



# Closing the Gap

## Putting the Right People in the Right Places

### *Minority Health Professionals Serve Community Needs*

By Nicole Lurie, MD, MSPH

**R**ecruitment, retention, training, and promotion of racial and ethnic minorities within the Nation's health professions workforce will not only help eliminate disparities in the health care received by minorities, it will improve the health of *all* Americans.

Racial and ethnic minority physicians are, in general, more willing to provide care

to poor patients who find themselves with no insurance or public insurance such as Medicaid, according to a recent survey of U.S. medical school graduates. The survey also revealed that almost one-half of underrepresented minority graduates, compared to less than one-fifth of their non-underrepresented counterparts, indicated that they planned to practice in an underserved area. These professionals fill a great need. Underserved communities with high proportions of Black and Hispanic residents have been described as four times as likely as others to have a shortage of physicians.

Research also shows that minority physicians are more likely to practice in areas where a high percentage of residents come from racial and ethnic backgrounds which are similar to their own. A 1996 study I co-authored in the *New England Journal of Medicine* with colleagues from the University of California, San Francisco, titled, "The Role of Black and Hispanic Physicians in Providing Health Care for Underserved Populations," found that Black physicians practiced in areas where the proportion of Black residents was nearly five times as high as in areas where other physicians practiced. Similarly, Hispanic physicians worked in communities with twice the proportion of Hispanic residents when compared to their non-Hispanic colleagues.

This willingness to care for minority populations in underserved areas may stem from attitudes of social responsibility held by underrepresented minority medical students. The Association of American Medical Colleges (AAMC) reported that 67 percent of underrepresented minority medical school students strongly agreed that physicians are obligated to care for the poor, compared with 56 percent of others. These attitudes translate into

voluntary placement of underrepresented minorities in underserved areas at the time of graduation. For example, 1993 AAMC data indicate that among graduates planning generalist careers, 60 percent of underrepresented minorities intended to practice in underserved areas, as opposed to 24 percent of others.

Minority physicians can also bridge linguistic, cultural, and historical barriers that hamper access to care. According to the 1990 census, 25.1 percent of Asian Americans, 23.8 percent of Hispanics, 4.5 percent of Pacific Islanders, 4 percent of American Indians/Alaska Natives and 0.9 percent of Blacks were linguistically isolated. The number of people with limited or no proficiency in English is growing, with the 1990 census indicating that 14 percent of people in the U.S. over age five spoke a language other than English at home, as opposed to 11 percent in 1980. For optimal communication, it is usually better if the patient and provider speak the same language; bilingual/multilingual translators are only a second-best, and often unachievable alternative.

This issue assumes importance when one considers the grave consequences of medical miscommunication, in that physicians could miss diagnoses or patients could become

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#### Minority Health Perspective

See the Web version of this issue for an article on NIH programs in health professions development. Visit our Web site: <http://www.omhrc.gov> and look under "What's New" for a list of current Closing the Gap issues.



OFFICE OF PUBLIC HEALTH AND SCIENCE  
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# HRSA Opens Doors for Minorities in Health Professions

By Claude Earl Fox, MD, MPH

The Office of Minority Health Resource Center (OMH-RC) provides free information on various health issues affecting U.S. minorities including cancer, heart disease, violence, HIV/AIDS and diabetes. The center also distributes information on funding sources for minority health programs.

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**D**isparities between the health of racial and ethnic minorities and Whites persist for a complicated interplay of causes, some of which medical science does not yet know or understand.

But one cause is very clear: inadequate access to quality health care, particularly preventive and primary care. Uneven access to care is known to be more of a problem for racial and ethnic minorities, who tend to earn less, to be uninsured, and to live where health care professionals are scarce.

The good news is that the Health Resources and Services Administration (HRSA) is helping to change this through a range of programs that improve access to health care for underserved people.

Because one obstacle that stands in the way is financial, HRSA supports health centers, Ryan White Comprehensive AIDS Resources Emergency (CARE) Act programs, maternal and child health services, and other health care efforts that care for people regardless of their ability to pay.

But access is a matter of more than money. It's also having the right people in the right places. In our increasingly diverse nation, that means making sure we have racially and ethnically diverse health care providers at work in underserved communities, where minorities are more than half the population.

Minority physicians, nurses, and other health professionals are two to five times more likely to care for minority patients than their White counterparts. Only about 10 percent of health professionals are African American, Hispanic, American Indian, or Alaska Native. To assure access to essential health care for racial and ethnic minorities, HRSA also mounts an aggressive effort to bring racial and ethnic minorities into the health professions, including primary care medicine, nursing, dentistry, allied health, and public health.

### *Opening doors for young minorities*

It was in high school that Martha Laura Aleman discovered science. St. Mary's University sent students and faculty to her school in Kingsville, Texas. The goal: to challenge students like Martha to excel in subjects that can open doors to health careers. For three years, she participated

in the St. Mary's program and set her sights on medical school. Although she and her mother always struggled to make ends meet, Martha realized her dream and entered the University of Texas Medical Branch in Galveston in 1995.

When she graduates this year, she and her husband, Mario Esparza—also a participant in the St. Mary's program and a medical student in Houston—will try to practice medicine in a way that inspires other disadvantaged, minority students to take similar career paths.

Before minorities can become health professionals, they have to become health profession students. This is a feat often more difficult for racial and ethnic minorities and students from economically disadvantaged backgrounds. Math and science requirements are demanding. Test scores must be high. Students have to be motivated. They also have to believe they can succeed.

To give promising minority students a boost in both academics and confidence, HRSA's Bureau of Health Professions' 132 Health Careers Opportunity Programs (HCOP) bring health professions schools into high schools and undergraduate programs. Students meet minority health professionals, learn about the rewards and opportunities in health care careers, and participate in intensive academic enrichment programs that prepare them for the rigors of course work and clinical training. Last year, more than 6,000 students participated in HCOP. Their acceptance rates into health professions training were 20 percent above the national average.

Minority communities wanting to "grow their own" health professionals, look within themselves through "Partnerships for Health Professions Education." In seven regions that are predominantly African American, Hispanic, American Indian, Native Hawaiian, or Pacific Islander, health professions training programs work together with local health care providers, schools, and other partners.

Beginning in elementary school, the partnerships build awareness of health professions and make sure minority children see minority health care providers in action. Summer science programs and camps, even health care magnet school programs

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encourage and prepare young people for health professions training.

### *Preparing schools, not just students*

While helping minority students prepare for health professions training, we must also help health professions schools prepare to educate a diversity of students. Culturally competent curricula, community-based clinical training, and racially and ethnically diverse faculty all create a favorable environment for minority students.

Just four percent of faculty at U.S. health profession schools are minorities. One remedy: HRSA's Minority Faculty Fellowships, which last year enabled two medical schools to train two minority individuals for faculty positions in their departments of family medicine.

Of course it's also important to create change on a larger scale and make recruitment and retention of minority faculty and students a front burner issue at training programs across the Nation. That's why HRSA's Bureau of Health Professions support 22 Centers of Excellence programs that increase the capacity of training programs at Historically Black Colleges and Universities, Hispanic Serving Health Professions Schools, and programs that serve concentrations of American Indians, Native Hawaiians, and other minorities.

Centers of Excellence are models of infusion. They recruit and retain minority faculty and students, carry out research specific to racial and ethnic minorities, provide culturally appropriate clinical education, and develop curricula and information resources that respond to the needs of minorities.

### *Centers of Excellence make a difference*

**Florida A & M University College of Pharmacy and Pharmaceutical Sciences:** The school's Center of Excellence promotes career opportunities in pharmacy to African American high school students and counselors throughout Northern Florida. African American students in the pharmacy program are matched with mentors. Faculty and students also work together to conduct research on pharmacy in the African American community.

