

>> Welcome to our 2018 Public Health Ethics Forum, Minority, Elders, and Healthy Aging, sponsored by the Office of Minority Health and Health Equity, and the National Center for Bioethics in Research and Healthcare at Tuskegee University.

I'm Craig Wilkins, senior advisor within the Office of Minority Health and Health Equity, and will be serving as your MC today.

It's a distinct honor to welcome each of our special guests, our plenary speakers, our session speakers, our discussants, our post-assessment presenters, and other students, and our distinguished panel members.

The purpose of today's forum is designed to reduce the gap in awareness regarding factors that affect healthy aging among minority elders. Experts in the field and distinguished group of elders will explain and illustrate these factors through data, programmatic activities, and personal experiences.

This forum will address the epidemiology of minority elders in the United States, how to effectively recognize and support resilience among minority elders, challenges encountered by minority elders.

The biological, social, and cultural factors that impact healthy aging among minority elders, and approaches for achieving healthy aging for minority elders.

I had the pleasure of being part of a small planning committee that helped organize and plan this year's forum.

My sincere appreciation and gratitude is extended to each of them for all of their hard efforts in planning this year's forum.

Their names are printed on the agenda, and also appear on the screen.

I would like to recognize them with a round of applause after I call off each of their names.

Dr. Leandris Liburd, Dr. Reuben Warren, Dr. David Hodge, Captain Drue Barrett, Dr. Karen Bouye, Dr. Denise Carty, Wendy Holmes, Heidi Holt, Tara Hurley, Ginny Kincaid, Uma Ohiaeri, Dr. Laura Ross, and Jo Valentine.

Can we give them a round of applause, please?

[ Applause ]

So again, on behalf of our planning committee, our office, and Tuskegee University, we appreciate your attendance and participation in today's forum.

Before we begin today's forum, I have a few housekeeping items.

If you didn't sign in before you came into the auditorium, please do so at the registration table.

For each of you who register for the conference, you will receive a link to an evaluation where you can provide feedback about this forum.

Look for the survey in your e-mail box by next week.

We really value your feedback, and your responses will be completely anonymous.

For CDC staff and others viewing the conference on IPTV, we may not have your registration information,

so please contact us at this e-mail address, [omhhe@cdc.gov](mailto:omhhe@cdc.gov)

if you would like to receive an evaluation survey.

For those of you who are watching online on IPTV and live stream, if you have any questions, you can also e-mail us at this address, [omhhe@cdc.gov](mailto:omhhe@cdc.gov).

For those of you who are interested in receiving continued education credit, please note this information on the bottom of the agenda.

For those of you who have ordered lunch through Which Wich, those lunches will be available on tables in front of rooms 246, 247, and 248, which is outside the auditorium.

You take a right, and take the first hallway on the right.

On the agenda, after Dr. Redfield's remarks, the poster session will begin at 11:30.

The posters will be located out in the foyer area.

I would also like to ask you, if you haven't already, to please silence your cell phones,

your Blackberrys, and pagers.

For our breakout sessions

that will occur starting this afternoon, those breakout sessions that you will note on the agenda will be in 246, 247, 248.

For our breakout presenters, AV support will be available at 12:30 to help you load any slides that you may have for your presentations.

Throughout the day, I'm here

to answer any questions that you may have.

And now, to begin today's forum, I have the privilege in introducing to you Dr. Leandris Liburd and Dr. Reuben Warren.

Dr. Liburd is currently the associate director for the Office of Minority Health and Equity at the CDC. In this role, she leads a wide range of critical functions in the agency's work in minority health and health equity, women's health, and diversity and inclusion management.

She plays a critical leadership role in determining the agency's vision for health equity, ensuring a rigorous evidence-based approach to the practice of health equity, and promoting the ethical practice of public health in vulnerable communities.

The Office of Minority Health and Health Equity ensures a pipeline of diverse undergraduate

and graduate students pursuing careers in public health and medicine through its administration of CDC undergraduate Public Health Scholars Program, and the James A. Ferguson Graduate Fellowship.

Dr. Liburd has been instrumental in building capacity across CDC and in public health agencies to address the social determinants of health, and identifying and widely disseminating intervention strategies that reduce racial and ethnic health disparities.

She has skillfully executed innovative models of collaboration that have greatly expanded the reach, influence, and impact of the Office of Minority Health and Health Equity. And raised the visibility of health equity through peer-review scientific publications, engagement with academic institutions, presentations at national and international conferences, partnerships with national and global organization, and other communications and educational venues. Dr. Reuben Warren is professor and director of the National Center for Bioethics in Research and Healthcare at Tuskegee University. As well as the adjunct professor of public health, medicine, and ethics, and director of the Institute for Faith, Health, Leadership at the Interdenominational Theological Center in Atlanta, Georgia. From 1988 to 1997, Dr. Warren served as the associate director for minority health here at CDC. During the years 1997 to 2004, he was an associate director for urban affairs here at the agency for targeted substances and disease registry. And in 2005 to 2009, he was an associate director for environmental justice at ATSDR. He was a director of infrastructure development for the National Institute on Minority Health and Health Disparities within the National Institutes of Health in Bethesda, Maryland from 2005 to 2007. Prior to joining CDC, Dr. Warren served as dean and associate professor of the school of dentistry, department of preventive dentistry and community health at Meharry Medical College in Nashville, Tennessee. Dr. Warren is also a clinical professor, department of community health/preventive medicine, Morehouse School of Medicine, adjunct professor, department of behavioral sciences and health education, Rollins School of Public Health, Emory University, both in Atlanta, Georgia. And adjunct professor in the school of dentistry and school of graduate studies at Meharry Medical College in Nashville, Tennessee. His extensive public health experience at community, state, local, national, and international levels range from clinical and research work in the Lagos University Teaching Hospital in Lagos, Nigeria, to heading the public health dentistry program at the Mississippi State Department of Health. Please join me first in welcoming Dr. Leandris Liburd.

[ Applause ]

>> Thank you, Captain Wilkins, and good morning, everyone.  
>> Good morning.  
>> It's so good to look out and see all of your beautiful faces. Welcome to the Centers for Disease Control and Prevention. To our guests, and to our colleagues, we appreciate the time that you're taking away from your desk to be with us today,

and we know that you won't regret it.  
I cannot describe how excited I am to be part  
of this year's forum on minority elders and healthy aging.  
We are all in for a treat.  
The planning committee has organized a lively, thoughtful,  
and inclusive program.  
A broad range of voices  
and perspectives will be heard today.  
This will not be an ordinary gathering  
of public health professionals.  
We have been privileged to partner with the National Center  
for Bioethics in Research and Healthcare  
at Tuskegee University to host these forums since 2015.  
The inaugural Public Health Ethics Forum was part  
of a year-long commemoration of the life and legacy  
of Dr. Booker T. Washington.  
Founding president of then-Tuskegee Institute,  
and creator of National Negro Health Week, which has evolved  
to become National Minority Health Month  
that we celebrate every April.  
Each year that we've come together to plan this forum,  
I leave with history lessons  
that I would not have learned on my own.  
The breadth of my understanding of minority health,  
of public health ethics, and social justice has deepened  
in ways that wouldn't have -- that would've been absent,  
that wouldn't have happened absent this partnership.  
Tuskegee University is rich in its history  
of scientific discovery and conducting research --  
biomedical, agricultural, and social sciences research,  
among others -- to improve the health status  
and overall possibilities of African-Americans and others.  
The notorious syphilis study, which members  
of the Tuskegee community will quickly remind us was the U.S.  
Public Health Service's study,  
marked a dark and hurtful period.  
But the university's reputation for excellence and leadership  
in science and research has not been marred.  
The Public Health Ethics Forums build upon long-established  
relationships with the Division  
of Sexually Transmitted Diseases, and CDC's Office  
of Public Health Ethics.  
And I want to thank Jo Valentine  
and Drue Barrett for taking their seat  
at the table each year to plan this forum.  
Our goal each year is to examine and then call  
out ethical dilemmas in public health research and practice,  
particularly in our work to reduce racial  
and ethnic health disparities,  
in our work to improve women's health, and in our work  
to achieve health equity for all.  
This year marks the 30th anniversary of CDC's Office  
of Minority Health and Health Equity.  
And I am honored to stand on the shoulders  
of my predecessors, Drs.  
Warren and Dr. Walter Williams, to never lose sight  
of the vision where all people have the opportunity

to attain the best health possible,  
and to strive every day to realize the mission possible,  
which is healthy lives for everyone.  
If we are to achieve the mission of protecting the health,  
safety, and security of all population groups,  
these kinds of opportunities  
to bring together community leaders, scholars, students,  
public health researchers and practitioners, and national  
and local organizations, are needed.  
Thank you for being part of the mission,  
and today's forum will leave a mark you won't forget.  
Thank you so much for being here.  
[ Applause ]

>> Good morning.

>> Good morning.

>> Dr. Liburd has said it all, so I won't belabor  
or repeat what I heard her say.  
I'd like to thank you for being here.  
There's a tremendous value in presence.  
Presence is a powerful message that all should hear.  
Not being a doctor, lawyer, or whatever, not having two, three,  
four, five, six degrees, not having even traveled the world,  
but just being present.  
The power of your presence is what makes this forum important.  
If you look around, it's not crowded,  
because we were intentional on who to invite.  
You're special.

