**DIALOGUE PART II: INTEGRATED HEALTH CARE- BALANCING SCIENCE & SPIRITUALITY IN HEALTH CARE DELIVERY**

**BEVERLY EARLE**: This panel will establish the scientific link between spiritual, mental, and physical health, and talk about how providers can address the whole person. This panel will also -- this panel will also talk about how we, as individuals and communities, can be empowered, and how legislators can help.

Again, the bios are in the back of your binder. Dr. Kaytura Felix. Dr. Felix works in the Health Resources and Services Administration of the U.S. Department of Health and Human Services, where she is leading efforts to expand and strengthen community-based program evaluations and research at the Office of Planning and Evaluation. Dr. Ruby Cain -- Dr. Cain is assistant professor of adult and community education, and an academic advisor for two graduate programs in the Department of Educational Studies at Ball State University. She is also president and CEO of Creative Training Excellence and volunteer director of "It's Well With My Soul." Dr. Donald Williams. Dr. Williams is emeritus professor of psychiatry at Michigan State University, where he also chaired the department for five years. He is a Distinguished Life Fellow of the American Psychiatric Association and a member of the Black Psychiatrists of America. Dr. Mercy Obeime. Dr. Obeime is the director of community and global affairs at Franciscan St. Francis Health. Dr. Obeime is an assistant clinical professor at the Indiana University School of Medicine, and founder and CEO of Mercy Foundation.

**KAYTURA FELIX:** Good morning. It's a real pleasure for me to be here, and I'm very touched to be here. And I just want to say that I really recognize, you know, this organization's leadership, being focused on transformation, transformative living, and spirituality. So what I'd like to do with you this morning is to really share with you the growing recognition of the role of spirituality in healthcare. So in 2003, I wrote a paper titled "African American Church Participation and Healthcare Practices." I looked at the relationship between church participation and six healthcare practices.

Now you would ask, "Why would I do that?" I mean, I grew up -- again, I grew up in the church myself in the Caribbean, but when I was in Baltimore and living in Baltimore and working in the community, I really got to understand just how people use their practices and how important spirituality was. And so, I wanted to go to see in the research, you know, what the relationship was not only between spirituality and health, but spiritualty and healthcare practices. So I looked at six healthcare practices. I looked at pap testing for women, the receipt of mammography, looked at dental visits, blood pressure measurements, and there were two other things I looked at. I looked at having a regular source of care, which is having a relationship with a provider, as well as delays in care, having no delays in care, meaning having good access to care.

So in that community, we surveyed about 2,000 patients, 2,200 residents. And at that time, about 37% of them reported that they went to church at least once a month. So we found in that survey, that those who went to church were much more likely to have positive healthcare practices than their neighbors, people living in that same community who did not go to church or went to church less frequently. So let me give you an example of this. Those who went to church were 1.5 times more likely to visit the dentist, and 1.6 times more likely to have their blood pressure taken.

When we look at women, particularly women without insurance, and I think that's really striking, those who attended church were 2.3 times more likely to get a pap testing than those who weren't. Those who had two or more chronic conditions, meaning people who were very sick, again, going to church made a huge difference. And so they were much less likely to be having delays in care. Now this is just one study looking at church participation and healthcare behaviors. And so I have to say that churchgoing and religiousness is very different and distinct from spirituality.

So what I'd like to do now is to just talk to you about what, you know, the definitions of what spirituality is and how it's dealt with in the research literature as well as religiousness. So researchers have defined religiousness in three ways. One, whether people belong to organizations. So it looks at formal or public participation in religious congregations. The second thing they look at is non-organizational involvement, meaning do people pray, their private devotional affairs, Bible reading, and reading of other scripture. The other way they look at religiousness is how people present. Do they think of themselves as religious people? Or do they present themselves as religious people?

Spirituality is a related concept, but it's also a distinct concept. As you can imagine, there is some overlap between these two concepts. So spirituality refers to the basic or inherent quality of a belief in something that is above us, something that transcends this physical and material world, a belief in something greater than the self, and a faith that positively affirms life. When we look at the whole body of research -- so I started with this one study that I did, but when we look at all the studies, and there are a number of studies that look at religiousness and health, when we look at that, we see that religion mostly exerts a protective effect on health. When you look on the levels of illness, when you look at longevity, depression, the sense of well-being in the African American community, that is really important.

For example, religious membership and participation is associated with less coronary heart disease, strokes, high blood pressure, and overall mortality. So how does that happen, right? So why would, you know, going to church, you know, maybe once a week or praying -- again, I mean, what are the pathways for this to happen? So there are many ways we think that it happens. And so somebody would also say, well, you know, the skeptic here would say, well, I know this person, you know, who'd go to church all the time, yet they died early, you know? Or somebody who would say, well, I know this person who never went to church or never did

any of that stuff and lived to 100. So most of the studies we have look -- are described as epidemiological studies, so they look at populations of people. So they look at populations of people and they say, okay, these are the populations. How are they different, right? Let's look at their practices.