### **University of California at San Diego:**

The Center focuses on increasing the number of Hispanic students and faculty in its school of medicine and forging a strong link with nearby Hispanic neighborhoods. The Center promotes science studies among Hispanic middle and high school students, provides primary health care in community-based clinical training sites, and conducts research into the health issues that affect Hispanics.

**University of Washington School of Medicine:** American Indian traditional healing and modern medicine complement each other in the classroom and clinic. Students serve clerkships at rural and urban providers that primarily serve American Indians. Fellowships support American Indian physicians' research and prepare them for academic careers.

### *Critical links: scholarships and loans*

Disadvantaged minority students who dare to dream of enrolling in health professions still need one more link to complete the chain. To make the connection between student and school, HRSA provides financial assistance in the form of scholarships and loans to disadvantaged students. HRSA's National Health Service Corps places health care professionals in underserved areas, where they fulfill a service commitment in exchange for tuition assistance or student loan repayment.

Students who overcome financial barriers to health professions training, we have found, are much more likely to work in medically underserved areas and care for underserved people. Patients report that these health providers also understand firsthand how cultural and economic differences affect health. Two programs, "Exceptional Financial Need Scholarships" and "Financial Assistance for Disadvantaged Health Professions Students," cover the full costs of medical and dental education, including tuition, fees, and related expenses, for students with exceptional financial need. In fiscal year 1997, 1,060 scholarships were awarded. More than half (57 percent) of the recipients were minorities. In exchange for their scholarships, students commit to at least five years of primary care practice.

The National Health Service Corps also awards scholarships for medical, nurse practitioner, nurse midwife and physician assistant training in exchange for practicing primary health care in shortage areas upon graduation. In fiscal year 1998, 34 percent of the 326 students who received Corps scholarships were minorities. More than 2,000 Corps providers are currently caring for underserved people.

Also, in exchange for service in shortage areas, the Corps offers a loan repayment program. In 1998, 33 percent of the program's participants were minority physicians, dentists, nurse practitioners, nurse midwives, physician assistants, and mental health providers. HRSA's Bureau of Health Professions makes low-cost loans to disadvantaged health professions students directly or through participating primary care training programs. More than a third of these loan recipients are minorities.

Health professionals may also receive help from HRSA in repaying their student loans. Physicians, dentists, veterinarians, optometrists, podiatrists, pharmacists, nurses, and public health professionals who have not served as faculty in a training program within 18 months may contract to serve as faculty for at least two years and qualify for loan repayment or faculty fellowship.

This year, HRSA will invest \$416 million in health professions training to increase diversity and improve distribution. This relatively small investment will yield more than 10,000 new health care providers who are attuned to the needs of racial and ethnic minorities. The high quality care they provide, the role models they become, the cultural sensitivities they possess—these are the vital connections needed to eliminate racial and ethnic disparities in health in the next century.

*For more information about HRSA Bureau of Health Professions training programs, visit: <http://www.hrsa.gov/bhpr>, or call 301-443-2100. For information on the National Health Service Corps, go to <http://www.bphc.hrsa.gov/nhsc>, or call 1-800-221-9393.*

*Dr. Fox is Administrator of the Health Resources and Services Administration, U.S. Department of Health and Human Services.*

# Project 3000 by 2000: Expanding Our Network

By Herbert Nickens, MD, MA, and Timothy Ready, PhD

Just 35 years ago, U.S. medical schools were as racially segregated as most other institutions in American society. Ninety-seven percent of medical students were non-Hispanic Whites. As recently as 1964, only 2.2 percent of the 32,000 students enrolled in the nation's existing 83 allopathic medical schools were Black. The two Black medical schools, Howard and Meharry, enrolled three-quarters of these students.

This meant that on average, each of the other 81 schools enrolled only one Black student every other year. In 1971, the first year for which there are data on minority groups other than Blacks, only 19 Mexican American, 14 mainland Puerto Rican, and 2 American Indian physicians graduated from U.S. medical schools.

## *Moving toward diversity*

In the 1960s we agitated for civil rights, and there were urban riots. But it was Martin Luther King's assassination that was the catalytic event that led to greater racial/ethnic diversity in medical schools. At the 1968 annual meeting of the Association of American Medical College (AAMC), medical students, faculty members, and administrators successfully pressed for the creation of a task force to set goals for minority enrollment and recommend strategies to achieve those goals.

Private foundations and the federal government provided broad support for programs directed at increasing the number of minorities in medicine. Enrollment of minority medical students increased from approximately 3 percent of new entrants in 1968 to almost 10 percent in 1974.

As minority enrollment rose in the early 1970s, a backlash occurred not unlike the one we are experiencing now. There were charges of reverse discrimination and lawsuits that had a chilling effect, such as the De Funis and Bakke cases. Though it is difficult to prove cause and effect in these matters, we do not believe that it was a coincidence that minority enrollment in medical schools leveled off in the mid-1970s at about nine percent. There it remained until we began organizing Project 3000 by 2000.

The name Project 3000 by 2000 derives from our goal: to enroll 3,000 underrepresented minorities annually in U.S. allopathic medical schools by the year 2000. Underrepresented minorities by AAMC's definition are Blacks, Mexican Americans, mainland Puerto Ricans, and American Indians and Alaska Natives.

Achieving our enrollment goal would mean that we had reached approximate population parity for underrepresented minorities, those racial/ethnic groups that had historically been denied economic and educational opportunities. This goal is not new, but it has been embraced by the AAMC since 1970. Our intention was to energize people around this initiative and emphasize the need for accountability.

## *Getting to the root of the problem*

We set about analyzing past strategies to determine why they had not been more successful. Our conclusion: The programs put in place in the late 1960s and 1970s, while helpful and necessary, were insufficient to address the primary problem. That problem is the failure of our nation's K-12 schools and our colleges to produce a sufficient number of academically well-prepared minority students.

Data from the U.S. Department of Education's National Assessment of Education Progress (NAEP) starkly demonstrate this problem. NAEP measures the academic skills of our young people at several ages and in various subject areas. The data aren't pretty.

There are substantial racial/ethnic gaps in average scores. Even more alarming are the disparities in the percentage of Black, Hispanic, and White students who demonstrate advanced academic skills. This is especially troubling because these are our future physicians, dentists, and other health professionals.

One can estimate the number of students from various racial/ethnic groups with high-level academic skills by examining the percentage of 17-year-olds who score 350 or higher on the NAEP science exam—13 percent of Whites, 1 percent of Blacks and 2 percent of Hispanics. Data are not available for American Indians.

By multiplying these percentages by the number of 17-year-olds in each of those groups, we estimate that there are about 334,000 White 17-year-olds with advanced skills in the sciences, compared to only about 3,500 Blacks and 4,500 Hispanics. And it gets worse.

Because students who do well in science also tend to do well in other subjects, these numbers not only give us some fix on the small pool of high school students who are ready to pursue science-based careers, it also reflects the small number of students who have the level of academic skills needed to succeed in law and business schools or earn doctoral degrees in liberal arts and social sciences.

As we grappled with troubling statistics such as these, we concluded that any socially responsible and effective new program intended to increase minority enrollment in medical schools must address these fundamental academic shortfalls.

## *Launching Project 3000 by 2000*

The underlying premise of Project 3000 by 2000 is that we must increase the number of students who are both interested in medicine and academically prepared for medical school. We also believe that massive new resources are not necessarily required to address this problem. What is required are leadership, vision, and a willingness for educational institutions and community organiza-

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tions to collaborate.

We must ensure that many more minority students are exposed to school, home, and neighborhood environments in which high academic achievement and high career aspirations are valued and expected. We must nurture interest in health careers and monitor the academic performance of both students and educators.

We launched Project 3000 by 2000 in 1991 with a series of workshops for medical school deans. Starting with the deans was essential because the Project's success depended on setting institutional priorities, and on the ability of medical schools to secure similar commitments from leaders at partner institutions.