Everybody can't get into CDC.  
You know what you went through to get in,  
and you know what folk are still going through trying to get in.  
So just know you're special.  
The other part about this forum in particular is our focus  
on those who have been there, done that.  
You know, people lament about what it is to be old,  
what it is to be a senior, to be elderly,  
and those who have been there know.  
So we don't debate, and I say we, because I'm 73.  
Proud of it.  
And when I say that to my students, to the students  
at Tuskegee, they look at me real strange,  
like you're not even supposed to be alive [laughter].  
What are you doing here?  
And so, what you'll hear today is those  
who have been there, done that.  
We discussed -- we debated.  
How do we frame the conversation with the elders who have come?  
And what we've agreed, and maybe agree to disagree,  
is just being here for them is enough.  
They don't need a reference.  
They don't need a bibliography.  
Their presence tells a story.  
And so, you'll hear from them, and just know,  
because they said it, it is.  
And if you live long enough, you'll find out.

Let me take this last one before we get started,  
because the day is full --  
is to talk about the evolution of this forum.  
In times such as these, ethics is a critical part  
of everyday conversation, and everybody thinks they're right.  
And in some ways, everybody is, but our struggle, our challenge,  
is to -- how do we come up with a collective right?  
That's public health ethics.  
How do we agree what is best for all of us, not for you or me?  
You're important.  
Not for you -- you're important.  
For all of us.  
And so, somewhere between what's best for you, and what's best  
for us, comes public health ethics.  
So we are supposed to debate.  
We're supposed to argue, if you will, and even disagree.  
But we must agree on -- what is best  
for the collective is what we must do.  
That's what we will do.  
And last and most importantly, we're ranging from those  
who have been there to those who are coming.  
Please note the poster presentations on the outside.  
These young scholars -- let me be clear --  
young scholars have worked hard to bring science to you,  
and I want you to look at it  
and challenge it, and challenge them.  
The power of their presence is what we're looking forward to,  
and the power of yours is more importantly.  
So, again, welcome to this forum.  
We need to hear what you think, what you think is important.  
Thank you.  
[ Applause ]

>> It's an honor for me  
to introduce our opening plenary speaker, Dave Baldrige.  
Dave is a member of the Cherokee Nation,  
a national recognized native advocate for elder issues.  
Dave has served as executive director  
of the International Association for Indigenous Aging since 2003.  
Prior to that, he was executive director  
of the National Indian Council on Aging from 1992 to 2002.  
During that time, he published nearly two dozen monographs  
and papers dealing with long-term care and elder abuse.  
Under his leadership,  
NICOA became the nation's foremost non-profit advocate  
for American Indian and Alaskan Native elders.  
The organization tripled in size while significantly influencing  
legislation and federal policies affecting Indian  
and Alaskan Native elders.  
Dave has been actively involved in public policy  
and research efforts on federal, state, and local levels.  
He has vast experience in the legislative, budget,  
and advocacy process, representing the interests  
of older American Indians to Congress, states, and tribes.  
He has testified before Congress on several occasions.  
He has twice served on the board of the National Committee  
for the Prevention of Elder Abuse,

and has been a technical assistant contractor to the Department of Justice Office of Violence Against Women, assisting Native program grantees. His accomplishments include leading national advocacy for the Older Americans Act, services for American Indian elders. He has authored numerous papers on Indian advocacy, health, demographics, and culture. His work has involved extensive relationships with tribal councils and organizations, and sovereignty issues. His publications on a wide variety of Indian agent issues have been widely distributed and cited. He has interpreted Indian aging issues for congressional sub-committees, federal task forces, state aging organizations, long-term care providers, Indian organizations, tribal and inter-tribal councils. So please join me this morning in welcoming Mr. Baldrige.

[ Applause ]

>> Thank you, Captain, and good morning, everyone.

>> Good morning.

>> I want to start our conversation about health ethics by looking at a few misconceptions that Americans have about American Indians and Alaskan Natives.

[ Music ]

>> Proud, forgotten, Indian.

[ Music ]

Navajo, Blackfoot, Inuit, and Sioux, survivor, spiritualist, patriot.

Sitting Bull, Hiawatha, and Jim Thorpe.

Mother, father, son, daughter, chief.

Apache, Pueblo, Choctaw, Chippewa, and Crow, underserved, struggling, resilient.

Squanto, Red Cloud, Tecumseh, and Crazy Horse, rancher,

teacher, doctor, soldier.

Seminole, Seneca, Mohawk, and Creek, mills, Will Rogers,

Geronimo, unyielding, strong, indomitable.

Native Americans call themselves many things.

But one thing they don't.

[ Music ]

>> Some of these perceptions are romanticized.

Others are derogatory.

Are we noble savages, or despicable heathens?

Disney Media concurs.

In either case, the perceptions are damaging.

They cause us to generalize our opinions of Indians,

who are in fact neither saints nor sinners,

and we don't always see them as other Americans struggling with the hassles of daily life just like us.

The romanticization of Indians is particularly common

in western art, which often portrays a live Indian maiden

communing with a white buffalo who appears in the sky,  
or a wizened chief offering a peace pipe to the spirits.  
And I would say only on very rare occasions do these  
characterizations accurately reflect who we really are.  
So, who's an Indian?  
Really? Well, it depends on who you ask.

Elizabeth Warren, for example, claims, like many Americans,  
to have Cherokee ancestry,  
although her claim is undocumented.  
Cherokee interracial marriages were and continue  
to be very common since the 1880s,  
when this progressive tribe was moved  
from Georgia and North Carolina.  
For many thousands of natives mixed-marriage descendants,  
accurate birth records weren't kept, or were destroyed,  
and their only source of ancestral validation consists  
of family stories, which were passed down through generations.  
Well, for who's an Indian,  
the federal government says an enrolled member  
of a federally-recognized tribe, and it brings a question  
of who do we serve as an Indian.  
For public health, it's tribal members.  
The nation's 567 registered tribes occupy lands  
in 35 states.  
My own tribe, Cherokee Nation, the second-largest  
in the country, has more than 300,000 members,  
many of whom live in other states around the nation.  
Tribal lands are 14 counties in northeast Oklahoma,  
and Cherokee Nation bases its membership on descendancy.  
If you can show that your ancestors were designated  
by the 1898 Dawes Act or other earlier federal census rolls,  
you can register a member -- to be a member of my tribe.  
For most other tribes, they based their membership  
on blood quantum,  
with requirements sometimes as high as 50%.  
The issue of tribal membership can become especially  
contentious when, say, a small tribe operates a  
highly-successful casino, as in the case  
of several California Rancherias.  
In those cases,  
tribal membership can be worth a significant fortune.

Ever since our nation was founded,  
the Indian issues have been considered a federal matter,  
not one regulated by states.  
The federal trust responsibility exists as a mandate  
to provide healthcare and other services to Indians.  
It was established by Congress on the basis of treaties,  
statute, and case law.  
As Congress granted quasi-sovereign status  
to tribes, authorizing them to administer their own affairs,  
states and tribes have conflicted over issues  
of jurisdiction and services.  
Former Chairman of the Senate Committee on Indian Affairs,  
Daniel Inouye, commented in 1998 -- I was there in Washington --  
that Indian legal issues are among the most complex



in all American jurisprudence.  
Tribes and states continue to experience conflict over matters of law enforcement, criminal prosecution, gaming, and Indian child welfare.  
States don't provide health services for tribes, and don't consider themselves accountable to the federal trust responsibility.  
That FTR, the federal trust responsibility, is critical to Indian Country's survival, and it's the basis for public health entitlement in Indian Country.  
But here's a little-known aspect.  
I point this as a very important one.  
The Cobell Commission's 1977 final report on trust responsibility said, quote,  
"The trust obligation extends not only to tribes as governing units, but also to their members, wherever they may be.  
There is nothing in the law which holds that the federal trust responsibility stops at the reservation gate, nor do sound policy considerations dictate such a result.  
On the contrary, consistency and fairness demand just the opposite," unquote.

Overall, the census reports 5.2 million American Indians and Alaskan Natives.  
Our population, fueled by a cohort of the youngest mothers in the nation -- average age 23 -- means the overall Indian population will triple by 2050.

Need to bump one here.  
Native baby boomers -- a cohort which will grow by 700% by 2050,

are now elders, with all the attendant problems associated with aging.

Many boomers are -- in Indian Country are reaching the ranks of the old-old.

And we continue, as we have for the past 30 years, to move off the reservation.

About four out of every five Indians is now urban.  
My long-time colleague and friend, Dr. Mario Garrett, is a psychology professor at San Diego State University.  
He calls this the greatest demographic shift in American history.

The reasons for this huge out-migration from reservations are multiple, and the effects far-reaching.  
The implications for public health are enormous.

Our public healthcare delivery system, primarily administered by the Indian Health Service, is still based on a paradigm from the 1930s, when 90% of Indian elders lived on reservations.

Today, that number is only 20%, one out of four.  
The paradigm continues, however, to direct our public health services to tribes, not to individual Indians.

Indians are moving away from reservations in remarkable numbers.

We leave for many reasons, but we can no longer be considered, understood, or served as an exclusively rural population.

We leave for our health.

Most health indicators show that Indians die of higher rates compared to whites of TB by 600%, alcoholism 500%, motor vehicle crashes 230%, diabetes 190%, unintentional injuries 152%, homicide 160%, and suicide 160%. Devastating.