And so that's where most of the research is done in terms of religions, spirituality. However, more and more work is done in the area of clinical arena. So there are five ways that church participation may prevent disease. One is the avoidance of destructive health habits. You know, again, some religions have very strict codes around alcohol consumption, around drugs and some kind of risky other risky behaviors. And so that's one of the ways, you know, we see that happening. Also, some religious organizations also promote positive, healthy behaviors.

The second way, which a lot of research has paid attention to, is this whole idea of providing a support network. You know, really having a support, a group of friends, having not just people who can support you, but really having access to information.

The third is that the whole worship experience may really positively affect your affect, meaning, you know, I mean, the way you feel, the way you look at life, your outlook on life, and that it really boosts, you know, the psychoneural immunological system. So you know, I mean, the connection between mind, spirit, and body. And these things are connected. And so in this Western tradition, you know, we've separated the mind from the body and we focus a lot on the body, but clearly a number of traditions really put those -- you know, those two together and that they're connected.

The fourth way that -- you know, that that also works is that, you know, participation in church and religious experiences may motivate people to take better care of themselves, such as visiting the doctor, the nurse practitioner. And finally, we believe -- or at least, you know, the research seems to suggest that there are positive expectations from reading the writings and that this really affects and prevents psychological distress. I mean, we've talked about multiple references about stress and its impact on health.

Now when we look at spirituality, we see a similar pattern, a very, very similar pattern emerging. Most of the studies on spirituality have been done in the general population, not as much work done on African Americans. However, we see a very similar pattern: lower mortality, better coping with illness and death, enhanced recovery from illness. And the spiritual practices we're talking about are things like meditation. We'll get into more depth about that. Yoga, mindfulness, relaxation techniques. For me, I mean, one of the areas that I'm very interested in and I'd like to talk a little bit about more, is the whole idea of forgiveness and work being done in that area. In terms of spiritual practices, we're talking about scripture reading, as well as praise and worship.

So in terms of forgiveness, this is a very, in my mind, a very exciting and growing area in terms of the

study of spirituality and health. Forgiveness is defined as a person's individual act offering mercy, compassion, and empathy towards the offender. It's very distinct from making excuses, from, you know, from excusing on fear behavior or from condoning or reconciling. You know, to really forgive is to acknowledge that an act has been done; it was wrong, without excusing it or even letting it go. So the studies to date indicate a general positive relationship between acts of forgiveness and health. These studies show that the psychology of forgiveness, really emotionally forgiving people promote not only psychological health, but physical health. Thank you.

So for example, forgiveness was associated with lower blood pressure, lower blood pressure, lower cardiovascular risks. It was associated with better quality of sleep, fewer bodily complaints and symptoms of depression, reduced stress on the heart, as well as a boost to the immune system. So I think this work is really very interesting, and much more work needs to be done in this area, I mean, as patients, doctors, and nurses get to put this into action.

So what I'd like to do right now is to really turn our attention to some of the practical implications of this work. So I think, for example, people are beginning to recognize -- practitioners are beginning to recognize that, whether they be doctors, nurses, physician's assistants, psychologists, are really beginning to engage patients in terms of their spirituality. And I think one of the things that they can do is to really create a space that makes it okay for patients to bring their spirituality forward. And so there are a number of practices that they can do. One of these is to practice compassionate presence, really being present. I mean, we know of times where we go to a provider and they're looking at the chart, you know, or they're looking at their clock or looking at the computer notes, either Blackberry or tablets. But to be really -- to sit with patients and to engage them. So that's one of the ways they can do. The other is to really listen to patients and to fully engage. Listen to them in terms of their fear, their pain, and their distress.

A third thing to do is to obtain a spiritual history. And that's really important, you know, to really engage patients, to really ask them about their faith and beliefs, to really get a sense of how important their faith is and how it influences their life, not just their health, but all of their life. The other is community. You know, I mean, do they belong to a religious community? I mean, are they part of a network? And lastly, lastly was to really, really talk about what actions need to be done. So after you've taken this history, what are the steps that need to be taken?

I think it's really important for providers to do that. One, it gives the providers a better sense of how patients and how we understand illness, right? Spirituality is huge in terms of how we understand illness. So, for example, illness can be seen as punishment, right? Punishment for sin or for whatever, you know. So really getting an understanding of how they see illness.

The second is to really understand how patients make decisions. You know, who do they turn to for decisions? A third is to cope with, you know, with those challenges. And lastly, it's to really have an integrated sense of patients. There are a number of organizations, prominent organizations that are beginning to move in this area. JCAHO (Joint Commission on Accreditation of Healthcare Organizations), for example, really looks at how healthcare organizations and how they integrate spirituality, particularly at the end of life.

I also wanted to, you know, to draw your attention to a couple of things. The John Templeton Foundation really supports the development of medical school curriculum in that area. And the National Center for Complementary and Alternative Medicine. In closing, I'd like to suggest that there are two things we can do in this arena. First, in your professional lives as legislators, I think you can support research and evaluation projects that look at this area. You know, I mean, looking at the area of mind-body medicine as well as in the area of forgiveness. And the other thing I think I would like to leave and I think it's for all of us here in this room, is that we really become aware of our own spirituality and how it affects our own general health. And so I'd just suggest that we just try looking at our emotions and the whole area of unforgiveness and how it reflects our health. So with that, I say thank you.