Despite the fact that the medical schools had no external funding to implement the project, all of our deans signed on. Within a few months, virtually every medical school had appointed a Project 3000 by 2000 coordinator. During the early years of the Project, the number of underrepresented minority matriculants increased from approximately 1,500 to more than 2,000, in part aided by an overall increase in the applicant pool. Although these early gains were not directly attributable to the new initiatives launched under the auspices of Project 3000 by 2000, they almost certainly are attributable, at least in part, to the high visibility given to the cause of diversity in medicine.

As the number of Project 3000 by 2000 initiatives targeting middle and high school students grew, it soon became apparent that these youngsters needed to be exposed to a wider array of health professions. We also realized that all of the health professions essentially draw from the same pool of high achieving students.

As a result, we began to collaborate with national organizations representing dentistry, nursing, osteopathic medicine, and others, and urged them to "buy in" to the Project 3000 by 2000 "pipeline" model. In 1994, the Robert Wood Johnson Foundation provided funding to support a "multi-health professions" grants program called the Project 3000 by 2000 Health Professions Partnership Initiative (HPPI).

### ***In memory of Dr. Herbert W. Nickens (1947-1999)***

*The Office of Minority Health (OMH) extends condolences to the family of Herbert W. Nickens, MD, the first director of OMH and the late vice president in the division of community and minority programs at the Association of American Medical Colleges (AAMC). Dr. Nickens died unexpectedly of a heart attack on March 22, 1999. He was 51.*

*At the AAMC, Dr. Nickens established ground-breaking programs that address the need for minority physicians and improvement in minority health. Dr. Nickens graduated from Harvard College in 1969 and received a medical degree from the University of Pennsylvania in 1973. From 1978 to 1986, Dr. Nickens was assistant professor of psychiatry at the University of Pennsylvania School of Medicine. In 1982, he began a series of federal appointments with the National Institutes of Health, rising in 1985 to director of the Office of Policy, Planning, and Analysis of the National Institute on Aging. In 1986, he became the first director of the HHS Office of Minority Health, and served in the post until joining the AAMC in 1988.*

*Dr. Nickens is survived by his wife, Patrice Desvigne-Nickens, MD, and their two daughters, Caitlin Marie and Chloe Chambliss. AAMC has established a memorial fund in tribute to Dr. Herbert Nickens. Checks may be mailed to AAMC-Nickens Memorial Fund, Attention: Richard Helmer, 2450 N. St., N.W., Washington, D.C. 20037.*

*We at OMH are very grateful to Dr. Nickens for contributing this article, which we received just days before his death. We will miss him.*

And in 1996, the W.K. Kellogg Foundation joined in supporting the HPPI. When grants from the third funding cycle of the HPPI are awarded in February of 2000, we expect that there will be 26 funded HPPI partnerships across the country.

### ***Up against the backlash***

We are often asked, "Will you reach 3,000 by the year 2000?" The short answer is "No." We will not reach our matriculant goal of 3,000. As happened 20 years before, we are now witnessing a backlash against initiatives designed to enhance racial and ethnic diversity in higher education and in the professions. Court cases with new names like Hopwood and Aadarand, and in a new wrinkle, Proposition 209 and Initiative 200, stir up resentment with accusations of reverse discrimination.

Yet America's fundamental challenge of persistent racial disadvantage and inequality, so eloquently described 55 years ago by sociologist Gunnar Myrdal in the classic, *An American Dilemma*, persists as we enter the new millennium. Although much has changed in America, we are nowhere near eliminating the gaping racial disparities in health and education that have plagued our nation.

It is these disparities that Project 3000 by 2000 programs will continue to address. Besides contributing to the substantial gains in underrepresented minority enrollment in medical schools that occurred during the 1990s, Project 3000 by 2000 has created a foundation for long-term progress by:

- 1. Contributing to the growth of the "pipeline model."** We have promoted this model as a way to address the academic needs of students as they progress from pre-college years into baccalaureate and post-graduate health profession schools.
- 2. Producing a significant body of published work.** We have been able to document and analyze some of the tough issues related to the problems of minority academic achievement.
- 3. Creating sustainable partnerships.** We have forged partnerships that we believe are sustainable among K-12 school systems, colleges, health profession schools, and community-based organizations, entities that have not collaborated in the past, but in the interest of our children, must collaborate in the future.

*Dr. Nickens is the late Vice President and Dr. Ready is Assistant Vice President of the Division of Community and Minority Programs, Association of American Medical Colleges.*

# Blacks, Women Less Likely to be Referred for High-Tech Cardiac Tests, According to Study

By Miguel R. Kamat, MD, MPH

A ground-breaking study in the February 25, 1999 issue of the *New England Journal of Medicine* (NEJM), titled, "The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization," found that Blacks and women with identical complaints of chest pain are less likely than Whites and men respectively to be referred by doctors for sophisticated cardiac tests. Since the study tightly controlled for confounding factors such as insurance and occupation, symptoms, patient presentation styles and physician perceptions of the probability of underlying coronary artery disease, the authors concluded that the different referral rates may reflect the presence of race and sex bias on the part of physicians.

"This study deals with a very serious problem," said U.S. Surgeon General David Satcher, MD. "It shows that the same problems that affect relationships in other segments of society affect the doctor-patient relationship."

While there is a growing body of medical literature documenting race- and gender-based disparities in health care, this is the first large-scale study to focus on whether such differences specifically reflect bias in physician clinical decision-making. For instance, a recent review of studies reporting racial differences in health care access and use among similarly insured populations by the Office of Minority Health found that racial disparities have been reported in a variety of areas, including consideration for diagnostic and treatment procedures, patient use of health services, treatment options, and survival rates. These disparities have been most thoroughly researched in the use of certain cardiovascular diagnostic and treatment procedures.

"Blacks are 40 percent more likely to die from heart disease than Whites," said Dr. Satcher, commenting on the NEJM study. "And this could be one factor."

Previous studies have shown that Blacks within the Medicare and Veterans Administration insured populations have lower rates of certain cardiovascular diagnostic and treatment procedures, even after controlling for coexisting conditions, age, supplemental insurance, access to hospitals equipped to provide invasive procedures, previous diagnostic procedures, and disease severity. Explanations offered for these discrepancies included unmeasured clinical or socioeconomic factors, willingness of patients to accept referral for surgery, and physician bias. The importance of the NEJM study is that it screened out these other variables, leaving only race and gender as the perceived differences among patients, which in turn permitted the study to exclusively investigate the effect of race/gender bias on the resulting physician treatment recommendations.

In the NEJM study, 720 physicians in full-time clinical practice who were attending either of two major national medical

meetings volunteered to participate in a computerized survey in which they were presented with a video recorded interview and other data about a hypothetical patient, following which they made recommendations for the patient's management. Six experimental factors, race (Black or White), sex, age (55 or 70 years), level of coronary risk (low or high), type of chest pain and results of an exercise stress test with thalium were utilized to create hypothetical patient presentations, which were simulated by eight actors. In an attempt to control for inter-patient variation in patient appearance, style and personality, the actors wore identical hospital gowns, used identical styles of presentation of clinical symptoms, and even adopted the same angle to the camera during the interviews. Simulated patients were given the same insurance and occupations. Finally, differences in physician perceptions of the prevalence of clinically significant coronary artery disease based on patient race and sex were controlled for by having the physicians estimate in advance the probability of the presence of significant disease.

The study found that the odds of being referred for cardiac catheterization were 60 percent less for Blacks than for Whites, 60 percent less for females than for males, and 40 percent less for Black females than for White males. Cardiac catheterization is a test in which radio-opaque dye is injected into the coronary arteries supplying blood to the heart, in order to make them visible on X-ray images. By looking at these images, heart specialists can estimate the degree of coronary artery disease, determine whether it presents a danger of heart attack, and decide whether to perform preemptive cardiac bypass surgery. Since the effects of other variables had been controlled, these findings suggest that physician bias affects patient treatment recommendations. However, the study could not assess the form of bias present (i.e., whether the prejudice was overt or subconscious). Overt bias results from deliberate actions or thoughts, whereas subconscious bias results from a cultural stereotype that relates to a patient's membership in a target group, regardless of the level of prejudice the physician may have.