Compared with the overall population, Indians, to put it mildly, have poorer health and higher poverty rates. The federal trust responsibility, our socioeconomic and political contract with Indian Country, is clearly failing them.

A few years ago, South Dakota Senator Byron Dorgan observed that men on the Pine Ridge Reservation have the lowest life expectancy, 55 years, of anyone in the western hemisphere except men from Haiti.

Navajo Nation, America's largest tribe, is as big as North Carolina, and has as many miles of roads. Their diabetes rates are two and a half times those of the United States.

At Tohono O'odam, an Arizona tribe 200 miles south of Navajo Nation, type two diabetes remain among the highest in the world.

We leave the reservation to escape poverty.

On San Carlos Apache Reservation in southern Arizona, 25% live in extreme poverty, six times the national average.

We leave to escape despair.

Indian youth have the highest suicide rate of all comparable ethnic groups in the United States.

It's the second-leading cause of death for Native youth aged 15 to 24.

Hopelessness is rampant on many reservations for our youth.

Nearly 77% of American Indians have a high school education, but inversely, on Navajo Reservation, again, for example, only one in four are high school graduates.

This picture holds true on at least nine other reservations, and probably many more.

It doesn't bode well for Indian Country's health literacy.

We leave for careers, but only 5% of Indians and Alaskan Natives have received graduate

or professional degrees, compared to 10%

for the total population,

and only 9% of American Indians have earned bachelor's degrees, compared to 19% for the U.S. population.

Very few career opportunities are available on reservations, so we migrate, which continues to fuel this massive migration.

So the effects of out-migration on reservation elders -- when their sons and daughters leave, what happens to the reservation elders?

As younger natives migrate away from reservations, fewer family caregivers remain to take up the slack.

The CRI -- some years ago, Dr. Mario Garrett and I created a report for CDC featuring the caregiver ratio index, or CRI.

It's a ratio of how many younger adults there are in a community for every older adult.

The figure tells us how many younger potential caregivers exist in a community for every older adult.

The results showed great diversity among Indian communities.

Some have a CRI of six, others of zero.

Low score or low ratings indicate

that these communities don't have informal support systems to rely on.

Whereas for many Indian communities, more than 90% of elders are supported by their children, especially female children, in some communities, this resource, because of out-migration, doesn't exist much anymore.

In the U -- the U.S. Census tells us that in the 1940s, 8% of Indians lived in cities.

In 1970, it was 38%.

In 2010, 78% resided in cities.

Today, more than 80% of Indian people live outside the reservation in what are known as urban areas.

This brings a real challenge for public healthcare systems.

Urban Indians are often not able to get IHS or tribal healthcare except back at their tribe, which may be hundreds of miles away.

Urban Indian centers have a multi-tribal service population.

The clinic in Oklahoma City, for example, serves Indians from 114 tribes.

It's huge.

Many will be low income, often socioeconomically and educationally disadvantaged.

They may have low levels of health literacy, and may not have access to health benefits coordinators or advocates in the cities.

Leaving the rez -- well, it's a big step.

It means loss of tribal law enforcement, the tribe's judicial system, local healthcare, and social services.

These are not available directed to Indians in cities.

It means the loss of tribal social and religious ceremonies, and probably most of all, it means loss of a close-knit community which shares common values and informal social supports.

Urban Indians in cities tend to scatter, not living in ethnically-intact communities or neighborhoods.

This makes them more difficult to serve, and again, they usually have to return to their tribe to get primary care.

Urban Indian centers -- public health for Indians continues to operate under an outdated paradigm

that provides almost all its services to reservations.

In the new Indian America, demographically, the paradigm is no longer valid.

Indian healthcare is provided by what we call the ITU system, meaning IHS, tribal, and urban.

IHS delivers care through 26 hospitals, 59 health centers, 32 health stations around the country.

That's a lot.

Tribes in Alaskan Native corporations run 19 hospitals, nearly 300 health centers, 80 health stations, and more than 160 Alaska village clinics.

Thirty-eight Indian clinics exist in the nation, although with limited funding, their services are also usually limited.

The Indian healthcare budget, the root of all evil, the root of most evil in Indian Country --

the Indian Health Service has provided Indians with healthcare since 1955, including both primary and public healthcare, along with facility construction and maintenance.

It uses a system of providers in 12 geographic areas.

Under compacting and contracting regulations, though, several hundred tribes, known as 638 tribes, now operate their own healthcare systems with money that previously was allocated to IHS.

They, too, operate under the same enormous budget shortfalls.

In 1992, I was still --

I was new in my job in Indian advocacy, and I learned there were only three tribes in the whole country that were taking over their own health services.

They do a better job, often, than anyone else, because they're so culturally-couched and culturally-appropriate.

Now that number of 638 tribes is greater than 400, maybe greater than 500.

It's been an enormous shift in the delivery system.

So the IHS mission has been impossible to achieve due to historical, chronic, and severe underfunding.

By comparison, the 2018 VHA, the Veteran's Admin -- or VA, the Veteran's Administration,

has a medical budget of about \$86 billion, more than 14 times that of IHS, while serving a population that's only four times greater.

Indian patients still receive only 1/3 the per capita health spending of the general U.S. population.

This is a fundamental reason why reservations and tribal villages continue to suffer third-world conditions and documented poor health outcomes.

Life expectancy averages four-and-a-half years less than that of other Americans, and even as high as 20 years less on some remote rural reservations.

In 2010, 78% lived in cities.

Historically, less than 1%

of Indian Health Service funding goes to grants and contracts for services to urban Indians.

Less than 1% of the budget for 80% of the people.

Probably the first public health initiative from Indians occurred in 1763, when Jeffrey Amherst, commanding general of British forces during the French and Indian War,

distributed smallpox-infected blankets to the Indians, quote, "to extirpate this execrable race," unquote. The resulting resilience of Indian elders is evidenced in part by their survival of this and other genocidal atrocities that occurred sometimes more than 100 years later, notably at Sand Creek, Colorado, and Wounded Knee, Montana, where hundreds of men, women, and children were slaughtered. Today, although plagued by health and socioeconomic disparities, which remain huge, the wellbeing of Indian elders remains one of the highest values expressed by the nation's 567 tribes. They are revered as wisdom-keepers, examples of courage, and spiritual leaders. They have served in the U.S. armed forces at three times the rate of other Americans.

Public health messaging works for Indians when it is -- the successful public health initiatives that follow share some things in common. I'm going to name three or four of them that I think are wonderful -- wonderful examples. They all use Indian providers, both organizationally and personally. These programs are not only conducted by Indians on the ground, but have been created from the outset with Indian input. The Eagle Books were designed by Georgia Perez, a Pueblo woman, and implemented by CDC's Native Program. The IHS Special Diabetes Program for Indians began supported by the tribal leaders' Diabetes Committee. Indian direction, Indian input. The Palliative Care Program at Fort Defiance began with strategies of the IHS hospitals' palliative care team. They were all Navajo local residents, deeply couched in their culture, and friends with their neighbors.

Let's look at the Eagle Books. By the way, thanks to Delight Satter, these are available at the table during the break outside. We have sample copies for you. They have been a spectacular success for us. It was created in -- the series of four books was created in 2006 by CDC's Native Diabetes Wellness Program. Targeted to children ages four to nine, it features animal characters -- a wise eagle, a grateful rabbit, a clever trickster coyote, and four young Native friends who promote the gifts of healthy food, and the joy of physical activity. More than three million of these books have now been distributed around the world. The first year alone, requests came in from as far away as Pakistan and Argentina. Dawn Satterfield, director of the CDC Native Diabetes Wellness Program, just had surgery, and can't be with us today, but she's arranged, thanks to Delight's help,

for copies of the book to be available for you guys.  
At the Smithsonian -- in 2008,  
CDC convinced the Smithsonian's National Museum  
of the American Indian to host an exhibit of 72 paintings,  
the book's original artwork.  
After a long show at the museum, the books were featured  
in a traveling exhibit.  
*Through the Eyes of the Eagle*, illustrating healthy living  
for children, which visited dozens of tribes  
over the next six years.

Another spectacular public health success began  
when Congress established the Special Diabetes Program  
for Indians, the SDPI, in 1997,  
to address this growing epidemic.  
These tribally-based programs have become the nation's most  
strategic, comprehensive, and effective effort  
to combat diabetes and its complications.  
SDPI currently provides grants for more than 400 programs  
at tribes in 35 states.  
Another great example -- despite multiple researchers concluding  
that discussing negative information,  
like end-of-life care, was considered culturally offensive  
and potentially harmful by 86% of Navajo elders, in 1990,  
at the Fort Defiance IHS Hospital, Dr. Tim Domer  
and his Native team turned that conventional wisdom on its head.  
Using a new approach based on PACE,  
the Medicare hospice benefit,  
and Eric Coleman's care transitions model,  
this team increased patient completion  
of durable medical powers of attorney from 4% to 89%,  
and advanced directives from 1% to 85% over nine years.  
Wow. Those numbers are far above national averages.  
Working at this remote reservation location  
with a highly traditional service population,  
Domer said simply, "We work to build trust."  
To their great credit, CDC, the Alzheimer's Association,  
and other national organizations have collaborated since 2001  
to create a national public health agenda  
through the Healthy Brain Initiative  
for addressing Alzheimer's disease  
and related cognitive health diseases.  
The agenda is expressed through a series of roadmaps designed  
to define and implement a series of collaborative goals  
and actionable objectives, or action items  
for our public health system.  
The first two roadmaps covered the periods 2000 to 2018.  
The next one, for 2018 through '23, will include,  
for the first time, American Indians and Alaskan Natives.  
Earlier this year,  
the Alzheimer's Association contracted with my team,  
the International Association for Indigenous Aging,  
to conduct two national consultative webinars,  
one for tribal health directors,  
one for tribal senior program directors,  
to learn their thoughts about the roadmap, and the effects  
of Alzheimer's in their communities.

