Foundation's AIDS program. I worked with Helene at the CDC and ended up appointing her to head the AIDS program there. Even though Helene was very young, I was impressed with her training and her abilities. She went on, of course, to not only do a good job at that center, but later be selected by the Gates Foundation. Now she heads the largest program in the world dealing with HIV, TB and STD.

Beverly Malone was a dean at the School of Nursing at North Carolina A&T when I met her in Washington, D.C., while she was with the American Nurses Association. I appointed her as my Deputy Assistant Secretary for Health, and we worked very closely together. We even ran the Marine Corp Marathon together. She's now heading the Royal Academy of Nursing for Britain. It was unusual for Britain to select an American for a position like that, and this is an African-American woman. I had a visit from the Select Committee on Health from the British Parliament who were interested in my obesity report. I asked them about Beverly and they said she's outstanding. I'm very proud of her.

So I've had the opportunity to interact with young people and develop relationships with them and be there for them when they needed counseling. It's one of the real joys

of my life. It's so fulfilling to see the young people you work with go on and do well. I was president of Meharry Medical College for almost 12 years, and it's amazing to see what some of those students have gone on to do. They give me more credit than I deserve. As president, you don't do a lot of one-on-one mentoring. But I made it clear when I got there that the two major priorities for me would be the patients in the hospital and the students, because that's why we're there. We always had students over to our house. I run into people now who are making more money than I am, and they recall when they came to the house as students. It's amazing.

It's so fulfilling to see the young people you work with go on and do well.

What is your passion and vision for the future?

People are part of my passion, especially young people. My staff came to realize very early on when I was Surgeon General that I brake for young people. I try to make plans. If I'm going somewhere to speak I try to find a way to go to an elementary school or junior high school. Over the years, I have really enjoyed interacting with young people.

I love to teach and I've come to love to speak. I do a lot of speaking, communicating to individuals and groups throughout the country and trying to influence policy. I think that's the way you do influence policy. It takes a long time, but you just continue to get the message out there and you hope that in time people will get it.

I was very pleased when the survey came out saying that now over 70% of the American people support universal access to care, even if it means a single payer system. That tells you that people are not going to continue to tolerate a health system that leaves so many people out. Ever since I was in government I've been pushing for what I call the balanced community health system—balanced in the sense that it emphasized more health promotion and disease prevention—early detection—but also provided universal access to care. That was one of my major goals as Surgeon General. In every report that we did we talked about the problems of access. I like to think that I may have made some contribution to the changes that have taken place in attitude.

Anything else you'd like to add?

A lot of people asked me why I made the decision to come back to Morehouse School of Medicine to direct the National Center for Primary Care. There are two things I can say. One, I was really not looking for a CEO-level position—some people think that once you're at that level you have to stay at that level—but I didn't want to be a college president. I really looked forward to getting back to the things I enjoyed before I got so much into administration, such as being able to work with young faculty members in research, which I'm doing now at the Center for Health Disparities Research, and being able to interact with students and the community. Two, I spend a lot of time working with community groups, doing something with the Atlanta University Center students and doing something with the 100 Black Men of Atlanta and Concerned Black Clergy.

You just continue to get the message out there and you hope that in time people will get it.

What I'm doing right now I really enjoy. I don't know where it's all going to lead, but I don't feel that I always have to be in a leadership role to contribute and I'm enjoying supporting leadership. I always felt that to be a good leader you also had to understand what it meant to be a good follower. I've had to make it clear to people that, in addition to my own leadership role as director of the National Center for Primary Care, I'm also here to support leadership, and that I'm very comfortable doing that.

Recommendations

The elimination of health disparities will require a concerted effort by individuals and institutions in the public health community and beyond. Reliable data about the health status of specific populations is essential to this endeavor. There are data sets being developed by the federal government, state and regional entities, and various health care organizations. Some of that data is included in the introduction to this publication. Using this data and other information, different recommendations have been developed to guide the effort to eliminate disparities.*

One thing becoming evident is that data alone will not be enough to accomplish the task. To effectively reach populations affected by disparities, providers need to have a personal understanding of the communities and people within those populations—who they are, what matters to them and how they can be supported in building a stronger foundation for health. To achieve meaningful change in American health care, data about disparities must be linked to experience and wisdom about people, and power must be shared. This bringing together of science and wisdom, data and heart, has been one of our primary goals in offering these interviews.

The leaders who have shared their ideas, experiences and inspiration with us here have articulated a set of recommendations critical to success in eliminating health disparities among African Americans and other blacks in America.

*See, for example, *Revised CLAS Standards from the Office of Minority Health*, outlining 14 recommendations for culturally and linguistically appropriate services, at www.omhrc.gov/CLAS; and *Healthy People 2010, 2d ed.*,U.S. Department of Health and Human Services, Washington DC.

General Recommendations

- Recognize and address the larger social and contextual issues—racism, poverty, lack of education, unemployment, lack of health insurance and access to care—that directly affect the health of black people.
- Strengthen social justice and human rights in our society and across the world as an essential step in addressing health disparities.
- Providers need to understand how respect is demonstrated in the cultures of their patients, and put that understanding into practice.
- Providers have a responsibility to provide leadership in the community concerning positive health behaviors, become involved in issues of health care and access at the policy level, and support others in taking leadership on these matters.
- Foster mentorship, which is instrumental in building the skills and success of health students and new professionals, and provides many rewards to both mentor and mentee.
- Make a commitment within the health professions and the culture at large to teach, inspire and support children and young people in building their skills and capabilities and in believing they can serve their communities.
- Recognize the connection between faith and healing. Boost effectiveness by working with faith communities to address direct health care needs, such as health promotion and screenings, as well as social needs, such as literacy and meal programs.
- Address the environmental issues that are implicated in many of the health care problems faced by black people, including exposure to toxins such as lead.
- Improve the social and physical environments to help counter the epidemic of overweight and obesity. People need walking trails, safe parks and healthful food sources near their homes.
- Develop strategies to address the under-representation of African Americans in health care professions, and work with all providers to help them become more culturally competent.