The authors acknowledged two limitations. The physician samples may have been nonrepresentative, since physicians attending professional meetings may be better informed than their colleagues, and volunteers may have had a greater interest in coronary heart disease than non-volunteering clinicians. Secondly, assessments based on video recordings may not reflect actual clinical settings as accurately as case vignettes.

Still, the study is a first of its kind in that it demonstrates that physicians bias is a factor responsible for underreferral rates of Blacks and women for high-tech cardiac tests in the U.S. Documentation of this provider bias should facilitate curriculum review at medical schools and residency training programs in order to teach doctors-

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## Study Explores African Americans' Attitudes Toward Research

By Michelle Meadows

Many African Americans view signing the informed consent form as signing away rights rather than protecting them, according to a recent study on research participation among African Americans in an urban hospital. The study, co-authored by Giselle Corbie-Smith, MD, will be published later this year in the *Journal of General Internal Medicine*.

The study also revealed African Americans' continuing fear of being treated like guinea pigs because of the Tuskegee Syphilis Study. For 40 years, from 1932-72, government researchers denied treatment to 399 men with syphilis.

The research indicates that we need to do a better job of acknowledging that these fears are real, said Stephen B. Thomas, PhD, a member of the research team. Dr. Thomas is director of the Institute for Minority Health Research and associate

professor of community health at the Rollins School of Public Health, Emory University. He said we also need to do a better job of talking with young African Americans about the purpose of research.

African American research participants generally give African American health care providers the benefit of the doubt when it comes to trust. "It's not automatic, but it's an advantage of establishing rapport early on," Dr. Thomas said.

But Dr. Thomas points out that White providers can connect with Black patients and vice versa. And providers and patients of the same race or ethnicity do not always communicate successfully. "You still have a social class gap that can be a barrier to communication." Dr. Thomas said he saw the gap first hand about 10 years ago when he sent a Black graduate student into a public housing complex in Washington, DC. The African American student felt uncomfortable with the poverty she saw, and it was a White student who ultimately connected with the community.

Stressing cultural competence and better preparation for students of all races will become increasingly important, Dr. Thomas said. "We can't throw professionals into situations we haven't prepared them for, regardless of their race."

Dr. Thomas lectured on "Assessing the Legacy of Tuskegee on Participation of African Americans in Medical and Public Health Research" at an anniversary meeting of the 1997 Presidential apology for the Tuskegee Syphilis Study.

Tuskegee and Emory Universities held the meeting May 15-16, 1999. Also on the panel was Fred Gray, founder and president of the Tuskegee Human and Civil Rights Multicultural Center and author of *Bus Ride to Justice* and *The Tuskegee Syphilis Study*.

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sicker because there has not been effective communication about problems or treatment regimens.

Other cultural barriers can be just as problematic. For example, many Vietnamese patients believe that Western medications are too strong—given the smaller size and weight of Asian patients—and in response may halve their doses, rendering treatment ineffective.

Finally, historical antagonisms between Blacks and Whites have often inhibited the formation of trustworthy relationships, jeopardizing the quality of care delivered. As long ago as 1973, our current Surgeon General David Satcher, MD, expressed concern in an editorial in the *Journal of the American Medical Association*, saying that traditional social relationships between Blacks and Whites had resulted in inhibited communication between the two. It was his observation that Black patients who are dissatisfied with their care resorted to non-compliance rather than questioning their White physician's authority.

These barriers to communication have deep historical roots, causing many Black patients to distrust the predominantly White medical profession. There is no reason to think that these dynamics are limited to Blacks and Whites. As Dr. Satcher concluded, the "community must develop trustworthy... personnel to help plan for better health care." One way to do so is to assure greater diversity in the workforce.

Minority physicians can play a valuable role in educating their colleagues. Having more minority physicians and other health care professionals would help eliminate racial and ethnic stereotypes that have existed for so long.

For all these reasons, it is important that we bring attention to the subject of health professions development. The articles in this issue of *Closing the Gap* give a renewed sense of the importance of this subject. It is my hope that with this information, we will press on with our efforts to ensure that our workforce represents and serves all Americans.

Dr. Lurie is Principal Deputy Assistant Secretary for Health, U.S. Department of Health and Human Services.

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in-training how to explore their own subconscious attitudes toward race and sex. Furthermore, the findings of the study may strengthen efforts by Congress and the Federal Government to address this issue.

"I think professional societies, medical schools and educators of health professionals at all levels should be involved in helping to sensitize and educate physicians and other health professionals about this problem," Dr. Satcher said.

Indeed, it is timely to focus the spotlight on the existence of provider bias as a factor responsible for inequitable access to health care in the U.S. and to surmount this obstacle, if all people in the Nation are to receive equitable, quality health care.

Dr. Kamat was a staff fellow (Medical Officer) with the Office of Minority Health, U.S. Department of Health and Human Services.

# Educating Health Professionals: Are We Failing Minorities?

By Miguel R. Kamat, MD, MPH

Major discrepancies persist in the representation of racial and ethnic minorities within the Nation's health professions workforce. For instance, African Americans, Hispanics and American Indians and Alaska Natives account for only 10 percent of the health professions workforce, even though they make up approximately 25 percent of the U.S. population.

## Blacks/Hispanics in Health Professions

Although there are wide variations among professions, Blacks and Hispanics are underrepresented throughout the health workforce, particularly in professions that require extensive training such as medicine, dentistry, and pharmacy (see Table 1). Blacks are well represented in a few professions that require substantial formal education such as dietetics (they constitute 18.2 percent of dietitians) and social work (23.4 percent), and are close to parity in some others (psychologists, physician assistants). They also are well represented in occupations that require little formal training (health aides and nursing aides, orderlies and attendants). Hispanics are well represented among dental assistants and dental laboratory and medical appliance technicians, but are poorly represented among virtually all other professions that require formal education.

American Indians and Alaska Natives constitute approximately 0.05 percent of physicians and less than 0.05 percent of dentists and pharmacists, although they represent 0.9 percent of the population. The Association of American Medical Colleges (AAMC) includes Native Hawaiians, but not other Asian American or Pacific Islanders, in its definition of underrepresented minority groups within the medical student body. However, it is important to keep in mind that the AAMC definition of underserved minorities does not acknowledge potential underrepresentation by certain Asian

American and Pacific Islander subgroups, such as recent immigrants and refugees.

## Trends over Time

The number of degrees in the health professions awarded to Blacks increased from a baseline of 5.0 percent in academic year 1985-86 to 5.9 percent in 1993-94, well below the national disease prevention and health promotion target of 8.0 percent set by Healthy People for the year 2000. Hispanics progressed from a baseline of 3.0 percent of all health professions degrees in 1985-86 to 4.3 percent in 1993-94, again below the target of 6.4 percent for the year 2000. Finally, for American Indians/Alaska Natives, the baseline was 0.3 percent

(1985-86); this proportion increased to 0.4 percent in 1993-94, still below the target of 0.6 percent for the year 2000.

## Medical Schools

Between 1950 and 1995, African American, Hispanic and American Indian/Alaska Native first-year enrollments in allopathic medical schools steadily increased. During the early 1990s, they accelerated at a rate faster than their growth in the U.S. population, instilling confidence that enrollment in allopathic medical schools might reach parity by year 2000.

