

## **Briefing: Missing Persons: Minorities in the Health Professions September 20, 2004**

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**DR. LOUIS W. SULLIVAN:** Missing Persons: Minorities in the Health Professions is a detailed look at what this commission has found. Unfortunately, the title of this report is the reality facing our nation. The facts of the US health professions remains separate and unequal is hazardous to our nation's health.

It has been my pleasure to work with 15 fine experts in health, education, law, public policy and other fields who have dedicated their lives over the past 15 months to this effort. We have included leaders from medicine, dentistry and nursing, and have also reached outside of academia and health systems to include members from business, journalism, law and government to ensure a broad representation and thinking. Under charge from the Kellogg Foundation, this commission was formed to develop solutions. The Kellogg Foundation established this commission to be free from any institutional or bureaucratic restraints, and go directly to the public to get a closer look at what was keeping talented minority students away from the health professions. To complete this task, we traveled around the nation, we held six field hearings, we examined dozens of scientific studies and commissioned two papers to help better understand the problem and arrive at realistic solutions. We examined many individuals and organizations.

The problem of racial and health disparities, and the

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lack of minorities in the health professions are inescapably linked. The medical evidence is clear. Minorities in the United States have an increased incidence of disease and show less favorable health outcomes than whites. These disparities persist when you control for income and health insurance status. Health disparities resulting from the lack of a diverse and culturally competent workforce may be as great a problem for minorities as is the lack of health insurance for more than 44 million Americans. We know that minority physicians, dentists and nurses are more likely to serve minority and medically underserved populations, yet there continues to be a severe shortage of minorities in the health professions. Without more diversity in the health workforce our nation's minority populations will continue to suffer. There's a demographic imperative to act. Lack of action will put the health of one third of our nation at risk. This is an area where our nation once was making progress. Now, a new vision for healthcare must be articulated, one that focuses on excellence, and ensures high quality care for the entire population. Diversity is one of those keys to excellence.

As the charge to this commission was to develop solutions, we put forward 37 very specific and detailed recommendations. Each is realistic and each is achievable, if we have the will to act. Three overriding principals are essential to solving this problem. First, the culture of health

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profession schools must change. As our nation is changing, so too must our institutions for our future doctors, dentists and nurses and other health professionals. Our health profession schools must reexamine their practices. There's no place in this wonderfully diverse nation for a medical school class to have just one or two minority students. A culture that allows this to continue to happen is out of step with the realities in our country today. Second, new and non-traditional paths to the health professions must be explored. While there must be major improvements in our K-12 educational system, our health profession schools cannot afford to wait for a new generation of students. A range of options must be tried. From greater outreach to communities, to finding talented students, to developing new ways for junior colleges and continuing education programs to become a stronger pipeline into the health professions. Some of our best healthcare professionals have taken unusual paths to enter the health professions, including our current Surgeon General of the Public Health Service, and members of this commission. The system must work to encourage, not prevent this change. Finally, commitments must be made at the highest levels. Leadership is a key factor. It must come from federal, state and local leaders, as well as at the university and professional level.

Now, we've all been around Washington long enough to know that reports are frequent, and must be followed by

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specific actions if change is to occur. We intend to continue the work of this commission to spur those actions. I'm pleased to announce that this report has already been endorsed by a number of national organizations that can come together and make the kind of changes that we are recommending a reality. Two of these groups include the National Medical Association, the American Medical Association, the American Dental Association, the American Association of Colleges of Nursing, the Association of Academic Health Centers, the National Conference for Community and Justice, the National Council of Laraza [misspelled?], as well as medical, dental and nursing schools. And our outreach activities are just beginning. For those who may hope this commission or this issue will just slip away quietly, be forewarned: Silence is not an acceptable answer.

I'm delighted and honored by the support that this commission's esteemed honorary co-chairs have given. Senator Bob Dole and Congressman Paul Rogers. Senator Dole is with us today, and will address you shortly. And Bob, thank you for joining us this morning.

Congressman Rogers sends his regrets and asks that I read these remarks on his behalf. I met with him last week, and he expressed his regrets. Mr. Health himself has provided this commission with his wisdom and his guidance. As you know the Honorable Paul Rogers represented Palm Beach, Florida in

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the House of Representatives for 24 years before retiring in 1979 as chair of the House Sub-committee on Health and the Environment. Congressman Rogers is known for supporting the National Cancer Act, the Heart, Lung and Blood Act, the Health Manpower Training Act, and a host of other important laws promoting health. Congressman Rogers sends this message, and I quote: The Sullivan Commission has dedicated the past year to intense study and national activities on the issue of diversity in the health professions. An overarching fact remains clear: ongoing leadership must be provided to achieve diversity in the health professions. We know that change can happen and it must. History provides as strong example of the potential to effect change in the health professions. In 1964, the Cogeshaw [misspelled?] Report to the Association of American Medical Colleges sounded alarms of an impending shortage of physicians, noting that, and I quote, It is not likely that America will ever be able to produce all of the physicians that the nation would like to have, end of quote. The concept of shortage was reinforced three years later in the report of the President's National Advisory Committee on Health Manpower. These reports stimulated a number of actions by federal, state and local governments, foundations and private donors. These actions led to the establishment of a number of new medical schools and new opportunities to enter the health professions. It is time again to harness this resolve to expand and diversify the health

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professions to better meet the needs of the nation's changing demographics. We saw an impact of the Cogeshaw report in examining education in the health professions. With broad support from federal, state, private and educational institutions, the Sullivan Report is poised to have a similar impact in making our health professions more diverse and more representative of our nation's populations, end of quote.