We learned that really no systematic initiatives are in place to address this crisis. The HBI, for the first time, will now include Indian Country -- an Indian Country component, and it is launched through consultation with Indians. So where does that bring us? On August 19th through 22nd, in the year 2000, more than 1000 Indian elders from 105 tribes came together at Duluth, Minnesota for the National Indian Council on Aging's conference. For three days there, inspired by messages from tribal and spiritual leaders, the elders deliberated, then created a spiritual message to America. I quote some excerpts from their message. "We pray that we can respect the diversity of America. All life is sacred. We pray to learn ways to settle differences peacefully, teach respect for each other's ideas, value honesty on all levels, from children, to parents, to community, to governments. We will be happy only when we create peace with each other. To the seventh generation -- " excuse me -- "survive. Keep your hopes and dreams. Take care of yourself. Remember your spirit. Be there for each other. Respect courage. Share knowledge. Always keep learning. Remember your true values."

If we listen to them, we'll be okay as their public health partners.

Thank you very much.

[ Applause ]

>> Okay. Yeah.

Thank you, Mr. Baldrige, for a fantastic presentation. We have a few minutes for any questions for Mr. Baldrige at this time.

>> Yes, go ahead.

Sorry.

>> I just wanted to thank you so much for that perspective on Native Americans and the journey that they've been on, in terms of their healthcare, and throughout the last many years, the struggles that they've been up against.

What would you suggest would be next steps for us, in terms of solutions to some of these problems and inequities in service delivery?

>> The elements that have made our public health programs successful in the past are just key.

At the very top of the list --

I've been told that the most important issue for every tribe in the entire nation is self-determination, and so often, we bring our programs to them top-down. The program is developed,

and then we'll see how we can implement it in Indian Country. These successful programs, some that I've described, have started at the conceptual level by including Native people, whether it be tribes or Indian organizations, or experts about an issue. But that involvement from the start seems to be a fundamental key level. So I'd say develop every program with Native -- you know, Native partners from the very start.

>> Thank you.

>> And thank you for your question.

>> I have a question.

>> Yes, ma'am?

>> Yes, I'm sorry I was a little late, but what is the predominant tribe -- the predominant three tribes that are concerned with the issue of -- in the conference that you attended, the issue of Alzheimer's disease?

>> That's a good question.

What three tribes --

>> The predominant three tribes.

>> -- are dominant in the consideration of Alzheimer's disease?

>> Yes, and I'm sure you covered placement, such as -- Emory has rehabilitative hospitals, and Emory has an assisted living program.

So where -- what kind of placement facilities -- or does that exist?

>> Very good question, too.

Earlier this year, the Administration for Community Living, the ACL, issued \$5 million worth of Alzheimer's and related dementia grants. Some went to states.

Another category included nonprofits/Indian tribes. Because the need is so great in Indian Country, my organization started identifying tribes that were deeply involved and eligible to apply for these grants.

In order to apply, you have to be a member of an existing coalition that is addressing Alzheimer's and dementia locally.

We searched for three months.

We could not find a tribe that is part of a coalition.

We ended up talking with the United Nation in Wisconsin.

They are a tribe that's very capable, that are part of a small state coalition, but essentially, Indian tribes were excluded from the application process because we don't have yet coalitions in Indian Country.

I am sorry.

I could not name three tribes to you that are doing effective work with Alzheimer's disease.

>> Thank you.

And the second part of the question?

>> Sorry?

>> Second part of your question --

>> The second part of the question -- oh, is that --



I guess that response would be applicable also to the second part.

Since there were no coalitions, then they were not eligible to receive part of the grants for placement for assistance. Is that correct?

>> Yes. Next steps we could take -- during our consultative webinars, we got more than 40 responses from tribal health directors and tribal senior program directors. They indicated that the awareness of Alzheimer's and dementia is high, and Indian people are afraid of it, yet nothing programmatically is being done to address it. We're not getting early diagnosis from physicians. We don't have community programs on the ground to help with stuff. And so, my thinking is that we would start with inter-tribal councils. There are a dozen of these around the country. They range from the Northwest Portland Area Indian Health Board, which serves 42 tribes as its members, and the health directors of each of those tribes will be part of the board. The Five Civilized Tribes in Oklahoma, some of the nation's largest and most progressive tribes, only has five tribal members, but the intertribal councils deal with the health interests of all of their member tribes. And I believe that's a really viable point of entry to Indian Country. I hope that helps.

>> Thank you very much.

Thank you.

>> Thank you, Mr. Baldrige.

I was wondering what kind of advice you might have for those programs, particularly at CDC, where most of our funding goes directly to states. And you mentioned that states sort of don't see their responsibility to the tribes. They see it being a federal responsibility. So how do we facilitate better relationships? Because I work in the Division of STD Prevention, and most of our funds go directly to states and city health departments. And so, I'm really concerned, because we also want to make sure all populations get the services that they need. So how do we build better bridges, and what can we say to states to help them better engage to working with the Native American populations?

>> If I could -- if I could answer your question, I would become the most famous Indian you ever met [laughter]. That antipathy has existed, as I mentioned, for a number of years, decades, and we're finding cases now, as America becomes more homogenous in many senses, and Indians are far more acculturated -- I mean, our baby boomers ride Harleys. The partnerships are springing up between progressive tribes and progressive states.

There are other states --  
I could name four or five easily --  
where the states have not supported tribal interests  
at all, and that antipathy still remains.  
But I think there are examples in many places now  
of emerging new partnerships between tribes and states.  
The need is so great, yet the states are strapped for money,  
just like the federal government in many cases,  
and they can't afford to target a special population  
that they don't have a mandate to serve specially.  
So a difficult one, but I think it's doable.  
Yes, ma'am?  
>> Thank you, Mr. Baldridge, excellent presentation.  
You pulled together a lot of really, I think, important facts  
for us to think about as an agency as we're moving forward  
with our programmatic work.  
So my question is building on the question  
that was asked a minute ago about placement of individual  
who have Alzheimer's or related dementia  
when they need assisted living, or skilled nursing care --  
so in other words, long-term services and supports.  
You mentioned the caregiving ratio,  
and how we're seeing people leave reservations,  
and families -- younger -- and we see this in, you know,  
some cities across all different racial ethnic groups,  
that the kids are moving out and leaving mom and dad there.  
And so, I guess my question is, what is the picture  
of caregiving and support?  
So are there assisted living facilities?  
Where do American Indians and Alaskan Natives go  
when they don't have family or other people  
to help provide care for them?  
So what happens?  
If you could, tell us a little bit about that, please.  
>> That informal care system has been profound for, you know,  
centuries almost, and so we're --  
I'm seeing a lot of elders who are caregiving for other elders.  
So if there's an out-migration of kids,  
we've got to work with who's left.  
I think some tribes are having success with localized programs.  
They have, for example, volunteer groups who meet  
to discuss Alzheimer's, and what they can do  
as caregivers about it.  
And they're -- those programs originate locally,  
in the communities, and they're not funded.  
I mean -- and they're sparse.  
Excuse me for a second.  
There is a lot of denial -- as you mentioned,  
there is across the U.S., probably,  
about the embarrassment  
of having a grandma with Alzheimer's.  
Families really value their privacy, and in small,  
isolated communities, that's a really valued  
and difficult commodity.  
So it's a family matter is a common response,  
as we turn away from it.  
It's just a normal part of aging, as we turn away from it.

But we're just at a point in Indian Country  
of recognizing our denial for one thing,  
that it really is not normal, and that it is a problem --  
behavioral health diseases.

And so, we have so far to go, and certainly, I guess,  
from my perspective, we really need direction  
and participation with CDC.

That's the best I can do for you.

Sorry.

Anyone else with any comments or questions?

Well, thanks.

I really treasure my history with CDC, and being able to work  
on some of these projects, like with Lisa  
and with the Eagle Books over the years.

So please, just keep the faith,  
and remember those Indian elders' message, you know.  
Stay strong, hold strongly to your beliefs,  
and they will lead us all to the heart of Indian Country.  
Thank you very much.

[ Applause ]

>> To introduce Dr. Reuben Warren,  
who will be moderating our panel session this morning.  
Dr. Warren?

>> This is a very, very special session,  
because it's really targeted to those  
who need to learn something.  
So I suspect that means everybody in here.

And what we really want to do is --

-- have a conversation.

Thriving and aging with dignity --  
and the planning committee worked very hard to try  
to figure out what we were supposed  
to learn from this session.

So we sat, and we had discussions and debates  
about the objectives of the panel.

What is it that we are trying to achieve?

We talked about objectives, and so I'm going to read them  
to you, so you can see if we accomplish them  
at the end of our conversation.

To identify biases that comprise --  
that compromise healthy aging.

And I'm saying those so you can reflect on your own biases.

I mentioned it this morning.