But in 1996 and 1997, the number and percent of Black, Hispanic and American Indian/Alaska Native first-year

**Table 1. Black and Hispanic Employment\* in Health Occupations: 1998**

Health Profession	% Black	% Hispanic
Physicians	4.9	4.8
Dentists	2.8	2.0
Registered Nurses	9.3	3.2
Pharmacists	4.1	5.1
Dietitians	18.2	4.3
Respiratory Therapists	11.7	2.0
Occupational Therapists	6.5	0.7
Physical Therapists	4.2	5.4
Speech Therapists	1.9	6.3
Physician Assistants	10.6	2.8
Psychologists	10.2	4.0
Social Workers	23.4	6.4
Clinical Laboratory Technologists and Technicians	15.0	6.4
Dental Hygienists	3.9	3.9
Radiologic Technicians	8.2	2.0
Licensed Practical Nurses	17.4	5.8
Dental Laboratory and Medical Appliance Technicians	6.8	12.6
Dental Assistants	6.1	12.1
Health Aides (except nursing)	24.4	9.3
Nursing Aides, Orderlies and Attendants	34.0	9.8
<b>U.S. Population**</b>	<b>12.1</b>	<b>11.4</b>

\*Employed civilians ages 16 years and older.

Source: Current Population Survey.

\*\* 1998 Bureau of the Census

enrollees declined for the first time since 1985, widening the gap between their representation in medical schools and the U.S. population. This deficit is expected to increase according to year 2010 projections.

According to the AAMC, “over two-thirds of the decline occurred at schools affected by Proposition 209 (California) and the Hopwood decision (Texas, Louisiana, and Mississippi)—rulings that prohibited the consideration of race or ethnicity in the admissions process.”

Underrepresented minority medical students encounter greater obstacles to financing and completing their medical education than their colleagues. About 80 percent of underrepresented minority medical students were in debt when they entered medical school, compared with only 43 percent of others. And 94 percent of underrepresented minority medical students graduated in debt in 1997, compared with 82 percent of others. Only 80 percent of underrepresented minority medical school students graduated within five years of matriculation, compared to 93 percent of others.

### *Health Professions Schools*

The underrepresented minority enrollment in health professions schools is currently 13 percent and needs to be increased an additional 12 percent to reach parity with representation in the general population (25 percent).

A detailed analysis demonstrates that health profession schools have a low enrollment of African American, Hispanic and American Indian/Alaska Native students. Apart from American Indian/Alaska Native representation in osteopathic medical schools—which is at parity with the population—no health profession can boast African American, Hispanic, or American Indian/Alaska Native enrollment at parity with the U.S. population. And only in public health are the African American, Hispanic and American Indian/Alaska Native enrollees greater than 15 percent of total enrollment.

**Table 2. Selected Enrollment Compared With Populations in Health Professions Schools: 1996-1997**

	% African American	% Hispanic	% American Indian/Alaska Native
<i>U.S. Population*</i>	12.1	11.4	0.9
Allopathic Med (M.D.)	8.0	3.4 **	0.8
Osteopathic Med (D.O.)	4.1	3.8	0.9
Podiatry	3.7	3.4	0.6
Dentistry	5.4	4.0	0.5
Optometry	2.4	3.9	0.5
Pharmacy	7.7	2.8	0.4
Veterinary Med	2.2	3.0	0.6
Public Health	8.0	8.8	0.8
Nursing (RN)	9.9	3.9	0.8

\* 1998 Bureau of the Census estimates

\*\* Mexican American + Mainland Puerto Rican

Source: adapted from table compiled by HRSA, Bureau of Health Professions, National Center for Health Workforce Information and Analysis.

### *Undergraduate Education*

Degrees in science and engineering serve as valuable credentials for college graduates seeking to enter health professions graduate schools. The number of science and engineering bachelor's degrees awarded to underserved minorities increased by 47 percent between 1985 and 1993. This progress notwithstanding, Blacks, Hispanics and American Indians still earned a disproportionately low share of undergraduate degrees when compared with their representation in the population. Collectively, they earned only 13 percent of all science and engineering baccalaureates in 1995, although they constituted 28 percent of college-age students that year.

Attrition rates for these groups from undergraduate institutions are greater than those for Whites—a high of 36 percent for Blacks versus a low of 8 percent for Whites (contrasting 1991 and 1993 undergraduate cohort enrollment profiles).

### *High School*

During high school, where math and science serve as the foundation upon which future health careers are built, the types of math and science courses taken by underrepresented minority and White

students diverge sharply. For example, unlike Asian Americans and Whites, Black, Hispanic, and American Indian high school graduates were more likely to have taken remedial math than trigonometry, despite the fact that the proportion of Blacks and Hispanics taking math, chemistry and physics doubled between 1982 and 1992. A weak scientific foundation in turn adversely affects Scholastic Aptitude Test (SAT) scores. It's no surprise then that Whites had higher math scores than all groups except Asian Americans on the SAT in 1994.

### *Conclusion*

It is clear that Blacks, Hispanics and American Indians/Alaska Natives within the U.S. population are underrepresented in high school math and science courses, in college, graduate school, and in the workforce itself. We must work to increase the education, training, and recruitment of minorities to the Nation's health professions in order to overcome the health disparities experienced by minority communities. If we can do this, we will have a workforce that adequately reflects the rich diversity of this country, fully uses the potential of our people, and best serves the American public.'

# 9 Ways to Steer Minorities Toward Dental School

By Michelle Meadows

Even though the total number of applicants to the School of Dentistry at the Medical College of Georgia has doubled over the last few years, the number of African American applicants has dropped. There were 21 applicants in 1997, 15 in 1998, and only 9 in 1999, with one acceptance, said Michael Miller, director of student admissions for the school of dentistry.

Miller said the decline in both applications and acceptances results from state legal opinions that discourage the consideration of race in admissions decisions. "The state of Georgia has an African American population of 27 percent and it's disappointing that our dental enrollment doesn't come anywhere near that," Miller said.

Another challenge many dental schools face is competing against medical and other health professions schools for the same pool of applicants. Administrators said the reasons so many students are drawn into medical school over dental school vary. Some hear more about medical school from advisors, and others are reeled in by television portrayals of medical doctors.

Minorities made up 35 percent of first year dental students in 1996-1997, according to the American Dental Association (ADA). The breakdown: 23.4 percent Asian, 5.7 percent Black, 4.9 percent Hispanic, and 0.5 percent American Indian. A key recruiting strategy is to catch students before sophomore year and preferably in high school. The following strategies are designed to help minorities and economically disadvantaged students gain more ground.

**1. Conduct outreach to area undergraduate schools with the largest number of minorities.** Central to the recruitment efforts at the School of Dentistry at the Medical College of Georgia is an Area Health Education Coordinator. The coordinator will make one visit this Spring to four schools: Georgia State

University, Atlanta; University of Georgia at Athens, Augusta State University, and Georgia Southern University. The coordinator also maintains a health professions contact at each school.

**2. Look for ways to add recruiters.** "We've discovered that to cover more schools and make more visits, we need more recruiters," Miller said. The school, which has received Health Careers Opportunity Program grants in the past, is working on obtaining state funds to hire another recruiter. Other schools find it cost-effective to train current dental students to help with recruitment activities.

**3. Link up with other schools for dental events.** Miller said his school will continue to stay on top of events at other schools. Past activities include participating in dental week at Morris Brown College and speaking at Morehouse workshops that guide students in applying to health professions schools.

**4. Contact students who have taken the Dental Admissions Test (DAT).** Sending letters to minorities who have taken the DAT is one of the most effective strategies for the School of Dentistry at Meharry Medical College. The school receives the list from the ADA, said Sandra Harris, chairperson of Meharry's dental admissions committee.

**5. Administer scholarships that cover the range of dental careers.** To encourage entry of Hispanics into a variety of oral health careers, the Hispanic Dental Association (HDA) administers five scholarship funds. One supported by the HDA Foundation and Procter & Gamble gives scholarships for students in dental, dental hygiene, dental assistant, and dental technician programs. The association, which is led by executive director Raul Garcia, also publishes a newsletter that provides employment opportunities for dentists (1-800-852-7921, <http://www.hdassoc.org>).