**RUBY CAIN:** Oh, they did for me. Thank you. Good morning, my name is Dr. Ruby Cain and I would like to begin by brining you greetings from Ball State University, which is innovative and technologically connected. It is also an institution where education has been redefined and immersive learning is queen. I also like to bring greetings to you from Fort Wayne, Indiana where I reside and from the Allen County Health Disparity Coalition, which I am a founding member of and which is facilitated and convened by Health Visions, Fort Wayne, and It Is Well with My Soul. And today I'll talk a little bit about It Is Well with My Soul in relation to spirituality and health.

What I'd like to do is start with the caveat that we are not a monolithic culture. Those of us who self-identify as African American, Black American, people of African descent possess varied cultural identities. What we have in common is an ancestral connection that encompasses a physical, mental, and spiritual resolve to survive. If you are skeptical, please help me complete the following platitudes or common phrases. With God, all things are?

**AUDIENCE:** Possible.

**RUBY CAIN:** We must make a way out of?

**AUDIENCE:** No way.

**RUBY CAIN:** God is good?

**AUDIENCE:** All the time.

**RUBY CAIN:** All the time?

**AUDIENCE:** God is good.

**RUBY CAIN:** And although these words are not in the Bible, we heard them often in a biblical connectedness. Cleanliness is next to?

**AUDIENCE:** Godliness.

**RUBY CAIN:** Yes. And you could go to the next slide. I have control here. This is what I'll speak on for the next few minutes. I will talk a little bit about a community initiative in Fort Wayne, Indiana entitled, *It Is Well with My Soul*: *Surviving and Thriving and Unlearning Internalized Racism*. Then, I will move on to racism and African American health, strategies to improve health outcomes, and policy and community leader recommendations. It Is Well with My Soul is a program affiliate of the African/ African American Historical Museum and Society. And it is one of 119 racial equity grant recipients from the W.K. Kellogg Foundation's America Healing Initiative.

Our vision really ties into your theme for this particular breakout session on, for It Is Well with My Soul, what we would want to do is acknowledge and see and use the indestructible power of the African American community and looking at who we are, looking at our ancestral history, and the fact that it does include the many tragedies, many travesties, many issues that we did not have control over, but the fact that amidst all those, against all those odds, against the heinous of crimes, against the worse of circumstances, we survived. And how did we survive? It Is Well with My Soul addresses race as a social construction. Race is only -- the actual word has only been in existence for a little bit more than 200 years. And even though there is a lot of documentation that -- or publications focusing on the fact that there are differences by race, the scientific research shows that there's really more genetic variation across racial ethnic groups than it is within racial ethnic groups. There are disparities that are real, but in order to understand what those disparities are, we have to look beyond biology.

We also look at addressing historical inequities. We look at power and privilege, structural and internalized racism. And our strategies for overcoming internalized racism deal with looking at our ancestral legacy, our ancestral connections. So we want to do ancestral and historical research and presentation of African Americans. We must discover ourselves, research ourselves, document ourselves, and share that information with others.

One component of It Is Well with My Soul is the wellness team. And it is made up of health professionals, community individuals to identify and disseminate best practices on culturally proficient health interventions and partnerships. And one of those is shared decision-making. Dr. Felix talked about that just before me in terms of actually asking questions of the patient and seeing that individual as holistic, not just looking at the physical symptoms, but look at the mental circumstances and condition as well as the spirituality of that individual. And, in other words, actually establishing a relationship.

When we look at the impact race has on health, there exists today more than 100 research studies that actually link racism to poor health outcomes. And I've listed some of those within that slide. The effects of structurally and internalized racism, they're not just psychological; they're not just temporary, but they truly impact health and it impacts health in a very devastating way. Health disparities by race exist even when you control for income, education, and insurance. Often when we look at disparities, the first thing that's said is, it's because the individual's poor. It's because the individual lacks health literacy. And some of these things do come into play, but it's much more than that. It's the -- disparities by race are very complex and they are a combination of a lot of conditions: economic, social, biologic, and genetic. I have a health equity quiz, but I'm not going to use that for brevity of time. And I'll go on to the next slide.

When we talk about shared decision-making, what we're talking about here between a patient and a healthcare professional is bi-directional dialogue about the patient's symptoms and treatment options. And also providing options for the patient that actually address their preferences. Typically, health professionals like to identify the physical condition, come up with a prescription plan, and provide that, as opposed to presenting multiple options and taking into consideration the uniqueness of that individual.

African Americans, according to the research, they actually experience this shared decision-making less often than European Americans. A lot of this has to do with the majority of healthcare professionals are European American and they approach the interventions from a Eurocentric perspective. So they have less cultural awareness, knowledge, and proficiency with African Americans. There's also a mistrust of white, or European American healthcare professionals. And we can point to a lot of different studies to understand this. Many of you have heard the Tuskegee syphilis project. Also, the fact that many African American women were sterilized without their consent or knowledge up through the 70s. So we're talking distrust that's based on actual circumstances within in our lifetime, not generations ago.