Students where I teach have a bias about me,  
so I say without apology, "I'm 73."

And they're shocked, so their biases become very obvious.

And what it says -- what I take from that is that --  
what are you supposed -- what are you doing here, old man?  
That's the bias that I see in their face.

Explore community understanding about the difference

between being viewed as elderly, and elder,  
and an emerging elder, Dr. Georges.

We wrestle with that in our panel,  
in our planning committee.  
I got offended.  
We started talking about elderly,  
and all the conversation was about dying, and suffering.  
And I said, "No."  
So let's shift the paradigm.  
Let's think differently, if you can, and I'm sure  
when you finish listening to our elders, you will.

Examining ethical considerations that should have --  
that should drive public health efforts related  
to achieving healthy aging.  
What should public health do?  
And most of the folks in public health are not elders,  
so I would argue that they ought to listen.  
And that's part of what we brought the elders here for us  
to do, learn how to listen.  
And to assure social justice in the experience of healthy aging.  
Social justice, in my view, is public health 101.  
So that's what we intend to do with this group of elders,  
and so what I -- I'm not going  
to ask them questions for them to answer.  
I'm going to read the questions,  
and let them respond to the questions.  
But before I do that, I want to take one moment  
and let them introduce themselves,  
because I wouldn't -- I couldn't be so insulting  
to say I know who you are.  
So let them tell you who they are.  
So why don't we start with my immediate right,  
and just let one of our elders say who you are,  
your background, and where you're from,  
and anything else you want to say?  
And we have a mic.  
>> Yes, my name is Elias Segada. [assumed spelling].  
I was born in Puerto Rico, USA, and I am 88 years old.

[ Applause ]  
Thank you.  
And it's funny -- I have three cancers.  
They have been treated at Emory,  
and the main one that's giving me now, like,  
more trouble is a bone cancer.  
And I'm getting chemotherapy for that, but I'm doing okay.  
I live in Duluth, and I am -- I'm retired.

I look at what you were saying -- I mean, every day, I mean,  
I look at -- I live day by day, and I feel happy.  
I feel happy.  
I -- when I'm going to sleep at night, sometimes,  
I get a little -- and then I think of what I'm going  
to do the other day, what I'm going to have for breakfast.  
I have to prepare it myself, because I live alone.

But I feel happy.  
I watch my TV, and my computer.  
I mean, I love my computer.  
Because of my computer, I read papers from all over the world.  
I read newspapers, and then I --  
if I cannot see the letters well, I put them bigger,  
and I am -- I could say I'm living a happy life.  
>> Fantastic.  
Okay.  
>> And that's what I'm doing.  
[ Applause ]  
>> Ms. Cruz?  
>> Yes, my name is Nadine Irene Istanislau-Cruz  
[assumed spelling].  
I'm an immigrant from the Philippines.  
This year, my mother, who is alive,  
turned 97, and I turned 70.  
And our newest grandchild was born,  
and he's three weeks old [laughter].  
So this is a good year.  
I don't like credentials for myself.  
I think of myself primarily as a person who's searching  
for different ways of looking at things that are in front  
of our faces, like growing old, and being at that stage in life  
where I think more closely or more seriously  
with intentionality about how to die well as part of living well.  
And as part of being healthy.  
So I've worked mostly in higher education over 30 years  
in what is called public service education,  
so I've taught service learning, civic education, public service,  
scholarship at various institutions  
in the United States, and I have also run a consortium  
of 18 colleges.  
So I've been connected with education for a long time,  
but I'm also a very, very deep critic of the very thing  
that I'm associated with.  
So my typical way is to be a critic  
of the conventional way of looking at things.  
So I will be speaking out about how I feel uncomfortable  
with how elderly and elder is defined, at least as far  
as I can -- as far as I hear it around me.  
Thanks.  
[ Applause ]  
>> My name's Chester Antone.  
I'm from Arizona, southwestern Arizona,  
a member of the Tohono O'odham Nation.  
Our nation borders on Mexico,  
  
and we have been primarily involved with healthcare  
as a politician, I guess you might say,  
but I don't lie [laughter].  
But yeah, I was in denial for quite a long time until CDC  
and Tuskegee told me I was elder --  
elderly, so here I am [laughter].  
So, yeah, it's -- we run into a lot of the issues nationally  
with the Native American population elderly,

and we talk about it.  
We try to figure out ways of --  
how to serve, because in our way,  
and most Indian communities, the elderly are special.  
They're honored, but as you'll see,  
some of the conversation may turn into a gradual erosion  
of what we used to be.  
But I'm here, so I'll be participating.  
[ Applause ]  
>> You too.  
>> It's your turn to talk now.  
>> Okay. Good morning.  
>> Good morning.  
>> My friends --  
>> Yes.  
>> -- and I say you are my friends, because you're here.  
My name -- I'm going to give you a long name.  
My name is Mamie Viola Henry Watkins-Clemmons

And it took me a bit over 100 years  
to get here, to be here with you.  
[ Applause ]

Thank you.  
Thank you very much.  
I guess you would like to know a little something  
about my background, which I don't have long enough  
to tell you about it [laughter].  
But I was born in Evergreen, Alabama,  
and when you think you're in Evergreen,  
go a little further out to China -- China, Alabama.  
And I was told by several they don't know how we got  
to be there, because it was back in the woods.  
I was fortunate to be born of two parents  
that were both schoolteachers, and to be able to go to school  
to your relatives -- it takes a bit [laughter].  
But I'm thankful to be here, to tell you a little something  
about it -- my education, if you call it that.  
Able to walk to school while others rode buses to school,

but we were able to be taught of things  
that would concern you later on in life.  
Meaning that there's no stopping place if you really want  
to be somebody, so to speak.  
So I'm very grateful this morning to be here  
to tell you a little about life, education a bit.  
Being taught by my parents, then being taught by my brother,  
who moved from the country all the way to Tuskegee,  
and after Tuskegee, many, many other places --  
but I'm thankful -- grateful to be here now.  
Sound a bit repetitious, but that means that's  
so I'll be able to let you know, and you may want  
to ask questions after that.  
But able to go to school, to walk to school.  
After being -- finishing 12th grade,  
and moving to Alabama State Teachers' College at that time,  
being able to teach on a provisional certificate,

meaning that the community wanted you.  
I walked two miles to a two-room school,  
where two teachers taught, and kept warm by a stove  
that wood was cut to make fire  
for the children in order to study.  
Moving from there, being at Alabama State University now,  
to Tuskegee, and you've heard a lot about Tuskegee.  
You will be hearing about Tuskegee.  
Then, receiving a BS degree from the University of Pittsburgh.  
Now, I'm able to tell you a little about the school,  
and the teachers that came from that two-teacher school room.  
We could point them.

Yeah.

>> We going to get to that later [laughter].  
I've been knowing Ms. Clemmons for a long time,  
and she taught me -- she's Aunt Mamie.  
So I'm -- just wanted to let you know, that's Aunt Mamie.  
Let me ask -- that was the answer to the first question,  
so I didn't have to ask.  
Tell them something about yourselves.  
What I'd like to know now from the panel is,  
what has most impacted your life?  
We're going to start at the other end.  
What has most impacted your life?  
>> I'm trying to think.  
I've already done so many things,  
but I believe my mother had such an important part in my life,

mainly making me  
and my personality as a positive person.  
I'm an eternal optimist, and what -- the way she taught at --  
>> Speak a little louder.

>> -- can I -- yeah.

Can you hear me now?

>> Yes.

>> Yeah. Sounds like an American [laughter].

Anyway, can you hear me now?

[ Laughter ]

Thank you for telling me.

I was born in -- as I told you, in Puerto Rico  
at such a long time ago, and it was so, so different.  
We were poor, and it was different at that time.  
I know someone here asked a lady that she has 101, but I have 88,  
and it was so different.  
But that was what most impacted me, was my mother.  
>> All right.

Next?

>> What has most impacted me?

I'm going to say it straight-up, because it's part  
of what I would like to share.

There's a lot of stigma attached to it --  
is that when I was three or four years old, somebody came  
into our house, pointed a gun at my father,  
and gunned him down and killed him.

My mother, during World War II, saw her fiancée shot and killed  
by an American soldier  
who thought they were the Japanese enemy,

because all Asians look alike.

Those killings are part of --  
I think of inter-generational racial --  
historical racial trauma, and a lot of what I have --  
most of my 70 years has been focused on the particularities  
of my individual family.  
And it has taken me a very, very long time  
to see my family's health in the larger context of large swathes  
of history and social systems.  
And so, that's what I hope to be able to share,  
is what I have struggled to figure out about my own life  
in the context of the larger historical drama,  
to figure out how to be a healthy, thriving older person.

>> What has impacted me the most in education?  
My mother, who really didn't know too much made sure  
that I sat at the table and did my homework every night  
under the -- there was a kerosene lamp.  
For her to do that made me pursue education  
at different times in my life, and eventually make it  
out of the University of Arizona,  
and that's the first in our family.  
But the other thing that I think had more of an impact on me,  
as far as how I view life, right now, as being something given  
to you by the Creator, that you should honor it --  
I came to that realization by having to have lived  
through many dark moments.  
I'm an alcoholic for maybe over --  
been sober now for over 20 years.  
But --

[ Applause ]  
-- but that experience has taught me the value of life now,  
and I just want to be a part of it now, and be happy,  
and do what I can for the people.  
>> The most important thing -- the one most important --  
>> The one most important thing  
in my life has been the prayer life of my parents, and the idea  
that was put into my head was that you can --  
there's no height that you cannot reach if you are willing  
to pay the price all the way.  
So I've been impacted by people, dealing with people,  
knowing people, and being a part of their lives.  
That has impacted my life, to want to be a loving person,  
and be loved by those.  
[ Applause ]

>> This question is a little sensitive one.  
Give me an example of something that's been a bias  
or a prejudice to you -- something or some event,  
bias or a prejudice to you.  
Yes, sir.