**6. Keep close tabs on the academic success of recruits.** A couple of years ago, the University of Connecticut's School of Dental Medicine entered into a consortium agreement with local public schools and three colleges: The University of Connecticut at Storrs, Central Connecticut State University, and Wesleyan University.

**7. Hold study-skills programs that include room and board for students.** The University of Connecticut School of Dental Medicine holds a six-week intensive pre-enrollment summer program for prospective dental and medical students from the area colleges. Due to financial reasons, many students need to spend the summer working. To help ease that burden, the School of Dental Medicine works to obtain funding to pay for students' room and board. Funding has come from the Robert Wood Johnson Foundation, U.S. Department of Health and Human Services, and the State of Connecticut's Department of Higher Education, Dr. Hurly said. Students can return for subsequent summers for more coursework, rotations, and training in test preparation.

**8. Educate undergraduate advisors about dental school.** Dr. Hurly said many students haven't considered dentistry because they were never exposed to it. "Many times the health professions advisors in colleges are pre-med advisors," she said. There's a need to bust the myths about dentistry for both students and educators. For example, people don't realize that remuneration for dentists is on par with that of medical doctors. And some students assume dentistry is just about fillings, Dr. Hurly said. "There are so many exciting subspecialties in dentistry that people don't know about."

**9. Make opportunities easy for students to find.** That's the idea behind *Opportunities for Minority Students in U.S. Dental*

... continued on page 11

# Project Brings More Indians to Nursing

By Michelle Meadows

If you have poor math and communication skills, you're bound to have trouble recording a complete patient history or giving an exact dose of medication. That's one message American Indian junior high school students receive at presentations of Arizona State University's (ASU) American Indian Students United for Nursing (ASUN) Project.

Director Jan Pflugfelder uses a life-size baby doll and encourages volunteer students to play the roles of a mom, a dad, and a nurse. "As the nurse prepares to give the baby a shot, we talk about how everything they study in school can make them a good health care provider." Students also enjoy listening to each other's heartbeats with stethoscopes. "The earlier we get to them, the better," Pflugfelder said. Help students picture themselves working in health, and they will choose good preparatory courses in high school.

The project, which is funded by the Indian Health Service, has come a long way. When it first began in 1990, only eight American Indian students were taking nursing courses. That number inched up to 12 the following year and then jumped up to 24 the third year. Over the last few years, Arizona State has maintained about 45 American Indian students in nursing courses each year. Project staff maintains a database that tracks the contacts the project has made over the years.

Five more ways ASUN recruits and keeps students are to:

1. **Link up with other American Indian groups on campus.** For example, ASU nursing faculty members join forces with the campus' American Indian Institute to expose as many students as possible to nursing careers.
2. **Exhibit at career days.** The project goes to career days on reservations and encourages teachers and counselors to carry the message. Sometimes it's an indirect process, Pflugfelder said. There have been times when not only are students interested, but teachers want to share ASUN information with nieces and daughters.
3. **Make the most of travel visits.** To maximize efficiency, ASUN's program coordinator makes the most out of a 3-4 day travel period. She tries to visit a reservation, a two-year college, and an IHS hospital in the same area, for example.
4. **Set up an Adopt-a-Tribe program.** ASUN plans to assign its advisory committee members to a particular tribe. The idea is to set up an effective way for ongoing contact (probably once a month) as a way to establish solid relationships.
5. **Hold culturally-based recruitment meetings.** About 150 students and faculty participated in ASUN's 9<sup>th</sup> annual National Indian Nursing Education conference on April 16-19, 1999. It's not your typical conference, Pflugfelder said. Part of the

conference took place in a hotel, but other events were held on campus. Speakers addressed nursing from the perspective of Indian culture and health.

ASUN retention efforts include monthly social and academic meetings with pre-nursing students. Students also participate in a blessing ceremony before exam periods. The office has a living room arrangement so students feel comfortable dropping in. And a good referral system to other areas of the university ensures students receive the mentoring and tutoring they need.

Pflugfelder said the dedication of American Indian students at Arizona State is striking. "You can have a single parent who has left a child with a clan family, and has come here to our dorms," Pflugfelder said. "Not without pain for missing the child, but with a commitment to making a long-term difference in health care."

*For more information about ASU's American Indian Students United for Nursing Project, or the conference on Indian nursing education, call 602-965-0123.*

## Resources for Nurses

- **New book:** American Nurses Association announced the availability of a new book, *Strategies for Recruitment, Retention, and Graduating Minorities in Colleges of Nursing* by Hattie Bessent, EdD. *To order, call for an ANA publications catalog at, 202-651-7000, 1-800-274-4ANA.*

- **Fellowship opportunities:** With funding from the National Institute of Mental Health, the ANA offers fellowship programs for racial and ethnic minorities to support nurses in doctoral study in the behavioral and social sciences. ANA's Ethnic/Racial Minority Fellowship Programs administers three pre-doctoral and two post-doctoral fellowships. *For more information, visit ANA's Web site: <http://www.nursingworld.org/emfp/about.htm>.*

### Dental Schools...from page 10

*Schools*, a publication of the American Association of Dental Schools (AADS). The handbook covers dental school admission requirements, financing a dental education, and school-specific information directed at minority applicants, said Jeanne Sinkford, DDS, associate executive director of the

division of equity and diversity at AADS.

The new edition of the 200-page handbook profiles 14 men and women of various racial and ethnic backgrounds.

*To order a copy of the handbook, contact: AADS, Publications, 1625 Massachusetts Ave., NW, Washington, D.C. 20036, 202-667-9433, ext. 172.'*

## More Hispanics Needed in Public Health

By Adela N. González, MPA

It's been a decade since the Institute of Medicine (IOM) published *The Future of Public Health*. That report noted that our public health system lacked leadership and local public health agencies lack trained public health professionals. We still have a long way to go.

The variations and inadequacies of the public health system are most apparent at the local community level. In Texas, a shortage of public health nurses, social workers, and public health physicians is most apparent in rural areas and the Texas/Mexico border region. With a population of more than one million, the South Texas Border region lacks a public hospital, school of public health, and medical school.

Fortunately, the current workforce's capacity to meet future needs as we approach the 21<sup>st</sup> century is at the top of the list for state public health officials. The Texas State Health Plan is dedicated to workforce development goals and objectives this year.

### *A changing population*

It's also important to consider the increasing diversity among the country's population. Communities are in a state of continual change with the growing numbers of ethnic, racial, and immigrant populations. It's critical that health educators understand the cultural characteristics and close family ties among the Latino population. For example, treatment and education strategies for diabetics work best in familial rather than in individualistic settings.

Cultural competency skills also mean understanding ethnic variations among the Latinos in this country. Health risks and prevalence of disease vary among Latinos for diseases such as cancer, heart disease, and diabetes.

The Latino population is projected to grow to more than 41 million by the year 2010, or thirteen percent of the U.S.

population. This growth is most apparent in the Southwest, California, Florida and New York. Health professionals must resist a "one-size-fits-all" approach to health care because our Latino population is representative of many different Central and South American countries, Mexico, Spain, Cuba and Puerto Rico.

Most Latinos in Texas are of Mexican decent, with a growing population of Central and South Americans in the metro-areas of Houston and Dallas. The changes in population patterns require public health workers to accommodate the changes, remove language barriers, and promote access to care.

In a 1996 report prepared for the legislature, *Texas Challenged: The Implications of Population Change for Public Service Demands in Texas*, the state's demographer reported statistics relative to the population growth for Texas. In 1994, the state's population was estimated at 18.4 million and is projected to be 33 million by the year 2030. A key factor is the growth in immigration from other states in this country, along with immigration from other countries.

The projected growth among minorities will be 87 percent. The number of Latinos will increase by 25.7 percent and comprise 45.9 percent of the total population. The combination of this growth and projections of low rates of educational attainment, poverty, and high incidences of disease, could have alarming consequences for the state.