And the way they interact with individuals they see in a position of respect and authority is a little different than the way European Americans do. Often there may be a deference to the healthcare professional assuming that individual has the knowledge, therefore less sharing of health information. And also, there may be less likeliness to adhere to the regimen depending on if there's distrust, if questions aren't asked, if there's a lack of understanding.

Does racism exist in the United States? Here is some statistics that I'm providing for you that come from the National Association of County and City Health Officials in *Unnatural Causes* for "Is equality making us sick?" We have the highest rate of infant mortality, homicide, teenage birth, the greatest gap between high and low mortality rates, the highest poverty rate, the smallest middle class, and we have no requirement for employers to provide paid sick leave or paid holidays and vacation compared to other developed countries. The African American experience generally encompasses spirituality. And I've listed some examples in Fort Wayne

community, the Fort Wayne African American Cancer Alliance. They actually encourage physical health by providing exercise through gospel music. The American Heart Association's Go Red Sunday encompasses Biblical text with heart disease awareness. And It Is Well with My Soul wellness team has developed a family heath series at the National Black Genealogy Summit that will be held in Fort Wayne, October 20th through the 22nd. This includes free health screenings, workshops, gospel concert with intermittent health messages.

So in my last slide here, I have some recommendations, and one is the fact that poor health drives poverty more so than poverty driving poor health. If we address structural issues that are caused by racism in terms of labor practices, in terms of access to healthcare, we can address some of the health issues a lot better than we have in the past. The health disparities have increased over the last few decades between European Americans and African Americans rather than decreasing, even though we have much better health practices. Draft legislation to eliminate this disparity, promote health insurance coverage for integrative medical inventions, and have town home meetings on health at faith-based venues to get input from that community. And as a community leader, incorporate faith leaders, community members and community-based participatory research projects, invite health professionals into the faith community for health education screenings, partnerships for improved health outcomes, and then create wellness teams comprised of the whole community, the faith community, the social service, health, and academic professionals. Thank you very much.

**DONALD WILLIAMS:** I really am honored to be here today. This is the first time in my life that I've practiced addressing a legislative body. If my mother were alive, she'd be quite proud. Like this? Okay. I wanted to pick up on the themes that the two previous speakers have talked about and elaborate on some of the issues and then go on to particularly to talk more specifically about stress, about psychological and cognitive mechanisms that determine how we think and feel, and how important that is for us to be consciously aware of what is going on in our own heads because most of the time, many of us are operating on what we call very subconscious, or unconscious, thoughts and reactions to people. So that automatically, as we were talking about race, if we see a young African American young man with his pants hanging down and wearing a hood, many of us will get anxious just on that particular picture without allowing ourselves to understand or know that person as a human being.

And as a caregiver, and when we've been talking about providing care, I teach in the medical school on race and health disparities. And so we've talked about the miscommunication between doctor and patient, but also between a minority and majority physicians. We talk about the automatic thoughts that we have, the prejudices that we have, and how they work in our behavior. So I want to go talk some more about those issues. I also would like to talk about racism and stress and the relationship of how what are some of the mechanisms that cause illness that are stress related, and what to pay particular attention to talking about the

technique that we've been -- you've heard of mindfulness or meditation.

First, let me go to talking about stress. Whether or not we recognize it or not, we as people of recent African descent, because this human species originated in Africa. And the rest of the population of the world was populated by and migration out of the southeastern part -- excuse me, south -- northeastern part of Africa into the rest of the world around the Red Sea. So we're all Africans and the issue is whether or not we have been recently from Africa or more distantly related from Africa.

The point I'm making with that is that we all inside carry very much the same genetic composition, especially in terms of thinking and feeling. Now where that will lead us to that here, in the United States, what we have done is to really take a specific physical characteristic of our bodies, it's not the size of our nose; it's not our hair color; it's how we look in terms of our skin color. But that has really -- the skin color that we have has really been a natural selection process that protects our body from solar radiation. It is, if you will, God's will, or just in Darwinian terms, how we have evolved to protect our bodies from the harsh exposure to sunlight. What we have done with that, however, is to take a group of people who have this characteristic and have used that really to create a mechanism of subordination and exploitation. And that is the social construct of race, because race is a social construct just like the state of Indiana is a social construct. When I crossed the border from Michigan into Indiana, I needed that sign post to let me know I was in Indiana because it all looked alike.

So what we're talking about is how human beings have been able to create a structure, a cognitive structure that really -- that we have all bought into, and in some ways have believed as if it is real, as if it is real, as real as the sun coming up in the morning; it's as real as the earth revolving around the sun. It's real to us. And the reason that we've been able to have been so inculcated is very much related to fear and terror, because that's the way if you deal with people at an early age and you continue to do things that reinforce pain, suffering, anxiety, stress, pretty soon that person is going to start, a lot of times, thinking about ways of getting away from that stress and many times will incorporate the kinds of belief systems that their torturer is providing.