I'm pleased that Senator Dole is with us, and on a personal note, when I came to Washington in 1979, he and his wife Liddy welcomed Ginger and me to Washington, and I learned a lot from his many years and his advice in Washington. I'm continuing to learn from him, and with his honorary leadership of this commission, I'm very pleased that he has shared his wisdom with us. Senator Dole, welcome.

**SENATOR BOB DOLE:** Thank you very much. Well. Lou, thank you very much, and thank you for your leadership, and the Kellogg Foundation. The program being administered by Duke University, which started way back in 1966 with its first black student and has now become a model. I'll pass that on to Elizabeth since she's a Dukie. I was just sitting here thinking, I read the executive report. I am honorary in the strictest sense of the word, and I plead guilty to having been a member of Congress for a long time and never addressing this issue. And I think Paul Rogers, as you said, was certainly known as Mr. Health when he was in the Congress, and I served

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as Chairman of the Health Sub-Committee on the Finance Committee. Having had a lot of experience as a patient, starting with spinal injuries and prostatectomy and a nephrectomy, I haven't got so many ectomies left, and a colectomy, and all these other things. In fact, I'm writing a book we publish next April on my five year recovery, learning how to walk, how to feed myself, all that kind of stuff, and I was just sitting here telling Geraldine that in all those years that I spent in Army hospitals, I can recall maybe a half a dozen Hispanic, Asian or black physicians attending me. I remember very well a black dentist who became a good friend of mine, and a black anesthesiologist who put me to sleep and woke me up again, [laughter] and more recently Colonel Williams who was in charge of Pain Management at Walter Reed Hospital. So you get a pretty good glimpse at just how bad the problem is taking a look at 40 to 50 years that I've been rambling around hospitals. But you see some little increase, at least on the nursing side. And that's not covered in this report, but having come from Kansas where we decided way back when Topeka vs. the Board of Education said separate but equal is not good enough, and that's precisely the problem we have here. There ought to be some economic affirmative action—I always thought it ought to be based on economics rather than race or gender, but—economic affirmative action where you can provide the scholarships and programs with the help of the local, the state

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government, and as you said, you've got to change the culture of the universities. There are a lot of things that need to be done, but it's not going to happen until somebody starts. I'm just very honored to be here with all these distinguished people, most of whom I have met in the past, and all the people in the audience, whom I assume are going to help make this happen. I confess, I don't know the record of the University of Kansas Medical School, but it could probably be improved. That's probably the same in other cases, but I volunteered to help. If you can help me raise 50 million for Bennett College, I'll be happy to help you here, and as we move forward trying to make this happen. I've got a lot of ideas, probably none of them very good, but I'm happy to continue to be helpful. And I want to thank you Lou. It wouldn't happen without you. Somebody has to provide the leadership, and you do pay a penalty for leadership. It takes a lot of your time when you could be doing other things. So I thank all the members of the committee, and particularly you.

**DR. LOUIS W. SULLIVAN:** Thank you very much for your leadership and your support of our efforts, and thank you for your remarks. We will now hear from the commissioners, and I know that Senator Dole has other commitments, so when you see him sneak out that's because he changed his schedule to be here. Thank you very much, Bob, for joining us.

I'm pleased that we have members of the commission who

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are with us this morning, and we will hear from them at this time. The first of them will be Louis Stokes, himself a former member of Congress who has provided much leadership on this effort over the years. So, Lou—

**THE HONORABLE LOUIS STOKES:** Thank you very much, Mr. Chairman. The call by the commission for a new vision for healthcare is predicated upon very startling data. African Americans, Hispanics and Native Americans, Alaskan Natives are severely underrepresented in the physician workforce. In the year 2000 the American Medical Association reported that African Americans represented only 2.6 percent, Hispanics 3.5 percent, and Alaskan Natives 0.001 percent of America's physicians. In 2004 the American Medical Association reported even lower statistics for African Americans, 2.2 percent, and Hispanics 3.3 percent. These startling statistics demonstrate a need for robust efforts to diversify the medical student population to address this trend. Concordant with this is the fact that although some increases have occurred in enrollment of underrepresented minorities in nursing and dental schools, the percentages of minority students enrolled does not reflect the characteristics of the current US population. At the same time racial and ethnic minorities, especially African Americans, Latinos, Native Americans and some Asian Pacific Islander subpopulations typically experience higher rates of illness, disability and premature death than whites.