### *Increasing number of public health students and faculty*

The challenge we face in Texas is to address those issues that can minimize negative outcomes for Latinos. Currently, Latinos in Texas are among the poorest, most uninsured, underemployed, and uneducated. This trend will not sustain the state's economy in future years.

An educated workforce that can contribute to our economy is an attainable goal if appropriate funded programs are put in place in our educational systems. An educated workforce also presents an opportunity to increase the numbers of Latinos in different health professions. The shortage of Latinos in the health professions is a challenge that cannot be ignored.

A 1995 study on the public health workforce in Texas conducted by the Center for Health Policy Studies, School of Public Health, University of Texas, found that there were approximately 17,700 public health professionals in the Texas workforce. Latinos comprised 12.6 percent and African Americans comprised 10.3 percent of the public health workforce. The appalling underrepresentation is evident when one compares 12.6 percent with the state's population of Latinos — 25 percent. African Americans comprised 10 percent of the Texas population in 1995.

The schools of public health in Texas must address and correct this disparity. One Texas institution is already addressing this issue. The University of North Texas Health Science Center at Fort Worth has a new School of Public Health that aims to recruit and matriculate underrepresented minorities to achieve parity with the population. This means minority student enrollment should reach 41 percent by the year 2005. Currently, minority enrollment is at 25 percent in the MPH program. The school also intends to increase minority representation in a faculty that is already one-third minority. The outcome: More trained Latino and African American public health professionals in the Texas workforce.

*For more information, call the University of North Texas Health Science Center's School of Public Health at (817) 735-2252.*

*Ms. González is vice president for administration and institutional diversity of the University of North Texas Health Science Center in Fort Worth.*

## \$100,000 for HBCU Students in Retail Pharmacy

A new scholarship program sounds like the right prescription for attracting more African Americans into retail pharmacy. In March, Rite Aid Corporation and the United Negro College Fund announced the Retail Pharmacy Scholars Program—the first to be underwritten by a major corporation and designed to encourage more African Americans to consider a career in retail pharmacy. The program hopes to bring more qualified pharmacists to Rite Aid stores.

A total of \$100,000 will be distributed over the next four years to students attending Historically Black Colleges and Universities. Selected students will receive annual scholarships of \$2,500. Students must demonstrate financial need and maintain at least a 2.8 GPA.

For details, visit the Rite Aid Web site at: <http://www.riteaid.com>.

## Help Plan Pharmacy Conference for Underserved Groups

Your input is needed for the *National Conference on Pharmaceutical Services for Underserved Populations*, to be held April 3-7, 2000, in Chapel Hill, N.C. The University of North Carolina (UNC) at Chapel Hill is sponsoring the conference with assistance from the Public Health Service of the U.S. Department of Health and Human Services.

The conference will focus on topics such as medically underserved populations (including inner city residents, people living in rural areas, and minorities); cultural competency in pharmaceutical services; special population medication needs (including children, elderly, people with disabilities, people who are incarcerated, and refugees); services to indigent populations; and pharmaceutical care in disaster settings.

Input is sought on topics for inclusion in the meeting and potential speakers. To contribute ideas or to get on the list to receive the meeting agenda and registration materials when they become available, contact Steve Moore, a UNC research fellow and regional drug consultant with Health Resources and Services Administration's Bureau of Primary Health Care. E-mail: [steve\\_moore@unc.edu](mailto:steve_moore@unc.edu), or mail your information or inquiry to P.O. Box 212, Chapel Hill, N.C. 27514-0212.

## Minority Researchers and Faculty

### Get a Handle on Data and Improve Research with HCFA Guidance

The Office of Strategic Planning (OSP) of the Health Care Financing Administration (HCFA) has established several programs that increase opportunities for minority researchers and faculty members. Here are a few examples:

- **The Health Services Research Grant Program.** This program supports extramural research at Historically Black Colleges and Universities (HBCUs) and increases the pool of African American researchers available to carry out research and evaluation activities at HCFA. Since 1996, OSP has funded twelve research grants totaling \$2,369,672. The program sponsors a research conference that allows for networking and explores research findings. There's also an HBCU

Health Services Research Network that establishes partnerships between HBCUs, majority institutions, and state and federal agencies.

- **The Hispanic Health Services Research Grant Program.** HCFA instituted this program in fiscal year 1998. It aims to increase the participation, promotion, and professional development of Hispanic investigators in health services research. So far, three projects have been funded for \$360,000.
- **The Data Users Conference Program.** Through this program, HCFA conferences help HBCU faculty members access and analyze data sets. HCFA staff have helped HBCUs use HCFA data to conduct research on health care delivery,

access, and quality. HCFA also has a program on using HCFA Medicare and Medicaid data, guiding faculty in file layouts and data field definitions.

- **HCFA/OMH Health Services Sponsored Programs.** OSP, the Office of Minority Health, and the Minority Health Professions Foundation initiated this program. It's designed to increase the participation of 12 selected institutions in service, technical, biomedical, and scientific HHS initiatives. The program helps familiarize HBCUs with federal grant makers and assist HBCUs with financial management policies and compliance with federal guidelines. For more information, call Richard Bragg, HCFA, (410) 786-7250.

**American Association of Dental Schools**  
Division of Equity and Diversity  
1625 Massachusetts Ave., NW, Ste. 600  
Washington, DC 20036-2212  
202-667-9433; 202-667-0642 fax  
<http://www.aads.jhu.edu>

**American Dental Association**  
211 East Chicago Avenue  
Chicago, IL 60611  
312-440-2500; 312-440-2800 fax  
<http://www.ada.org>

**American Medical Association**  
515 North State Street  
Chicago, IL 60610  
312-464-5000; 312-464-4184 fax  
<http://www.ama-assn.org>

**American Nurses Association**  
600 Maryland Avenue SW, Suite 100 W  
Washington, DC 20024-2571  
202-651-7000; 202-651-7001 fax  
<http://www.nursingworld.org>

**American Physical Therapy Association**  
Dept. of Minority/International Affairs  
111 North Fairfax St.  
Alexandria, Virginia 22314  
1-800-999-2782; 703-684-7343 fax  
<http://www.apta.org>

**ASPIRA Association**  
1444 I Street, NW, Suite 800  
Washington, D.C. 20005  
202-835-3600; 202-835-3613 fax  
<http://www.aspira.org>

**Association of American Indian Physicians**  
1235 Sovereign Row, Suite C-9  
Oklahoma City, Oklahoma 73108  
405-946-7072; 405-946-7651 fax  
<http://www.aaip.com>

**Association of Black Cardiologists**  
225 Peachtree Street, NE, Suite 1420  
Atlanta, Georgia 30303  
404-582-8777; 404-582-8778 fax  
<http://www.abcario.org>

**Association of Black Psychologists**  
P.O. Box 55999  
Washington, DC 20040-5999  
202-722-0808; 202-722-5941 fax  
<http://www.abpsi.org>

**Association of Black Sociologists**  
P.O. Box 1108  
Mt. Clair, New Jersey 07042-0360  
313-577-1811; 313-577-2976 fax

**Association of Native American Medical Students**  
1235 Sovereign Row, C-9  
Oklahoma City, Oklahoma 73108  
405-946-7072  
<http://www.aaip.com/students/anams.html>

**Chinese American Medical Society**  
281 Edgewood Avenue  
Teaneck, New Jersey 07666  
201-833-1506; 201-833-8252 fax  
<http://www.camsociety.org>

**The Commonwealth Fund, Harvard University Fellowship in Minority Health Policy, Harvard Medical School**  
164 Longwood Avenue, Room 210  
Boston, MA 02115  
617-432-2313  
<http://www.hms.harvard.edu/fdd/commfund/html>

**Hispanic Dental Association**  
188 W. Randolph Street, Suite 1811  
Chicago, IL 60601-3001  
1-800-852-7921; 312-577-0052 fax  
<http://www.hdassoc.org>