So when we talk about race, and when we talk about living in the United States, we're really talking about living in a state of various levels of anxiety. I, like many of you, have worked primarily in a white organization. But when I talk to my other African American male friends, when we talk about it, many times we don't talk about going into the office feeling good or feeling relaxed. We talk about getting -- taking a deep breath and going in and surviving. That's stress. And we have stress all the time. Now we don't always acknowledge that stress because if we did, we couldn't get the rest of our work done. So we put it aside. But what happens is while we put it aside, what we're talking about, we put it outside of conscious memory. But that doesn't mean that our mind is still not struggling with those issues. And that the anxiety and the

frustration that these events and experiences have are still coursing through our body and creating a whole host of dis-eases and chronic dis-eases.

So that what we have been talking about depression; we've talked about hypertension; we can talk about fibromyalgia; we can talk about diabetes; we can talk about a whole list of things that are related either caused by stress or are aggravated by stress. Now we've heard that spirituality is really very important and that is because we are starting to use our cognitive functioning, our adult brain if you will, as a way of thinking and managing these kinds of events. Now one of the things that we haven't talked about is really the new studies that are coming out about mindfulness. And that means that mindfulness is really religious-based; it is really part of the eastern religions 2,000 years started with Buddhism or so. However, the techniques of mindfulness don't have to be related to any one particular religion. But what it does require is that we learn individually how to stay, what we call, "in the moment" so that we concentrate on the present on who we -- where we are now and become much more aware of what is going on within our bodies. If we had more time, I would have all of you have a little dose of mindfulness. But essentially what we've been doing in the Lansing area is to really try to introduce this into church groups as well as with patient groups as to how to better manage your pain, your anxiety, a whole variety of medical and psychological problems.

Briefly, what the model is, and you may have heard, is that you really start concentrating on your breathing, and you pay close attention to your breathing. And you breathe, you pay attention to -- you're not controlling your breathing, but you're attending and you're mindful to the breathing. And so you pay attention to your air coming in and you note its feeling, you pay attention to the feeling, and you pay attention to the air going out.

Now one of the things you'll say, well, boy, that is really kind of boring. And my mind is going to go somewhere else. But that's the point, that you want to stay in the moment. You want to bring your mind back to what you're paying attention to. And so that over time what -- and if so that your mind will, if you have pain, you'll note that you have pain. But you won't do anything about it, you'll just say, I'll let it go and I'll come back to my breathing. If you start having an itch, you won't scratch it. You'll just say, oh, I have an itch. And then you pay attention to that, but then let me go somewhere else. And the itch decreases.

Now this is us learning how better to gain control over our feelings and over the way we think. And there's a lot of literature that's coming out now that, with patients, where this has been very helpful. So that's been my contribution to stress reduction today.

But the final thing I want, with the time remaining, is that what I am very pleased is that you had me here and what took you so long? And the reason I'm saying that is my experience working in white organizations, especially as an African American man, and I've been a chair, as I said. But it's all right for there's

one of us. But if there are two, that's really bad. And if it's two men, that is really, really bad. When I was at Michigan State as chair, I ended up having two other black faculty. It turned out that I had the most black faculty in any department in the whole university, whole university. Now, there are no black faculty in my department. And if you look around, if you look at the medical students, very few African American men. Women? Yes. But not African American men.

So what I'm saying is that there has been, for us in terms of coming together and having a place to work together, to learn from one another, that does not exist in many organizational structures. And we either do it before we go to work or after. And so that what I'm saying to you as legislators is that hopefully that you will reach out to really not only have more time to interact with you and each other, but to have academics or others that we come and have a chance really to spend a long time talking and getting through some of the issues and talk about the issues that affect. Because I think there are a lot of things that are coming out in the literature by black psychologists in particular that are very relevant to the kinds of issues that you have to address every day. Thank you.

**MERCY OBEIME**: Good morning. I'm very happy to be here this morning and I wanted to thank Mr. Crawford -- Representative Crawford, I'm sorry, Representative Summers, and the entire black caucus in Indiana because I think that the reason that I'm here today representing the Indiana State Medical Association, St. Francis Hospital and the Aesculapian Society, Dr. Desadier is right there, is because of the experience I have gained working with them as they intern the last three years. And it's been really beneficial to me to learn how government works and how government influences the health of our state.

I work for St. Francis hospital. And as you heard Dr. Williams just talk about the stress of walking in on all white environment. I think, if I look around the room, I'm probably the most recently immigrated African American in the room. I think I am. So you would expect that the stress that I experience may be actually more than some of you because coming from Nigeria and having to learn a whole new culture, at the same time assuming the role of a physician taking care of a lot of people, can be very daunting sometimes. But I'm happy to say that it has been wonderful. When I went to work for St. Francis because of people like the members of the Aesculapian and the members of the legislative black caucus, I asked St. Francis in my contract to give me time to be able to spend time caring for people who looks like me, because when I went to St. Francis, there were not very many people who look like me as staff, patients, or administration. And for the last 16 years, I have had that part of my contract, it's probably the most permanent part of my contract that I've had. So because of that, I felt I had an obligation to be involved in the community and to find out what we needed, what were our problems, and what we could do to make it better.