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A finding of the Institute of Medicine Report of 2003, that these groups also clearly receive inferior healthcare, concurrently these same groups are and historically have been severely underrepresented in the healthcare workforce. At the turn of the 20<sup>th</sup> century the forerunner of today's healthcare delivery system comprised two separate and unequal systems, one for whites, and an inferior one for non-whites. The early periods of the US healthcare system set a tone which resonates even today, that America's healthcare professions were to be dominated almost exclusively by white and middle or upper-class citizens. The civil rights era brought about one of the most profound structural changes in the United States health system in the 20<sup>th</sup> century, while also leaving a considerable amount of unfinished business. Over the past few decades, significant progress has been made in improving minority access to the healthcare system. Still, in the 21<sup>st</sup> century, in comparison to whites, racial and other ethnic minorities continue to have low representation in the health professions, receive second-rate healthcare and die younger from treatable diseases. The legislation and political action in the 1960's did not alleviate these chronic problems. The last few decades have witness the publications of literally hundreds of pee-reviewed research studies. The findings are consistently the same: racial and ethnic groups receive inferior care. These racial and ethnic disparities in care have been documented across the

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three major health disciplines, medicine, nursing and dentistry. The publication in 2003 by the Institute of Medicine, entitled *Unequal Treatment* identified widespread treatment disparities across the full spectrum of disease categories and medical and surgical procedures. The report concluded that bias and stereotyping by providers significantly and directly contribute to minority health disparities. Thus, despite technological and scientific gains in addressing severe health problems such as heart disease, diabetes, kidney failure and cancer, not all segments of the US population have benefitted to the fullest extent from these advances. The evidence is clear, consistent and robust: if you are a racial or ethnic minority in America, there is a concrete and historically familiar risk that you will be subject to substantial diagnosis and treatment which may result in poor health outcome, including death. Thank you.

**DR. LOUIS W. SULLIVAN:** Thank you. Our next panelist is Attorney Eric Holder, who had a distinguished tenure as Deputy Attorney General, and we're very pleased to hear from him.  
Eric?

**ERIC H. HOLDER, JR.:** Thank you, Dr. Sullivan. I think I'd like to start by praising the leadership of our chairman. This is an effort that has been going on for the better part of a year in all different parts of this country. The thing that held us together in addition to the wonderful staff that we

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have, the glue in this effort has been Dr. Sullivan. These have not been easy things to do. We have a variety of people who come from a variety of different things that they do. It's not been easy to get to these meetings, and yet Dr. Sullivan has infused us with a sense that this was something important to the nation and for us personally. I just want to thank you, Dr. Sullivan, for your leadership in that effort.

For change to happen, it really comes down to one crucial factor, and that factor is leadership. Commitment in this effort must be at the highest levels. It has to come from federal, state and local leaders, as well as at the university and professional levels, as well as professional organizations. Often the commitment of a university president, chancellor or a dean has been instrumental in developing and implementing new policies and procedures, and at the same time have changed the cultures and attitudes that blocked diversity. It is the responsibility, we believe, of leaders of the organizations I talked about to set the tone for diversifying this profession as this nation prepares for the diversity, the demographic change it will be undergoing. By the year 2050, we all know that there will be more people of color in this nation than people who are white. We have to be prepared for that in this and in other professions. We have to be ready for that in this and other professions. This coming diversity, this coming demographic change can either be a positive factor if handled

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correctly, or it can be a divisive one. We have to call on our leaders to change the culture of the organizations that they head. They have to be prepared to deal with bureaucracy that will undoubtedly reflexively oppose change. They have to be willing to meet that opposition and enforce the change that is necessary.

The commission has made a couple of recommendations with regards to the notion of how important leadership is. The commission recommends the passage and funding of comprehensive state and federal legislation that will: One, ensure the development of diverse and culturally competent workforce, and Two, strengthen healthcare institutions that serve minority and underserved populations. Also, the Department of Health and Human Services should establish and report national standards and measurements for diversity and cultural competence in the health workforce and health professional schools in the Agency for Healthcare Research and Qualities National Healthcare Disparities Report.

Again, leadership is a key. We have put together what I think is a good piece of work that hopefully many people will read. But it is not enough at this point to simply be read and put on a shelf. People who call pull the levers of power in this area must look at this report and then come up with ways in which we can implement the recommendations that we have made. I want to make clear, and I hope the leaders will

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understand, this is not a black issue. This is not an Hispanic issue. This is not an Asian issue. This is an American issue that must be dealt with across this nation at all levels. We call on the leaders of the organizations and the institutions that will be touched by this report to read the report and to come up with ways to implement the recommendations that are contained in that report. Thank you.

**DR. LOUIS W. SULLIVAN:** Thank you, Mr. Holder. We'll now hear from Dr. Jeanne Sinkford, a member of the commission who's with the American Dental School Association. Dr. Sinkman.

**DR. JEANNE SINKFORD:** The American Dental Education Association. We changed it from the American Association of Dental Schools about five years ago. Good morning. I'm very happy to be here, and first of all, I would like to again, along with Dr. Holder's comment compliment Dr. Sullivan and the Foundation and everyone that was involved in this endeavor. It's the first time that we have come together, medicine, dentistry and nursing in a concerted effort to bring the problem of diversity to the nation. We have tried many ways individually to solve these problems. In fact, we've kind of kept it to ourselves. It's kind of been an in-house effort, and so many of the recommendations that we're making today don't reflect the effort that is already underway that has not been successful because of the barriers, racial, financial and cultural barriers that exist in this country that have

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prevented us from moving ahead with representation and also the access to careers in the health professions of many of our minority students. As Mr. Holder has already said, it's not just a minority problem. When we go to poor or low-income areas, the same kinds of barriers exist for those students that exist for minority students. So, the recommendations that we have here are very specific for medicine, dentistry and nursing, but they apply to all disadvantaged areas in this country. I think by raising it to a level of national attention and national focus, and the need for national resources, we will help the country in general, and the health of all Americans—borderline communities, Appalachian areas and those kinds of areas that are many times left out.