>> I -- I studied in the University  
of Miami Coral Gables long ago.  
And at that time, I remember there was still segregation,



which when I came, was so strange to me.  
Because we didn't have that in Puerto Rico,  
but I felt segregated -- what struck me -- once, it was a --  
like a chauffeur of a bus.  
And I handed him some money, and he made some comments.  
I don't even recall it now, but I felt myself --  
he made some comments as to -- because he heard my accent,  
as to derogative [inaudible],  
and I probably couldn't understand part of it.  
But a friend of mine that was with me --  
he was from Cuba, and he heard it.  
He knew a lot more English than I did  
at that time, so he answered him.  
And, I mean, that's an occasion I can remember when I felt  
like -- like, prejudiced because of my --

>> Thank you.  
>> -- you're welcome.  
>> There are so many [laughter] that I -- throw out a few.  
So I used to have hair below my waist.  
I chopped it all off because I could never, it seemed,  
establish a sense of my authority with the long hair.  
And so I chopped it off because nobody believed I was actually  
the teacher in the class.  
So where's the teacher?  
Well, I'm the teacher.  
Oh, you don't look like the teacher.  
That was one of many.  
Another would be, like, oh, why are you so emotional?  
Followed with, why are you so analytical [laughter]?  
And so, either I was overly-analytical,  
or overly-emotional, and then the last one -- example --  
there are just so many, but I'll just throw out these three --  
is -- so I was invited to give a presentation  
on United States-Philippines relations.  
And at that time, it was during the dictatorship  
of Ferdinand Marcos, and I was working  
on a social justice movement on human rights violations  
under the dictatorship of Marcos.  
And then, I included why the United States was implicated  
in giving military aid to a dictatorship for the containment  
of communism in southeast Asia.  
And the response at the end  
of my presentation was not curiosity about anything.  
It was, "Well, why don't you just go back, then,  
to the Philippines, if you don't like it here so much?"  
So, a few examples.

>> My experience has been that a corporation in our native lives  
from things outside coming in has been most difficult.  
And I don't want to say anything  
about something that's true nationally among tribes,  
but in my particular tribe,  
it seems that a corporation has kind of led us to become  
like the federal government.  
And the same thing

that oppressed us, we seem to oppress.  
We learned it.  
If you look at our system of government,  
ours is a three-branch government,  
but all that bureaucracy is the same.  
But we still argue with the federal government  
about their bureaucracy, which we inherited,  
and that has kind of, like, a negative effect on how we feel  
about Indian for our elders.  
Because that's what I said earlier, that we're seeming  
to lose that which we had for our elders.  
We have an adult protection ordinance.

Why? To illustrate that how far we've come to get to that point  
where we actually need an ordinance.  
And long ago, we didn't --  
we didn't need an ordinance because it was just natural.  
You took care of your elders like you go on a hunt  
and you were able to get lucky to bag a deer your first time.  
Take over to the elders.  
You don't get nothing out of it.  
Then after that, you always have to give some to the elders.  
So it's -- it changed from that due to the time period.  
And I guess that's what I wanted to --  
how to answer that question.

>> The great part of my life has been to be happy.  
To be happy and to make those around me happy.  
And whatever I could do to see happiness even in the face  
of a child, if the child looked worried at school,  
I'd like to make him happy.  
And I've always thought of this.  
If you are happy, can't anyone make you mad [laughter]?  
If you can make me angry, then you're smarter  
than I am [laughter] because I believe  
that no way should we walk  
around sad even though things may not go according  
to the way even others around you they may go  
of what you have seen or what you have learned.  
But you become that type of person that you can climb  
as high as the good Lord would let you go.  
That's what I think.

>> I asked Aunt Maime to give me an example of something bad  
or some prejudice, she wouldn't do it.  
She translated happy no matter what I say.  
I said it about five times.  
It all came out happy. [laughter].  
It all came on happy.  
The last question before we open it up for you  
to ask them questions is what advice would you give  
our audience?  
What advice would you give our audience?

>> I would give you advice that to live this life,  
to live is just a miracle.

And enjoy your life and do the thing  
that makes you happiest as much as you can.  
And enjoy doing that, doing what you really feel  
passionate about.

For a long time, I tried to do what others thought I should do  
and it didn't work for me.  
So I mean, that's the advice.  
I mean, follow your -- follow your vocation,  
whatever you feel like.  
Like doing that makes you happy.

>> What did you mean by the -- what kind of advice?  
>> Any kind that you want to give.  
>> Oh.  
>> It's yours [laughter].

>> For me, I guess the advice is what I've --  
I'd like to share as an advice, what I've been trying to do  
which is to develop some metaphors or pictures or visuals  
or vision of what it means to become elder  
and in the latter stages of the life cycle.  
And I don't know what it might be for you.  
It has helped me through a lifetime of chronic depression  
which I think is a very stigmatized illness.  
In my community of Filipino-Americans,  
they will cite obesity, hypertension, and diabetes  
and won't say anything about the high suicide rates of females,  
of Filipina-Americans.  
So some of my visuals are two and I'd  
like to share that as an advice.  
One is that one metaphor I think of for myself  
to make me feel happy as a useful person is  
as an old-growth tree.  
When you think about in the Redwood Forest,  
the old-growth tree with all the roots interacting underneath the  
soil, all we need to do as an old-growth tree is  
to stand tall and standing.  
Because then the new growth and the seedlings  
and all that they can come.  
And we develop a big forest.  
And to a great extent, it sounds like a passive thing  
but it's a very active thing and it is centuries' old.  
And so there is an inherent integral value  
to being an old-growth tree.  
And if I'm a kind of human --  
the metaphor of an old-growth tree, it is important  
for me to stay standing.  
And so that gives me incentive  
to overcome a lifetime illness of depression.  
The other visual that I use and I share it  
as an advice is the metaphor that transition.  
So I transition from firefighting which is  
like active, heroic, risk-taking, at the barricades,  
physically fit, able to do lots of things,  
and feel useful that way.  
But I'm no longer firefighting in the sense that I don't have

that part of my life anymore.  
But I can be weaving.  
And weaving is integral to the value of all communities.  
Weaving is invisible.  
It's not heroic, not seen as heroic.  
It's seen as feminine.  
It's everyday but all communities cannot survive  
without the constant weaving of the fabric of humanity  
and community and without the constant mending of that fabric.  
And I can do that even when I can no longer be physically fit,  
as long as I can interact with people, I can still have value  
as a weaver of society.  
[ Applause ]

>> Advice, I think that we -- that when it comes time --

>> What advice would you give?  
>> -- to go wherever one would go when it all ends, is to have,  
is to make your life, your characteristics,  
your [inaudible] and traditions, you know,  
you leave that into memories of people that you've known  
in the hopes that you really [inaudible] your life well,  
will have not -- it would have some value.  
Your life had a value.  
And hopefully, it will pass on to the people  
that remember you the way they do  
because you have these good things about you.  
I think that will be the advice I would give to live your life  
like that, to leave a good memory.  
[ Applause ]  
>> I learned early in life that prayer moves mountains.  
And I wanted to know, "Well, what is real prayer?"

So I brought to my knowledge from the Holy Spirit

that I could pray in seven W's and just  
about cover what God would have me be and do.  
The seven W's of prayer, I will give them to you.  
You might want to write them down.  
[ Laughter ]  
Number one, I pray that God's Will will be done.  
W number one.  
That I really don't know everything about me  
but there is some higher power somewhere that knows about me.  
What I need, what I can do at all.  
So W number one, I pray God's Will be done.  
Number two, I pray that it be done in His Way.  
You know, when I started out to school,  
I didn't know exactly what I wanted to be  
or even what I could be.  
But I remember that a higher power knows all about it.  
So I want His Will to be done in His Way.  
We may not learn all that we want to know quickly.  
But we might have to bypass some things in order  
to get to the best things.  
I pray that His Will be done in His Way,  
the way He wants to do it.

I may not know.  
I may not understand.  
So I pray that His Will, His Way and then His Word.  
We studied the Word.  
Everyone knows something about the Word bible.  
So if it's according to His Word, I know it's all right.  
His Will, His Way, His Word and then all I have to do is watch.

Watch and pray.  
And while I'm watching, while I'm watching, I have to wait.  
When I was teaching all of provisional  
and there were two ways school, I did not know  
that I could be 100 and one and be here  
and give you some knowledge of what I have gone through.  
So His Way and then I have to learn to wait.  
Wait till the proper time.  
I may not be able to do what I want to do  
but there is a time element.  
His Way, His Will, His Word, and then wait.  
And while you're waiting, don't forget while you are waiting,  
there must be some work done [laughter].  
There's something you have to do.  
There's something you have to know.  
So that's His Will, His Way, His Word, then wait, watch.