**Hispanic Serving Health Professions Schools**  
1700 17th Street, NW, Suite 405  
Washington, DC 20009  
202-667-9788; 202-234-5468 fax

**Indians into Medicine**  
University of North Dakota  
School of Medicine and Health Science  
PO Box 9037  
Grand Forks, North Dakota 58202-9037  
701-777-3037; 701-777-3277 fax  
<http://www.med.und.nodak.edu/depts/inmed/home.htm>

**Interamerican College of Physicians & Surgeons**  
915 Broadway, Suite 1105  
New York, New York 10010-7108  
212-777-3642; 212-505-7984 fax  
<http://www.icps.org>

**Minority Health Professions Foundation**  
3 Executive Park Drive, NE, Suite 100  
Atlanta, Georgia 30329  
404-634-1993; 404-634-1903 fax  
<http://minorityhealth.org>

**National Association for Equal Opportunity in Higher Education**  
8701 Georgia Avenue, Suite 200  
Silver Spring, Maryland 20910  
301-650-2440; 301-495-3306 fax  
<http://www.nafeo.org>

**National Association of Hispanic Nurses**  
1501 16th Street, NW  
Washington, D.C. 20006  
202-387-2477; 202-483-7183 fax  
<http://incacorp.com/nahn>

**National Black Nurses Association**  
1511 K Street, NW, Suite 415  
Washington, DC 20005  
202-393-6870; 202-347-3808 fax  
<http://bronzeville.com/nbna/default.htm>

**National Dental Association**  
3517 16th Street, NW  
Washington, DC 20010  
202-588-1697; 202-588-1244 fax  
<http://natdnt.org>

**National Hispanic Medical Association**  
1700 17th Street, NW, Suite 405  
Washington, D.C. 20009  
202-265-4297; 202-234-5468 fax  
<http://nhma@earthlink.net>

**National Medical Association**  
1012 10th Street, NW  
Washington, DC 20001  
202-347-1895; 202-842-3293 fax  
<http://www.nmanet.org/index.asp>

**Student National Medical Association**  
1012 10th Street, NW  
Washington, DC 20001  
202-371-1616; 202-371-5676  
<http://www.snma.org>

**National Association of Black Social Workers**  
8436 W. McNichols Street  
Detroit, Michigan 48221  
313-862-6700; 313-862-6998 fax  
<http://ssw.unc.edu/professional>

## CDC/ATSDR Internship Opportunities

Internship and fellowship programs are an effective way to boost the number of minorities who choose public health careers. The Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) have established programs through partnerships with the Minority Health Professions Foundation and the Public Health Sciences Institute.

Once focused on recruiting from Historically Black Colleges and Universities

(HBCUs), these programs now also recruit from Hispanic Serving Institutions, Hispanic Serving Health Professions Schools, and Tribal Colleges and Universities. Each year has shown an increase in the participation of Hispanics/Latinos and American Indians.

**1. The Minority Health Professions Foundation (MHPF):** is a non-profit organization that supports educational, research, and community service efforts that improve the health of poor and

minority populations. Through MHPF, CDC and ASTDR supports the National Center for Infectious Disease Fellows and the Public Health Summer Fellows.

• **National Center for Infectious Disease (NCID) Summer Fellows:** Initiated in 1988, this program aims to expand the pool of qualified minority candidates for careers in public health. It is designed for students of medicine, dentistry, pharmacy, and veterinary medicine. Minority students conduct research under CDC mentors. The goal is to expose students to an array of public health activities available upon graduation or after residency requirements have been completed.

• **Public Health Summer Fellowship Program (PHSF):** This program is a collaboration among MHPF, Morehouse, and Emory University's Rollins School of Public Health. Students learn to apply principles of epidemiology and public health practice.

**2. The Public Health Sciences Institute (PHSI):** Established in 1988 at Morehouse College, the institute offers introductory public health courses such as biostatistics, epidemiology, and occupational safety and health. It also holds field trips, public health awareness conferences, and runs academic and summer internship programs. PHSI's premier summer program is Project IMHOTEP.

• **Project IMHOTEP:** This highly competitive summer internship program targets undergraduate students. It is designed to train students for public health careers in epidemiology, biostatistics, and occupational safety and health. Students go through two weeks of classroom training, along with training in scientific writing, computer analysis, and home study courses. Students then take on practical work experience with data sets provided by CDC/ASTDR researchers.

For more information about minority student training programs, call Wilma Johnson at CDC, (404) 639-7210.

### Resources

**National Pharmaceutical Association**  
12510 White Drive  
Silver Spring, Maryland 20904  
301-622-7747

**Student National Pharmaceutical Association**  
Florida A & M University  
College of Pharmacy and Pharmaceutical Sciences  
Tallahassee, Florida 32307-3100  
850-599-3030; 850-599-3347 fax  
<http://168.223.36.3/copps>

**National Optometric Association**  
3723 Main Street, P.O. Box F  
E. Chicago, Indiana 46312  
219-398-1832; 219-398-1077 fax  
<http://www.natoptassoc.org>

**Society of American Indian Dentists**  
PO Box 15107  
Phoenix, Arizona 85060  
602-954-5160  
<http://www.ada.org/directs/org/said.html>

**Society for Advancement of Chicanos and Native Americans in Science**  
PO Box 8526  
Santa Cruz, California 95061  
831-459-0170; 831-459-0194 fax  
<http://www.sacnas.org>

## SOPHE Launches New Practice Journal

Looking for a publication that focuses on practitioners at work? The Washington, DC-based Society of Public Health Education (SOPHE) has announced a new journal called *Health Promotion Practice*. The journal publishes articles devoted to the practical application of health promotion and education in a range of settings, from the community to schools. The journal will promote linkages between researchers and practitioners and address the health issues of ethnic and racial minorities. Other topics include new or state-of-the-art interventions, policy advocacy, and social interventions that promote health.

Types of manuscripts published include those that feature applications and interventions, as well as literature reviews, policy case studies, and commentaries. Send four copies of your manuscript, one original and three copies with authors' names removed. Manuscripts must be accompanied by a disk and in MS Word.

For more details on the journal and submission guidelines, visit SOPHE on the Web at: [http://www.sophe.org/Publications/Health\\_Promotion\\_Practice.htm](http://www.sophe.org/Publications/Health_Promotion_Practice.htm).

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Public Health Service  
Office of Minority Health Resource Center  
P.O. Box 37337  
Washington DC 20013-7337

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# *Closing the Gap*

## Conferences: 1999

**June 2-4:** 57th Annual Meeting of the Texas-Mexico Border Health Coordination Office, "Looking to the 21st Century," in San Antonio, TX. Contact: (915) 581-6645; fax (915) 833-4768; Email: adm@usmbha.org.

**June 14-18:** Summer Public Health Research Video Conference on Minority Health, sponsored by the University of North Carolina, Chapel Hill School of Public Health. Contact: (919) 966-7011; fax (919) 966-0119; Internet: <http://www.minority.unc.edu>.

**July 23-27:** Association of American Indian Physicians Annual Meeting, held in Asheville, NC. Contact: (405) 946-7072.

**July 25-28:** 21st Annual Conference of the National Council of La Raza, held in Houston, TX. Contact: (202) 776-1728; Email: irosales@nclr.org.

**Aug. 8-11:** National Urban League Annual Conference, in Houston, TX. Contact: (212) 558-5358; fax (212) 344-8817; Email: mmcfarlane@nul.org; <http://www.nul.org>.

**Aug. 8-13:** National Medical Association Annual Scientific Assembly and Exposition, held in Las Vegas, NV. Contact: (202) 347-1895; fax (202) 842-3293

## NHMA Links Students on the Web

At the push of a button, Hispanic residents can join a database and link up with others in the same specialty, as well as Hispanic doctors/mentors. The National Hispanic Medical Association (NHMA) links students and mentors through its Resident Physician Database Project. Sign up on the Web at: <http://home.earthlink.net/~nhma/resdata.htm>.