I want to focus on several issues now. Let me tell you about how important I thought the field hearings were to us. I've been in minority issues for a number of years. We made six field trips. We heard from community leaders, from churches, from legislators, from legal areas, and we heard from students, and all across the country they were asking us, please do something to help us. Help us with this K-12 deficiency that we have in this country that prevents our students from excelling and understanding that they can achieve and they can move forward. Get us science teachers in those classrooms that can teach science and are interested in science, and not in putting people in academic situations where they feel uncomfortable and

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they don't have the knowledge and don't have the skills to teach. Help us to bring this to a level that will not only help you as you are trying to recruit or prepare a pipeline of students, but also will benefit all students in those areas that are deficient at this time. We heard about the academic climate in schools, and we heard that from the students, the students in minority institutions that felt isolated, that the resources were not there for their intellectual development nor for their social things that are development as you are developing the rounded practitioners that hope to graduate in the future. Also the need for cultural competency in not only the curricula and in-patient care, but also in all kinds of services. Our students are challenged today to meet the needs of a diverse population. Our population is changing so fast, and we are not graduating enough nurses, dentists, and doctors to meet the needs that are right there today. When we look into 20 years from now when the minority groups will be the majority groups in this country, unless we move today, we will be seriously handicapped.

We looked at the admissions. One of the things that the educators in this room will be very concerned about was that we wrestled with the admissions, the over-reliance of admissions practices, the Dental Aptitude Test and the Impact Test as identifiers. We saw those as barriers to the concept of what we're trying to do for the future. Those tests are screening

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tests; they are not diagnostic tests for the effectiveness of practitioners. We're not saying to stop using the tests, period, what we're saying is that they are to be used along with other criteria for admissions. This is a challenge that is being addressed in some of the schools, but not nearly enough. It is consistently a barrier because minority students statistically had lower test scores than the majority.

Lastly, we are concerned with ways to expand applicant pools. We haven't looked at the community colleges of ways of finding students that have been marginalized because of the academic systems that they come from. They are in community colleges as a way of bridging, and we want to be sure that those schools are looked at as opportunities for our four-year colleges and universities and our medical and dental schools as feed our schools and bridging opportunities for us.

Last, second-career individuals - We know ourselves that many of our academicians and researchers came from, initially, careers that involved science and other university disciplines. We need some of those individuals that might be interested in health careers as individuals that we would actively recruit and welcome to our academic institutions and research environments. And though these recommendations are specific for medicine, dentistry and nursing, they apply to many other health professionals.

We hope that you will use this document. Share it with

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your academic communities, your private sector communities, and your professional organizations. We have pooled together so much information so that it is concise, understandable and adequately and effectively addresses the issues that we were charged with by the Foundation. Thank you very much.

**DR. LOUIS W. SULLIVAN:** Thank you. Dr. Geraldine Bednash is Executive Director of American Association of Colleges of Nursing and a member of the Commission. We will now hear from her.

**DR. GERALDINE BEDNASH:** Thank you very much, Dr. Sullivan. Good morning to all of you, and thank you so much for having come to be a part of this very important event, and what we hope is going to be the first step in addressing the major healthcare concern in this nation. I'd like to say a few words about finances, and the financing of the health profession's education. Unfortunately, the cost of the health profession's education has put the dream of becoming a health professional far beyond the reach of many qualified minority students unfortunately, that financial barrier serves as the final barrier to the dream of becoming a physician, a nurse, a dentist or other kind of health professional. One of the most important steps to diversifying student population is to remove these financial barriers to a nursing education or other health profession educations. Students interested in pursuing a graduate degree often point to the lack of funding as the

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primary reason for not pursuing additional education.

Scholarships, grants, loan repayment plans, fellowships and other funding streams are needed desperately to attract more underrepresented minorities to these professions. Senator Dole was correct this morning when he highlighted those as some of the major initiatives that have to be undertaken. The financial realities mean many low-income students who do graduate from high school do not plan to attend a four-year college or take the necessary qualifying exams for entrance into a health professional school. And those who do pursue their dreams for health professions education experience high unmet financial needs coupled with excessive loan burdens.

I'd like to highlight a few of the recommendations that have come from the commission and which we believe are important steps to overcoming this barrier. To reduce the debt burden of underrepresented minority students, public and private funding organizations for health professions students should provide scholarships, loan forgiveness programs and tuition reimbursement strategies to students and institutions in preference to loans. The idea of a loan burden and acquiring a loan debt is a tremendous psychological burden to achieving that degree as a health professional. Congress should also increase funding substantially to support diversity programs within the National Health Service schools in Title 7 and 8 of the Public Health Service Act, and such funding should also

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provide for the collection of data on diversity in the health profession. Baccalaureate and college programs that provide nursing programs should continue their efforts to link to community college programs to move the graduate programs to baccalaureate and graduate degree programs, but particularly, incentives should be provided to currently underrepresented minority nurses to advance their education and move into leadership roles to service the scholars and faculty for the future, to create those welcoming environments to bring people to the health professions. We look forward to the wonderful efforts that we know all of you who are here today will engage in in order to achieve the goals of the health professions workforce diversity that are embedded in this report. We thank you for your support that's inherent by seeing you here, and look forward to future works.