Watch and then wait then continue to work  
because the Word says, "I must work the works of Him  
that sent me while it is day.  
Night cometh, no man can work."  
So we don't just sit and wait like we're waiting  
on the street car or a bus [laughter].  
But there must be some work done.  
So then we work the works of Him that sent us while it's day.  
Night cometh, no man can work.  
And after we have let His Will be done, in His Way,

through His Word, while we just watch and pray then we wait.  
We wait on the Lord.  
But we don't wait empty handed.  
We wait while we are working.  
We continue to work.  
You know, I thought about that work part and I learned to work  
because I -- when I would see this elderly gentleman plowing  
and you may not even know what the word plow [laughter].  
But he was plowing a mule in order to raise vegetables.

I would have him sit down under the shade tree  
and wait while I go around a row or two  
and do what he did with the plow.  
And I was only an upper teenager  
at that time but I wanted to help.  
And while I was waiting  
and I saw an elderly person drawing water out of a well,  
  
turning a [inaudible] to get water.  
And I stopped to help them draw water.  
And then with the drawing and the waving, I had to wait

until the cows that we milked.  
I had to wait until they grazed in the wood and come.  
And I had to draw water to give the animals water.  
And I thought to myself,  
"It looked like they never would stop drinking water."  
They were thirsty.  
So with that, and I repeat those seven times, the seven W's --

God's Will, His Way, do His Word while we watch and pray  
and then we wait on the Lord and while we're waiting, we work.  
And after we have done that, you can feel  
like worshipping [laughter].  
You feel like worshipping  
because you've done something that helped with it.  
So I am very thankful to have been able to see how to work  
and make vegetables grow so that we could eat properly  
and your health could be good.  
You'd be strong and mighty.  
[ Applause ]

>> And I suspect you have some burning questions.  
Why don't you ask the elders the questions you might have?

>> Good morning.  
I'm Debra Joseph.  
First of all, I want to say I am so proud  
of each and every one of you.  
I'm so thankful that you showed up this morning  
to share your knowledge and wisdom with us.  
And I'm extremely blessed to hear what you have to say  
because you guys truly spoke from your heart.  
[ Applause ]  
And my question to whoever wants to take it is,  
"How do we make sure that your voice is heard?"  
Today, everything is driven by technology and I hear  
from my mom all the time,  
she don't even understand what the computer is  
so let alone turn it on or done.  
I was impressed when you said you read all the different  
newspapers on the computer  
because I can't get my mom to even turn it on.  
But how do we ensure that your voice is heard?  
Not only as we try to carry out this thing called public health  
but to ensure that your messages keep going  
on from one generation to the next.  
>> I'd like to jump in and suggest that maybe we shift  
from thinking mostly about the individual voice  
of minority elders to organized associations and groups.  
For example, in the Filipino-American community,  
one of the assets even though people keep saying all these  
risk factors, all these deficiencies,  
I keep thinking why don't we think about the pluses.  
And the pluses are people congregate around food, music,  
events that are intergenerational.  
And so hearing the elder minority's voice, I suspect,  
will be more sustainably heard if the unit of focus is a group

like the family or association.  
The joke goes, if there are 10 Filipino-American families  
in a town, there are 30 associations  
that are Filipino-Americans [laughter].  
They like to be in groups.  
There are groups for dancing.  
There are groups for meeting over food.  
There is groups over baptisms and weddings.  
People are always gathering.  
I think that particular minority voice will be very well heard  
if we focus on the groups and not one by one by one  
through a survey or the usual methods.

>> I'm glad that technology is so if you can push  
that button you'll have a mic.  
So I won't have to run around,  
>> I can't move it.  
>> Yes, my name is [Inaudible].  
And I first want to say, I'm going to ask you this question  
as an older son who is now dealing  
with an 88-year-old father and an 82-year-old mother.  
A father who just came from beating colon cancer  
and is trying to rehabilitate and the siblings  
and I are trying to step in there and help without hurting  
or making my parents feel like we're taking over  
or somehow not trying to take away  
from them still being the parents.  
My question to you is this.  
What are the things that we should avoid  
that might hurt them or make them feel  
that they don't have value to us as mom and dad anymore  
or that we're trying to take over?

>> I think that [inaudible] -- trying to --  
I mean, just listen to them.

Be as much as -- spend as much time as you can with them  
and that'll be any -- just listen to what they say.

Whatever, you can just tell them.  
I want to know about these and they can give you.  
There is so much, for example, I can give to my two daughters.  
So much. They have their lives.  
They married late because they have circumstances.  
They have to work and study.  
But one of them is a doctor in medicine in a psychiatry center.

And she has a -- and she has only one daughter.  
When she -- well, she has a lot of things that take.  
The other one is a veterinary doctor and she is only --  
the only -- she owns a clinic and she is --  
she has two daughters.  
They are like -- I feel sometimes like I,  
myself, I'm irrelevant.  
But you were implying that.  
There is nothing I can --  
I cannot order or give them to -- to mind.

I just, when I read, I print a lot.  
And what I do is I just give them the prints because I know  
that if I tell them to go and go to a place  
in the web, they may not do it.  
But if I give them a printout, they may read or read it,  
if they find it interesting.  
I'm making it sure to make them feel that they have something  
to give that the experience they have,  
hurried life is worth a lot.  
You see, really, it is.  
And just, just listen.  
Just listen.  
>> Thank you.

>> Just a few words, I think the main thing would be  
to communicate.  
Talking about things, really you get what your elder wants.

And just for an example, through our [inaudible] my mom  
wasn't sick.  
She always found a way for a time to tell us  
when she calls what she wanted us to do.  
Tell us [inaudible] her control.  
We just listened and do what she expected us to do.  
So I think talking with your loved ones  
at that level is the best thing to do  
because it also helps the family.  
There is no infighting over anything.  
It's just done the way it should be.  
>> One thought I have and I struggle with that.  
My mom is 97 and has felt like we're taking  
over because she needs so much assistance and help is I found  
that I need to actually deliberately develop a  
"curriculum," so that I don't --  
when I visit, start immediately with, "We need to do this  
and we need to do that.  
And there's this appointment.  
There's this reservation.  
And what have you decided about this and that?"  
So instead, I start with, "You know, here's a photo  
of the grave site of our father, your first husband.  
And we're trying to figure out, you know, who's he related to?"  
So I come with set-up questions where it's valuable to me  
but it's clear she's the one that has the source.  
So that every single interaction is a mutuality of needs  
that I need this for the ancestry of my kids,  
your great-grandchildren and I'm going to start there instead of,  
"We need to do this, this, this, this, this."  
And why haven't you done that, that, that?"  
You know, and so there's a practicality to it  
but always softened, I guess, by a mutuality of needs  
that isn't quantifiable.  
>> Thank you.

>> Okay, as speaking of what you learned along the way,  
in learning to meet people where they are,  
not trying to make them what you want them to be



or what you think should be.  
But in order to meet them where they are  
and receiving their attention.  
As I sit here, and as I look, I think I've seen every face  
in here because my mind has gone in that direction in dealing  
with students, in dealing with auditoriums full of people.  
I can look and tell the ones that are bored.  
[ Laughter ]  
I can learn and tell there are some I have looked  
at you already that you have made my life better  
because you have looked like you were interested.  
Whether you're not, I'm not.  
[ Laughter ]  
So as I looked, as I looked, I can pick out a few people.  
I can point out some right now.  
I could pick out a young man that has listened  
to every word I've said and he has listened.  
And then, I've seen others that said, "Well,  
they may -- they didn't stop."  
[ Laughter ]  
Yeah, when are they going to quit?  
When they will quit [laughter]?  
They said the same thing over and over again [laughter].  
I've heard that before.  
I've heard other people say the same thing.  
And now, here they come with the same old story [laughter].  
Bring me something new.  
I appreciate you on this.  
[ Laughter ]  
I like your questions.  
>> Yes, one more.  
>> I've been -- to this one?  
>> Oh.  
>> There's a question out here for you.  
Thank you.  
>> I'd like to know like when sometimes,  
I try to remind my mom and she's like 89 years old.  
And I have to remind her all the time, you know,  
to take her medication at a certain time.  
And she tells me, she said, "Oh I can't go down there.  
They don't [inaudible] up when the expense  
of it and everything."  
So my question is, "How do you feel about the prescriptions  
or the way your doctors take care of you as far  
as the insurance companies or your medications and stuff?  
Do you feel like you're adequately taken care  
of as a senior citizen?  
I mean, do you think the doctors or the pharmacists or --  
are they just as attentive to you enough to make you feel  
like that they're taking care of you,  
doing the best they can to help you?  
Do you any of you feel  
like they're neglecting you in some facet?  
Or do you think the government is shortchanging you  
in some facet?"  
  
>> I would like to clarify what the questions are that you have.

>> Well, how do you feel about the way your doctors that you go see for treatment? How do you feel about the way they take care of you? Or whether or not they're -- your insurance companies that give you, you know, care, that helps you out, pay for your medicine and do you think your doctors give you enough adequate care, you know, from the insurance that you have? >> I feel like, I feel like maybe I'm expecting too much. But sometimes, when I go in to see my physician and I think we get as a system, Kaiser Permanente in California is excellent system.

I feel the absence of an understanding of aging.

>> Amen.

>> Because I go and I say I have these aches and pains or whatever, and I can't tell if that would have been the case for a 20-year-old, a 30-year-old, a 40-year-old, an 18-year-old or it's part of aging.