I started dealing with obesity, that was about 10, 15 years ago when I first started. And then lately, I thought, you know, there's more to just living that we are not addressing. And if you look at what St. Francis

has helped me on this plan is that it's okay to take care of the whole person because basically -- sorry, can you role these slides for me, please? I think I'm already talking ahead. Can you go to the second one? Oh, I can? Sorry. It's okay. I might have messed it up a little bit. Let's try that. Nope. The top one. No, that's the -- oh, there we go. So I was just talking about what I would be doing when I talk about taking care of people. I went to medical school on the advice of my grandmother, who never stepped into a school, telling me to choose medicine because she thought it was the one profession that would give me the ability to take care of life.

And the more experience I have, the more I realize that defining life is very complicated and it gets more and more complicated. Many of you will be aware that we're again redefining when life begins. Some people are beginning to say that it is at the very time that the egg is fertilized. Whereas, some people are going back as far as saying, it is with the woman having the egg in their ovary, that is already a human being. So we cannot even define the beginning of life or the end of it because a lot of people argue about that. We do know that they are two very distinct events that happen in all our lives. All of us are born and all of us are going to die. And you would think that it is so clear that we would know that these are events that would definitely happen. I remember my grandmother telling me before I left Nigeria, "Mercy, when I'm gone, I want you to do this. When I'm gone." She talked a lot about, "I want you to do this before I'm gone. I want you to finish medical school, get married, have a child before I'm gone." So it was not as traumatic as you would expect when she eventually passed away.

However, that is something we don't do here. We don't concentrate enough on wellness. Everybody this morning has spoken and talked about wellness in so many different ways. A few years ago, I designed this bracelet and I have some to give to you guys if you're interested. That said, Wellness: the Ultimate Goal. Because I know that if you live well, you will die well. I have been in delivery rooms to see women deliver and I have helped bring some children into this life. I have also been given the opportunity to be at the bedside of patients who were dying. And I can tell you, it is amazing to see somebody who has lived a good life pass on because I have described a woman's death once as, oh my god, that was such a majestic exit. I hope I leave like that when my time comes. And it can be done because I have seen it done and I know it can be done.

I talked about St. Francis giving me the ability to be able to do what I do today and be able to face you and tell you that it is okay to take care of the whole person. So if you  let me indulge here a little bit, I could play for a little clip of what it means to work in the footstep of St. Francis. Is it going to work? Let me see if my IT guy can -- oh, I have it here too? I'm sorry. Well, one of my favorite prayers was a prayer of St. Francis as I grew up. And for those of you who know that, it talks about being an instrument of peace. So, "In love where there's hatred, pardon where there's injury, faith where there's doubt, hope where there's despair, light where there's darkness, and joy where there's sadness." And you know, for a physician, every time I think about this prayer, I tell myself that there's so many opportunities for me to do this every day. And I try to do it with

everybody I encounter regardless of what they are dealing with.

And when we talk about components of health, everybody ahead of me has talked about a different component. We had the physical, which if we're talking about something like that, be this when you're ready, yeah, you can go ahead.

**[VIDEO BEGINS]**

**MALE:** When St. Francis walked out into the world and began his ministry, he left everything behind. It was a selfless act, symbolic of his desire to care for those in need. Today, in the halls of our hospitals, we follow in the footsteps of a single man whose timeless mission continues to inspire the 18,000 doctors, nurses, and healthcare professionals of Franciscan Alliance.

**[VIDEO ENDS]**

**MERCY OBEIME**: Thank you. The sisters have always said that this was their philosophy and this is what they wanted us to do. And I can tell you over and over and over again, I have gone to them and challenged them when I thought that there was something that we needed to do for our community that we're not doing. And I would say, this is what we said we're going to do. This is working in the footsteps of St. Francis. We have to do it. And very many times, I have been allowed to do those kind of things. It's stuck again.

Well this brings me to my current role. I am a board certified physician who practices palliative medicine. If you listen to what everybody has been saying today, we kept talking about taking care of the whole person. Where there's such a specialty and I'm hoping that those of you who are aware of it are working with your state physicians who are interested in this specialty to help us expand it and, more especially, to make sure that we are able to provide this kind of help to minority patients because in my opinion, they need it the most. Because of a lot of people who are -- when somebody is diagnosed with a serious illness, if you have all the money in the world and all the support in the world to take care of it, it is not such a big deal. But when you are diagnosed with a serious illness and you do not have anything, your life just crashes and everybody's in shock and nothing happens. But today, there is a specialty in medicine that allows physicians and other healthcare providers like chaplains, social workers, and aids to take care of the person as a whole person so that we are taking care of our patients with all the dignity they need.

So palliative care is an approach that improves the quality of patients and their families, facing the problems associated with life-threatening illness through prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychological, and spiritual. So you would wonder if there is such an opportunity, why a lot of patients do not get referred for

palliative care.