**DR. LOUIS W. SULLIVAN:** And now we'll hear from Dr. Patricia Gabow, who's Chief Executive Officer and Medical Rector of Denver Health. Dr. Gabow.

**DR. PATRICIA BAGOW:** Good morning. It has been an honor to serve on the Sullivan Commission on Diversity in the Healthcare Workforce to help address the urgent needs in our workforce. It is stunningly clear that we must quickly find these missing persons. As a CEO and Medical Director of an urban safety net institution and teaching hospital, I see the patient, provider and institutional issues the commission is

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trying to address. Like other urban safety nets, 70 percent of our patients are members of the minority community. For many of us in healthcare, there is a growing focus on quality. From the perspective of the minority community, quality has three aspects, access to care, lack of disparity in care, and cultural competence in care delivery. Every healthcare organization should commit to the concept that access to healthcare is the first essential step in achieving quality, and that an equally important aspect of equality is erasing disparity. Acting on the recommendations of the commission to increase diversity in the health professions will increase access, reduce disparity and increase cultural competence. As someone who has to hire health professionals, it is clear to me everyday that we have a major healthcare workforce shortage. To the extent that we find these missing persons and achieve a broader inclusion in our health professions, we will reduce this ominous shortage that is facing our nation and we will find new talent and provide better access and quality for everyone, including minorities. The presence of increased numbers of underrepresented minorities will create increased cultural awareness for all students, practitioners and faculty. This cultural awareness will deepen the patient/provider relationship and improve outcomes. The commission recommends all health professional schools must commit to increased diversity and leadership development for these new

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professionals, and improved cultural competence for all providers. By doing this, we will all be better abler to provide meaningful and excellent quality healthcare to our growingly diverse population and ensure the health of our entire nation.

**DR. LOUIS W. SULLIVAN:** Thank you very much, Dr. Gabow. Before proceeding to questions, I'd like to recognize the other members of the commission who are with us this morning. I'll ask each of them to stand to be recognized as I introduce you. First is Dr. Regina Benjamin, who is founder and Chief Executive Officer of Bayou La Batre Rural Health Clinic and former President of the Alabama Medical Society. Dr. Ben Mannelta, who is past President of the American Association of Indian Physicians. Dr. Mannelta. Mr. Tom Perez, Assistant Professor of Law, University of Maryland School of Law. Dr. Joan Reed, Dean of the Office of Diversity and Community Partnership, Harvard Medical School. And Dr. Elena Rios, President and Chief Executive Officer of the National Hispanic Medical Association. Also, I'd like to recognize Dr. Brenda Armstrong from Duke University, who was the principal investigator for this project. Dr. Armstrong. And we have with us this morning also, Dr. Luddy Bristow, who chaired the Institute of Medicine's report, released earlier this year, In the Nation's Compelling Interest. Dr. Bristow. Other commissioners who could not be with us today include Miss Helen

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Darling, President of the Washington Business Group on Health, Dr. John Rich, Medical Director of the City of Boston Public Health Commission, Mr. George Strait, Associate Vice Chancellor for Public Affairs, University of California at Berkley, Mr. Bill Weldon, Chairman and Chief Executive Officer of Johnson & Johnson, Dr. John Rowe, Chairman and Chief Executive Officer of Aetna, and Paul Rogers, I previously mentioned could not be with us today. I'd also like to recognize Mrs. Marguerite Johnson, who is Vice President for Health Programs for the Kellogg Foundation, and also who worked with us closely, Mr. Bob DeVries, formerly of the Kellogg Foundation. Bob. We'll now invite your questions. If you have a specific person you'd like to respond, please so indicate.

**MARSHA CLEMENT:** Marsha Clement, Medicine and Health. The White House Office of Management and Budgets for several years recommended zeroing out those Title 7 diversity in health professions diversity programs on the ground that they're completely ineffective, and I'm wondering if you have evidence that those diversity programs actually work, or are we just going to take it on faith and attempt to collect more data and see if they do? Congress has not thrown them out, but the White House has said they're ineffective.

**DR. LOUIS W. SULLIVAN:** I think there's no question, when you look at specific institutions who've made commitments. These programs do work. I think that what we need to have, to

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make change, however, is greater support for these changes around the country. And also within Washington, as you know, often there are games that are played between OMB and the Congress, with some programs being zeroed out in anticipation that Congress is going to make up for them, really for budgetary dynamics. I'm convinced they work. There is much evidence for that, so we indeed intend to emphasize that. Dr. Bristow.

**DR. LUDDY BRISTOW:** Thank you, Dr. Sullivan. I'd like to just make a very brief comment in response to that question. Not only have the studies demonstrated that there is significant efficacy associated with such efforts, the studies also show that there is a distinct value to having a diverse educational experience, so much so that it's been demonstrated, particularly at the undergraduate level, that student experience increased or improved democracy outcomes, and they also experience increased or improved intellectual outcomes as a result of their diverse experiences. And that improvement is directly proportional to the quantity and quality of the diverse experience they have. So there is hard evidence to show that to the extent that America does not avail itself of these opportunities, it is in fact holding itself back. That applies to all students, not just minority students.