- Establish a national health care system that provides access to people of every economic status and ensure that all patients, irrespective of color or ethnicity, receive the same quality of care.

Lenora E. Johnson

- Work to break the stronghold the tobacco industry has upon communities of color through its support of scholarships, magazine advertising, events sponsorship and many other sophisticated, dependence-driven tactics.
- For many students, education is not only an investment but also a sacrifice. Those who mentor students must remember that it's a personal as well as a professional goal for them.

Carol Easley Allen

- Concentrate on service. Understand nursing and public health as vocations in the old sense of the word—something you're committed to, that you'd do whether you were paid for it or not.
- Philosophical research—looking at ideas and concepts—can make a meaningful and positive difference in the practice of health care.
- Nurses and other health providers can learn more about genetics and provide information and guidance to families dealing with issues of genetics and health. Recognize that some blacks are distrustful in these matters because of past experiences involving discrimination.

Collins O. Airhihenbuwa

- Seek experience in an environment that puts you in the role of an outsider for a period of time to better understand the unique ways people of different cultures process information.
- Always remember that there is no universal truth or single solution—there are multiple truths, there are multiple solutions.

- Invest in having the voices of different groups represented at the center of the conversation about eliminating health disparities.

Byllye Y. Avery

- Work to effectively lift the standard of care for those who are most disenfranchised. Raising those on the bottom is the only way to raise the whole system.
- Understand that different populations may have different priorities. They may share many of the same issues, but have different views about what is most important.
- As a practitioner, be honest with people and present all the options for care. Decisions should not be based on assumptions about money or the ability to pay.

Carl C. Bell

- Recognize the connection between early childhood trauma and wellness and mental health, and reflect this in public policy and the understanding of physical medicine and public health.
- Rebuild the village and reestablish the adult protective shield as key strategies in reducing violence and effecting behavior change.
- Address the lack of research on disenfranchised populations, such as poor black people or prisoners, and redress the monocultural ethnocentrism of health research. Find ways to include the clinical experience of community practitioners, who generally see many more people than researchers.

James L. Kyle II

- Strive for a spiritual reformation within American health care that deemphasizes the importance of wealth and fame and stresses the importance of sacrifice, service and continued commitment to excellence.

- Help people become smarter medical consumers so they will ask questions when they're in the doctor's office, seek second opinions when surgery is recommended, and learn how to get what they need from the health care system.
- Acknowledge that we are a spiritual people and apply spiritual principles to health care and prevention to improve outcomes and success.

David Satcher

- Connect with other people who have a commitment similar to yours. This is especially important for young people and students.
- Understand that culture counts, and learn to recognize the ways it influences how people experience an illness and how professionals diagnose and treat an illness.
- Work to eliminate disparities one patient at a time. Take the doctor-patient relationship seriously, counsel patients about ways to stay healthy, and identify and diagnose problems early.

Resources

National Organizations & Foundations

- Commonwealth Fund: Underserved Populations/Minority Health
  www.cmwf.org/programs/minority/index.asp
- Congressional Black Caucus Foundation
  www.cbcfonline.org
- Minority Health Professions Foundation
  www.minorityhealth.org
- National Association for the Advancement of Colored People (NAACP)
  www.naacp.org
- National Black Child Development Institute
  www.nbcdi.org
- National Black Nurses Association
  www.nbna.org
- National Dental Association
  www.ndaonline.org
- National Medical Association
  www.nmanet.org
- National Urban League
  www.nul.org

Government Resources

- Agency for Healthcare Research and Quality
  www.ahrq.gov
- Centers for Disease Control and Prevention, Office of Minority Health
  www.cdc.gov/omh/Populations/BAA/BAA.htm
- Healthfinder
  Office of Disease Prevention and Health Promotion
  U.S. Department of Health and Human Services
  www.healthfinder.gov

- National Center for Health Statistics
  www.cdc.gov/nchs
- National Institutes of Health
  www.nih.gov
- National Center on Minority Health and Health Disparities
  www.ncmhd.nih.gov
- National Women's Health Information Center
  www.4women.gov
- Office of Minority and Women's Health
  http://bphc.hrsa.gov/OMWH/home.htm
- Office of Minority Health
  www.omhrc.gov
- U.S. Census Bureau
  www.census.gov

Health Studies & Projects

- African-American Men's Health Study, Center for AIDS Prevention Studies
  www.caps.ucsf.edu/projects/AAMHSindex.html
- Minority Health Project at the University of North Carolina at Chapel Hill, School of Public Health
  www.minority.unc.edu
- National Black Women's Health Project
  www.blackwomenshealth.org

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Eliminating Health Disparities
Conversations with Blacks in America

is one of a series of *Public Health Profiles* published by ETR Associates, a private, nonprofit agency committed to providing health education/promotion resources for underserved populations. Each book in the series focuses on a cultural group that has traditionally experienced health disparities, profiling leaders working to promote health and prevent disease. The content includes background information on existing disparities and recommendations to improve practice and outcomes in the future.

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