There are a lot of issues about this. A lot of it is lack of knowledge about the availability of this service. The other service, unfortunately, is economic. If you know in America, a lot of providers are paid based on what you're doing to the patient not really what you're doing to help the patient. So if an oncologist, for example, has diagnosed somebody with cancer, the more you do in the office to take chemotherapy treatment, the more money they are going to make. So I have been in situations where I can have to tell the patient, you know, this medicine you are getting for chemotherapy is not helping you. If the doctor says it's palliative, you don't have to get it unless you need it. And if you don't know that you are not going to be able use it. So please, I want you to be aware that there is such a service that your patients can get.

If you look at this, it tells you why we are talking today as African Americans of the need for us to get involved and of the need for us to protect our community, especially those who cannot speak for themselves. If you look at the black and Hispanic poor, you can see how high their incidents of poor health is. We need to do everything we can to change that. I often use pictures like this to tell you that, you know, life is full of perceptions. And lot of the times we see what we want to see and what we've been made to see. This is a picture that was taken in Nigeria during a medical mission trip. If you look at this picture, you could be on a resort anywhere in the world. Somebody owns this place and actually lives in it. But if you look just a few blocks away from there, this is right there. So for some people in this community, this is their life, this is what they see. Whereas what you just saw before is what they see. So we have to be here and we have to tell our community, we know you can do better. Even though we are all in this community, we know that you're not getting what you deserve and we can help you get it. And end-of-life care and caring for the whole person is one of those things.

I think that a lot of people have heard this before, that "The only thing necessary for triumph of evil is for good men and women to do nothing." I am very privileged and I can say that I'm thankful to St. Francis again because they've allowed me to practice medicine beyond the office. They've allowed me practice medicine beyond just sitting down in a room with a patient. Because of the leverage they've given me to serve and work with the black community in Indianapolis, I have been able to be out there in the community been able to educate and help people to understand that we have to ask. I tell patients, if you don't like your doctor, fire them. There's no reason to be in a relationship where you're not getting anything out of it.

And the last thing, we are talking -- if we pay palliative care providers who have more, going to training to do it right now is not paid for. A lot of hospitals eat up the cost like St. Francis does. And here we are also talking about the POLST (Physician Orders for Life-Sustaining Treatment). And basically that is what Sarah Palin called the death sentence. I want to tell you that it is not -- I have copies of that that we can mail to you later. And I'm hoping that each of your states look at it and hopefully we adopt it. Thank you very much.

**BEVERLY EARLE:** I want to thank our panelists again. This has really, really been good. It's very exciting to have all this information. You heard about attending church has a positive effect on your health. So I'm sure Sunday, we all are going to be in church from now on. And also you heard about surviving racism. And we certainly can identify with that, especially in the last couple of years we all have witnessed this kind of up-close. And also aside from knowing what to eat and how to prepare it, it's really important to be in touch with your inner self, with your inner spirit and know the impact that that has on your health. So with both of our panels today, I think we have gained a lot of information that we can share and that we can personally benefit from. We've got time for a couple of questions. Yes, sir, if you come to the mic.

**BILLY MITCHELL:** Billy Mitchell, representative from Georgia. Dr. Cain, you referenced in your remarks how bigotry, racism, cultural discordance as you called it, contributes to health disparities. And I don't think you can get anyone in this room to disagree with that. But we as legislatures, we try to come up with remedies. And I was wondering, would you be willing to go so far as to say how we might address this issue is for our black constituents to seek healthcare providers that are of like ethnicity?

**RUBY CAIN:** That's only part of the solution because where were the health care professionals of our culture trained? Typically, it's in Eurocentric institutions. So they may have a Eurocentric perspective because we tend to be very segregated. We have a lot of healthcare professionals in our culture who understand the issues and also come from our culture which is a lot more communal, you know, a lot more relationship-driven. In order to really address some of the health disparities.-- And I've got a copy of the health equity quiz and I did not bring enough copies of this one for everyone, but I can give it to the planner so that each and every one of you can get a copy. And what it says is look at where we were four, five decades ago and look at where we are today. Look at where we were four, five decades ago with other developed countries and look where we are today. We spend more on healthcare than any other developed country, but we have the poorest health. We have the greatest poverty and wealth gap of any developed country. Our one percent of individuals who are affluent make more money than 90% of the rest of our population. We've shrunk the middle class and there are so many issues in terms of, you know, labor, in terms of healthcare coverage, in terms of even having time off.

We do not -- we're the only developed country that does not legislate vacation and sick leave. And the typical person only gets two to three weeks, but if you look at most developed countries, they get six or more weeks of vacation. So we need to bring forth a lot of the information of how we're different and why it's hurting us, why it's killing us. And Dr. Satcher said if you just took away the disparity with  which is causing more African Americans to die, you go a great way in eliminating poverty because if you die prematurely, what about your family? If you're the main bread winner in your family, that puts them into poverty.

So addressing the social, the economic, the employment issues will go a long way to improving our

health as well. And yes, we do need more health professionals of color. Dr. Williams?