**DR. WINSTON PRATT:** Thank you Dr. Sullivan. Dr. Winston Pratt, President of the National Medical Association, which

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represents the more than 30,000 physicians primarily of African American descent. Number of course should be more than 90,000, but that's an issue that you brought to bear. I want to thank you for preparing this report. I want to thank our honorary NMA physician, Dr. Louis Stokes and the other members of the panel as well. Dr. Sullivan, you've done a marvelous job in preparing this document, and it's a compilation of the issues that the NMA has tried to bring to bear in its hundred-year history. But as you know, we don't need more rhetoric, we don't need more reports. We need to put teeth behind the Sullivan Commission Report to assure that the recommendations become reality. And I say that because as you present your report, the powers that be are polishing the chain to close one of the four remaining historically black medical colleges, Charles Drew in California. So, the teeth behind the report has to create a venue by which our federal government and others can make that not happen. Now the other historically black medical colleges in themselves are strained in their budgets and their capabilities, and it may be a matter of time before they are threatened with closure. We cannot afford that, and so my question to you would be, have the Presidential candidates been given an opportunity to respond to this illustrious report and to tell us what they plan to do to assure that this becomes a reality? Thank you.

**DR. LOUIS W. SULLIVAN:** Thank you for that question.

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Indeed, among our recommendations, in response to your question, a recommendation that those institutions that have been very remarkable in having significant minorities in their classes should be supported. We worded it that way, because we are speaking not only of the African American medical schools and other health profession schools and Hispanic serving schools, those institutions that have made significant commitment to address this issue. So we are recommending that those institutions that have programs that they have demonstrated that work, they should be supported. We have not presented these recommendations as of yet. Certainly, they will have the opportunity to respond to them, but in addition to those, we will be presenting these recommendations to the members of Congress, the state legislatures, as well as private sector organizations, because we emphasize in our report that for this change to occur, we need to have a broad commitment of all elements in our society, business community, the foundation community, individuals, state and local government, and the federal government. In other words, this is an issue that the solution demands buy-in and participation by all segments of our society. It's not someone else's problem, it is our problem, wherever we are. It is for us to find solutions to address this. So our 37 recommendations, plus the recommendations from the IM committee by Dr. Bristow really should be implemented, and when I stated that we will be

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following the release of this report with action, those actions are designed to inform all segments of our society that this is the problem that exists. Too many people believe that this is a problem that was solved 10, 20, 30 years ago when in reality it has not been solved. We believe that educating the public and getting buy-in and demanding action by all segments of our society is the way to get our results, so that's how we intend to proceed.

**JULIET CHOY:** My name is Juliet Choy and I'm with the National Asian Pacific American Legal Consortium. As the medical community is aware, in fact the medical community is pushing more for this, which is more research around the health needs for Asian Americans, and we had this discussion around health disparity. In terms of evidence there was a push for disaggregating the data specifically for the APA community. In reviewing the commission's report, I understand that there has been discussion around pushing the medical schools to consider modifying their admissions processes in order to build that pipeline to address that diversity of our citizens today. I wonder if the commission could discuss—I don't know how aware the audience might be, but with regard to medical school admissions, Asian Americans are typically considered part of the Caucasian pool—so when we're talking about systemic reform in terms of building the pipeline, could the commission address what efforts it is expending in terms of continuing that dialog

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with regard to modifying medical schools' admissions, and if there isn't enough progress, if you could perhaps offer some recommendations as to what next steps we could take? Thank you.

**DR. LOUIS W. SULLIVAN:** Thank you very much. Let me invite my other commission members who might want to comment on that.

**DR. GERALDINE BEDNASH:** One of the points that we made in the report is the fact that there's tremendous diversity represented within the Asian community. This was a point that was made over and over, and I believe what you're referring to is the fact that in some instances, Asians are considered over-represented in some professions in terms of their representation in the entire demographics of the US. In fact, we made a strong effort in our report to say that that's really a very narrow view of the diversity represented within the Asian community, and we urged strongly that all health profession schools look more closely at the diversity within a variety of racial or ethnic groups, and not look in simplistic ways at meeting the needs of those communities, or bringing those individuals into the health profession schools.

**DR. LOUIS W. SULLIVAN:** Mr. Perez has a comment.

**MR. TOM PEREZ:** Good morning. When we were in Los Angeles we learned a lot about the issue that the questioner is raising. We heard from a representative from the Pacific American Legal Center who talked about the issue of under-

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representation in API communities. That's an issue that's not unique to California. If you go to Wisconsin and you look at the burgeoning Mung community and the need to have a workforce that reflects the diversity of that community. That was front and center in our debate. I know a colleague and friend of mine, Charlie is in the corner of the room there, with the AAMC. The AAMC has been looking at this situation for a number of years and underwent a very exhaustive and inclusive effort to redefine the definition of underrepresented minorities, because frankly the old definition worked perhaps for 35 years ago, but it doesn't reflect today's America. And the AAMC recognized that and put a very exhaustive process that I believe has led to a new definition that we were well aware of in our deliberations, and have embraced. When we're talking about these diversity issues, we're talking about diversity broadly defined as a result of the AAMC and other leadership in this area.

**DR. LOUIS W. SULLIVAN:** Mr. Holder.

**ERIC H. HOLDER, JR.:** Just a brief comment. One thing that we want to make sure that people understand is that we do not see this diversity effort as a zero-sum game, that is, if one group wins, some other group must lose. Our view is that is if we encourage diversity, if we get our leadership behind this notion of diversity we will all win and our society will be better for it.

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**DR. LOUIS W. SULLIVAN:** Thank you. Question. Oh! We'll come to you next. Yes.

**MALE SPEAKER:** [Inaudible, off-mic] Association of American Medical Colleges, Vice President for Division of Diversity, Policy and Programs. In answer to the recent question, I suggest that in medical education, admissions policies have been changed significantly to look at students holistically. I do think that MCATs provide, certainly a barrier to those underrepresented in medicine just because we typically do not do as well on those exams, but in really 20 years on the admissions committee at a well-known medical school in this country, I know that we did everything that we could possibly do to admit students with MCATs that we would have liked to have seen higher, and I think this is more common than not. I wonder if K-12 victimization has as much or more to do with where we are than a whole series of institutional policy level decisions. One of the things that I commented on in Chicago when I spoke before the commission is that I think that as a community we're going to have to start taking more of a responsibility for where we are, looking at some alternate pipelines, like pipelines to the prisons, pipelines to sports, pipelines to entertainment, and look at our own values and choices, and make sure that we bring a group of people to the table to these health profession institutions that are undeniable when they get there. I think we have to do much more

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there, but certainly at the AAMC we're going to continue to provide extraordinary leadership.

I'd like to add to that comment the fact that in the commission's report we emphasized the fact that there must be much more interaction between all segments in the educational pipeline, much more bridging between the colleges and high schools, between colleges and community colleges, and we particularly note that the community college community needs to be particularly involved in this process. Just about ten days ago, I happened to be in Richmond, Virginia being part of a unique program there I'd like to comment on. I think we have somebody here from the University of Nebraska who's a part of that. Virginia Commonwealth University and the University of Nebraska have formed an alliance with the five historical black colleges and community colleges in Richmond to bring more minority students into those medical schools. I'm sure this will also benefit other medical schools by forming a consortium to indeed work closely together. I learned that in the state of Virginia, 63 percent of students in college are in community college, and was told that the percentage of minority students in the community colleges was higher than the baccalaureate four-year institutions. We need to indeed find ways to tap into that resource. That is one of the things in our report that we emphasize. I think there's a question here.

**MILAGROS BATISTA:** Exactly my point. My comment and my

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conversation is around the issue of the missing voices in the community that I think that he brought up. We presented in New York two programs, a pipeline program in a very active community, major neighborhood, poor neighborhood where teaching universities are very present, but we don't receive, the communities do not receive much of the benefit those institutions should receive. I was going to ask you, what are your recommendations to make sure that all those teaching hospitals that are in poor communities respond and involve better the community that is immediately affected by their institution being in the community? And that could be research being done in the community, and also that our members of the community should be directly recruited by those institutions or assisted to become health professionals. I think we presented two group programs that should have been highlighted in your recommendation, of how active we are in making sure that cultural diversity really happens in the real sense. WE are part of the culture of that community. We should be linked in the teaching hospitals and that we should be looking at what is happening in the immediate neighborhood. I would like to know how you are going to make sure that those institutions that are receiving a lot of federal and foundational resources, really, really employ and do what they say they are to do for those communities.

**DR. LOUIS W. SULLIVAN:** Thank you for that question. As

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you know, I did mention already the recommendation that those institutions that are shown a real commitment to addressing this issue should indeed receive significant support, but in addition to that, we recommend that accrediting bodies should also look at this issue as they accredit programs, whether they are undergraduate health professions programs in medicine, dentistry and nursing, but also residency programs as well, to see that not only the health staff in those institutions, but also the administrative staff and the faculties also are culturally diverse. So that is among the things that we are recommending to see that the community benefits. Plus, as you know, if we are successful in increasing the number of minority young people trained in those institutions, the data are already there showing that they are much more likely to end up providing services to those communities and practicing in those communities. So there are a number of actions that we are recommending that would really impact that in the way that you suggest.

**MILAGROS BATISTA:** Excuse me, I'm sorry. I just need to say my name. Milagros Batista, and I represent the Community Fellowship to Increase Diversity in the Health Profession. It's a [inaudible] in New York City. Thank you.

**DR. LOUIS W. SULLIVAN:** We have time for two more questions, and then I want to hear from Miss Marguerite Johnson. Yes? That's Dr. Rios.

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**DR. ELENA RIOS:** Dr. Sullivan, in response I just wanted to make the case for the importance of the community and the health professional associations that are in the community, our community dentists, our community nurses that are not part of the institutions of academic health centers. We recognize in the report the importance of the partnership that needed to exist, that really needed a national agenda, that this health professionals diversity isn't going to happen just with federal support to a few institutions. There really needs to be an embracing of all of us getting involved in the health sector, whether it's the community, the business sector, the foundations, and that we start developing public/private partnerships at the local level that make more sense to that local community building its own pipeline. We have to grow our own. Also, for the Latino community specifically, we did put in recommendations for cultural competence, limited English proficiency and the need for more of our community leaders, like yourselves to be a part of the pipeline effort.