**DONALD WILLIAMS:** As you may know, the State of Michigan has passed an anti-affirmative action constitutional amendment, which means that all of the state funded medical schools have had to end any type of specified, targeted outreach to African American communities either in the in-state or out-of-state. And what is happening is that the number of applicants, African American applicants, is dropping in the state to the state medical schools. And that the programs that had been in place really to do outreach no longer exist. And I can imagine that in this time in other states, some legislatures are going to use budget cuts as this is -- and cutting back on the state support of medical schools, you will lose your influence that you have to keep these programs in place. So it's really something that you need to worry about. I think we need to look at really getting much more specific mandates maybe around having students come from a specified geographic areas or what have you. But that's the issue.

The other part, of course, is that as legislatures, you have allowed physicians from third world countries to come in. And where they come in, they come in to meet the healthcare needs of the poor in the communities so that what we have done is to make it possible that there is no demand for more black physicians because we are replacing them with physicians from the third world.

**BEVERLY EARLE:** Thank you. We have time for one more.

**ERNEST HEWETT:** Representative Hewett, State of Connecticut. I've got a quick statement and then a question, since I have to formulate it into a question. Connecticut this past year actually in July, we just passed first paid sick days in the United States and the governor just signed it into law. So I just wanted to know from Dr. Cain and all the rest of panelists, do you think it's a good idea for the rest of these states to go back to their states and propose such a legislation? Thank you.

**RUBY CAIN:** Absolutely and as quickly as possible.

**BEVERLY EARLE:** Thank you. We got one more question from the Internet. Okay.

**KAREN YARBROUGH:** I'm Representative Karen Yarbrough from Illinois and I have one of the questions from our Internet audience. Healthcare providers at all levels need more diversity education, especially as it relates to how the patient views and practices his or her religious beliefs to deal with physical and mental disorders. How can this be addressed and implemented?

**KAYTURA FELIX:** Again, I mean, I certainly agree with the observation. Okay. I certainly agree with this and I think what I tried to address in my remarks was what providers can do really engaging patients. You know, really practicing compassionate presence, listening to patients, really taking a good spiritual history. The truth is that I mean in that area, the provider may not be the expert in that area. And so they -- I mean, in that area, they may have to follow the patient's lead. But asking open-ended questions like questions that start with what

and how, usually are helpful so that you listen. The other thing they can do is to work -- I mean, some providers that work in hospitals have chaplains. And so that they can connect with the chaplains and help the chaplains, you know, support them.

**RUBY CAIN:** Typically the way diversity or cultural competence training is enacted is one event. And that's where we really have an issue because we are in a culturally evolving nation. And what was relevant last year may not be relevant this year. So that this should be integrated into the practice, there should be ongoing activities in training in order to address the changing cultural makeup of your community and the patients that you serve. And there needs to be more engagement in the community. The health professionals cannot, as they say, sit on the heel and have everyone come to them. When I was a kid, my doctor came to my house to see me. And granted, we can't have doctors do that today, but they can come out into the community and into the churches and talk to individuals of different cultures so that they get a chance to see them when they're not sick and develop a relationship and a respect and a trust for the health profession.

**DONALD WILLIAMS:** The AAMC (Association for Medical Colleges), which is the accrediting body for American medical schools that graduates MDs has required training in health disparities. The osteopathic schools also. But as, again, as legislators, you certainly can bring pressure on the medical schools in your state, the state-funded ones, to implement such programs that are outreach. That's one thing that you could be talking about. But as you cut back on your funding and discretionary funding of medical education, what is going to happen when we talk about putting physicians out there, who's going to pay for it? Because the only -- the way the healthcare system is set up is if I'm not seeing a patient, I don't get paid. And as you cut out state support, more and more of the medical school faculty income is based on their clinical work and not their training. And so those are some of the areas where you as legislatures, you may -- as you were good at stick something in your budget sometime along the road. That might be a way of doing it.

**KAREN YARBROUGH:** Thank you, thank you. And we want to thank our Internet audience. Did you want to respond as well?

**MERCY OBEIME:** [inaudible]

**KAREN YARBROUGH:** Your microphone is not on, I don't think.

**MERCY OBEIME:** Oh, I'm sorry. You know, sometimes a patient comes to my room, it doesn't matter whether you're black or white. And then you try to ask them a question about why they are there to visit you. And then you try to clarify something. "I don't know, you're the doctor." Well, if you really think that you're going to go to any doctor and the doctor is going to know your body better than you, and the doctor is the one who is going to know which and how many of your 30 medications you are taking, you're wasting your time. Some of the topics that were discussed earlier today about nutrition, exercise, and the things that you need to do are

more important than anything else you can get from a doctor. Secondly, with the healthcare reform movement and even before that, there's such a thing now that is called "medical home." And the medical home means that if you are going to a primary care center that is certified as a medical home, you're not just going there to see the physician. I don't think that we're ever going to have enough doctors where all your nutritional needs will be met.

Again, also it's too expensive. If you go to a doctor where they have a nutritionist and an exercise counselor, a lifestyle behavior specialist who talks to you about smoking cessation and all of that stuff, you get a lot more money for your buck instead of just seeing a physician and then saying, we're not doing x, y, and z. So I think we need to look at some of those options.

**KAREN YARBROUGH:** Thank you, and thanks to our Internet audience for participating with us.

**BEVERLY EARLE:** Let's thank our panel. Thank you all. We certainly appreciate you sharing …