**DR. LOUIS W. SULLIVAN:** Thank you. Thank you, Dr. Perez, and then. . .

**FEMALE SPEAKER:** Hi. As has already been said, thank you so very, very much for this report. I think we've gotten to the point where a challenge, I guess, to ask whether this commission, given these recommendations are in a position to actually oversee the implementation of these recommendations,

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so that we will begin to make the changes and see the diversity on all levels that is necessary?

**DR. LOUIS W. SULLIVAN:** Thank you very much. The first response I'll give to that is, the members of this commission, as well as the members of the committee of Institute of Medicine, chaired by Dr. Bristow, have been polled and have indicated not only their willingness, but their enthusiasm to follow on activities. Indeed, we are hoping to do just that, but we will be hearing more about that later. Yes?

**UMBERTO BROWN:** My name is Umberto Brown. I'm part of the same coalition, and I'm the Director for Initiative for the Arthur Ashe Institute of Urban Health in Brooklyn, New York. My question is more about the linkage and the concept of partnership. We have a science academy where we help train high school students in the sciences. One of the things that we think is fundamental is commitment from the universities to strengthen the programs in the high schools in their communities, in which there's a gap. If you look at New York City, the quality of education in the public schools has deteriorated, and you see thousands of people forming a line for gifted schools with limited access availability. We think that that's of [inaudible]. And we have heard through some conversations where the concept of pipeline is considered a failure. We think that we have not invested enough at that level of education where in junior and senior high school,

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where you need to strengthen and invest, and get commitment. I really believe that we recommend that besides recommending that we create a plan of action that determines some kind of timeline for outcomes, because in most communities, people report their recommendations and there's strong failure of implementation, and that limits the community and the families and the parents to get involved, because they don't see a plan of action and a viable possibility with a timeline. Thank you.

**DR. LOUIS W. SULLIVAN:** Thank you very much. Certainly among our recommendations is just what you specifically noted. That is, institutions need to link with their communities on creating pipeline programs. We certainly support you there.

I'd like to simply acknowledge the presence of two people and ask Miss Marguerite Johnson to come forward. I'd like to acknowledge Dr. John Ruffin who's head of the Center for Minority Health and Health Disparities Research at NIH, which is mentioned in our report as one of those institutes that should get additional support because of the tasks they are carrying out which helps to address this. Dr. Ruffin, thank you for being with us. Then, Dr. Roger Bulger, who is President of the Association for Academic Health Centers is here. Dr. Bulger, thank you for joining us. Now, Miss Marguerite Johnson.

**MARGUERITE JOHNSON:** Good morning. It's my pleasure to join you on this important occasion for advancing diversity in our nation's healthcare workforce. I bring best wishes from the

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Board of Trustees and the staff of the W.K. Kellogg Foundation in Battle Creek, Michigan. We express our sincere thanks and appreciation to Dr. Sullivan and to all of the commissioners for the time and dedication to the many tasks essential for producing this thoughtful report. We also want to thank Duke University and its staff for administering this national effort over the last 18 months. The Kellogg Foundation's interest in addressing issues of racial and ethnic diversity in medical professionals is long-standing, and yet despite our best efforts and our millions of dollars of best efforts, the numbers of students from underrepresented and underserved communities for minorities available for service in the health profession systems has not notably increased since the 1950s. In medicine, nursing, dentistry and health administration the numbers have decreased, especially in the last five years. And yet, our population here in the US continues to become more increasingly diverse. So it's a sad fact that the access to and the quality of healthcare has lagged behind for populations of color. Now, it's not just a problem for communities of color. As has been said earlier, this really is a problem for the nation because after all, it's a fundamental truth that the health of each depends on the health of all, and the health of all depends on the health of each. Two years ago, in collaboration with Dr. Sullivan and six other foundations, we explored and analyzed how these issues could be realistically

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addressed, and this led Kellogg to award \$4 million for a series of efforts, including the initiation of the Sullivan Commission, which as you know is a free-standing commission in the public domain administered through Duke University. Other grantees in this effort include community Catalyst in Boston, the Institute of Medicine, and the Public Health Institute in Berkley, California. Now, we challenged these groups with not only examining the existing body of research and looking at successful programs that exist, but we also challenged them to having hearings and town meetings to get input from educators, providers and healthcare consumers, because after all, it's been said here earlier, it really is the broader community that we are all accountable to. So hearing that community voice is crucial in doing this work. So we're very pleased that the commission has become the central entity in a multi-pronged approach across America to advance the recruitment, admissions, retention and completion of education for those critically needed, underrepresented minorities in the major health professions. And now, with this report in hand and about to be broadly disseminated, we look forward to working with the principal stake holders, the universities, governments, national associations, consumer advocates, accrediting bodies, funders and businesses to carry out a plan of action to make this report into a reality. I congratulate the commission for a most thoughtful, constructive report, and for its deep

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commitment to the public good. We thank you. We thank all of you for your efforts to help us in the fulfillment of our mission and of Mr. Kellogg's vision to help people to help themselves. Thank you very much.

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