And when I ask, "Is this part of aging as opposed to, I don't know, some other, is it a symptom of some other thing?" The reason why it matters to me is because I feel like if I know that it's part of aging then my expectation for my acceptance of it is different than if, oh, this is a sign of some big trouble that we really need to correct at age 30, 36, or 40.

Whereas if this pain is going to be with me for the rest of my life, I need to begin to have a transition within myself that this body is going to be aching like this for the next 20-some years if my mother's age of 97 is an indication of how much longer I'm going to live then I need to expect to live like this for the next 25, 30 years.

And often, the physicians don't know the difference between a symptom of at this stage in life as opposed to some other stage in life.

And there, I feel that there is a deficiency, even in excellent medical systems that don't have any gerontology background.

>> That's right.

>> Right.

[ Applause ]

>> I, myself, I feel -- you know, I have so many things that are wrong with my body mainly because my mind is okay but there are so many [laughter].

That said, I have so many doctors.

I tell you.

[ Laughter ]

My-- Really, I mean my social life --

[ Laughter ]

-- is with doctors.

[ Laughter ]

I myself--

But you know, my father was a doctor, a physician.

And he used to say that if you would allow the patient to talk, he will bring you the -- I'm lack of words, the diagnostics, the diagnostics on a silver plate.

Just listen to the patient.  
And sometimes, I mean, the way the system is, some doctors,  
they are -- they just want to leave.  
They don't [laughter], they don't want you to explain.  
And then that, together with the fact that I am,  
in lack of words, due to my lack of whatever  
and my brain is not working the same as when I was 30 years old.  
And they either have, I used what I said,  
general rule I made up.  
I feel that I am getting a very good medical care here  
in Emory.  
I had in this Oncology Department,  
I am getting -- what service?  
Okay.

>> I found out this.  
We need doctors but I found out a doctor can only do  
for you what you have already kind of explained  
to them what's happening [laughter].  
And we can remember in going to doctors,  
doctors are not mind readers.  
I'll say that again.  
Doctors are not mind readers.  
I didn't get anything from it.  
[ Laughter ]  
Maybe you think doctors are mind--  
Maybe you think doctors are mind readers.  
They should read your mind  
and know what you are doing and not doing.  
But they can really only go by what you tell them,  
really to a certain extent.  
And you don't tell it all, they can't work well at all.  
>> That's right.  
>> So we need doctors.  
That's all I can say.  
>> Amen.  
>> Why don't we have a kind of closing comment from each  
of our scholars at this, on the stage  
because we have to move on?  
So any closing remarks that you might wish to have, sir?  
Any closing remarks?

>> As to myself personally, I would stress the importance  
of your mind, of your attitude.  
It's so important.  
I mean, I go to -- for example, to Emory and oncology  
and I just like everybody there.  
I love the nurses.  
I love the doctors.  
I mean, it is -- God really is love, I believe.  
And I feel myself oh, good, when I'm in contact with persons.  
And I -- that makes me feel good to just -- just that.

I mean, be appreciative of -- that they are doing for you  
and that they are human beings.

And that they may have days  
when they are not really, I mean, too likeable.  
But I've got, when I have nothing to give, I give a smile.  
I smile. I smile and I love people  
and that makes me feel happy.  
And that's so important that they think --  
the mind, it's so important.  
Even though I got like I told you, so many doctors.  
Specialist in that, specialist in that other  
and then I have an agenda.  
Today, I have to go -- sometimes, I have to go to one  
in the morning and one in the afternoon.  
And I keep my medicines--  
Oh, I have these timekeepers because I have, in the morning,  
I have to take a medicine,  
wait half-an-hour and take another one.  
Wait 15 minutes and take about 20 of them.  
[ Laughter ]  
I tell you.  
I have sometimes difficulty swallowing it  
but I have found a way [laughter].  
I do swallow them.  
And I'm doing fine.  
I don't like, I don't want to die.  
No, no, no.  
No, no, no.  
I love life.  
>> You got it together.  
[ Applause ]  
>> Well, since the title of this is Minority Elders  
and Healthy Aging, I can't help but think  
about how my individual struggle for health has got to be  
in the context of so many minorities  
across the decades have suffered  
as people's histories of oppression.  
And I can't help but think that my individual struggle  
to be happy can't happen without an understanding of how that is  
in the context of my peoples having been oppressed  
and having suffered intergenerational historical  
racial trauma.  
And that seeps into life in ways that because we're in the water  
of it, becomes so every day and ordinary that it becomes  
like part of the accepted by nature almost.  
So when I think even of my mother, who as a widow  
with two kids, became a professional.

She adopted all the ways of modern European-based medicine  
and abandoned all the various Filipino indigenous native  
practices that now we are scientifically studying  
and saying, "Oh, these are really good things to do,  
these herbal medicines, these et cetera.  
Now, we have scientific validation of it."  
But that was part of her colonial mentality.  
So she adapted into the imperialist paradigm [laughter],  
abandoned what was ordinary and every day and accessible  
without expensive prescription medication.  
And so I feel like part of the challenge with minority elders

and healthy aging, I think, is first for somebody to do the R and D work, the intel -- the labor to somehow put everything together and make it into an integrated whole.

So that what was abandoned because oppressive, imperial, colonial, heavy erasure of what was known to people becomes integrated with modern medicine? And that somehow, I have a feeling, if we can do that, that would be part of the healthy aging of minority communities.

[ Applause ]

>> My closing remarks, pretty much at the same lines of my colleague here. But there's a thing called the -- that we came up with and it's called the cultural wisdom declaration wherein we declare that we know that our traditional practices work.

We're also asking federal agencies, any agency that has the resources that they need to work with us. CDC is a good example of at least one, Good Health and Wellness in Indian Country. That happened over a series of three meetings with traditional healers, development of their language, finalized it, made a part of that [inaudible]. I think that's where we need to go now, to include us. Include us rather than do something for us. You need to do it with us.

[ Applause ]

>> I know you probably would like to hear maybe something that you think maybe would keep you healthy, wealthy, and wise. You would like to get a certain age or you wonder maybe how a person got that age. One thing, be happy. Make others happy around you. Do what you can do for yourself. Only depend on others for what you cannot do. I can still cook good food, clean food, healthy food. I can still do it because you keep doing.

Don't stop doing what you can do. Don't stop doing what you think you can do because sometimes your thoughts will carry you astray. Continue to do what you can do.

>> Yes.

>> I'll say it again.

I'd like to repeat it again.

Do all that you think you can do even that you think you cannot do.

Make a try.

Try for yourself.

When I broke my leg, as I'm in these chairs now, broke my leg in three places.

It was healed.

Oh-oh, I won't say that.

>> Go and say it.

>> It was healed.  
I won't say without a doctor, but they didn't have to cut it.  
They didn't have to do that.  
But I look to the higher power, God, that has done all  
that for me, because I made the promise to myself and to others  
that all that I can do -- if I'm preaching,  
I can preach from a wheelchair.  
Nothing is wrong with my mouth.  
I may not hear as well, but they made hearing aids.  
Sometimes they don't work well.  
I don't see as well at times.  
Got my glasses.  
I mean. I will be looking terrible  
if I didn't have my dentist to make some teeth  
to make me look a little better.  
So my hearing, my seeing, my talking --  
I'm still adhering to what I'm saying.  
I know what I'm saying.  
I know where I am.  
Those are big things that we can do for ourself to continue  
to live and live long.  
I said that I was going to keep preaching if I had  
to preach from a wheelchair.  
And you know what happened.  
[ Laughter ]

I said they made all these things.  
I started out with one cane.  
I walked with one cane.  
They told me about the doubled cane  
that you walk with and take steps.  
I tried that, too.  
I got one of those.  
So I said the next day if you can move better  
if you get the one with the wheels on it.  
I got the one with the wheels on it.  
They said, you can push your own self.  
And I learned to go to the bathroom by myself  
which was very healthy.  
Here I am today, all the way from Pittsburgh,  
Pennsylvania, and we had to.  
The doctor even got a hitch so I could bring my standby with me  
so that I could look good, feel good,  
travel a little faster, you know.  
It even has speed on it.  
I was told by one of the officers when we came  
in the gate out there, he said the speed limit is --  
you can't do it.  
[ Laughter ]  
I had been told, I had been told, I had been told  
that I sometime could speed.  
So I've been watching the speedometer,  
I've been watching the speedometer to be sure  
that I'm not speeding on these grounds around.  
So you can take this.  
You can be happy.  
You can be happy.

I was even happy at a funeral.  
Had the people laughing at the funeral, so --  
and I said that I would keep talking as long  
as I could remember to keep my news right up here  
and not say too much, if I could listen a little more  
and speed a little less, then I could move on.  
And you come to the next stop.  
So I just say again that this is a wonderful world.  
Keep living in it.  
Keep helping others to live better.  
Keep helping others to feel good about themselves  
because if you don't feel good about yourself,  
nobody else is going to do it.

>> Yes.

>> So we do it, and I appreciate that.

I still cook.

I still can cook.

I still can wash clothes.

I still can be clean.

I can still wash my body

and still smell good when you are coming.

[ Laughter and Applause ]

>> Let's stand up and thank her.

Let's stand up.

[ Applause ]

>> One thing I say to you,

and I got that from William Cullen Bryant,

William Cullen Bryant's "Thanatopsis."

I try to remember something from school.

The last verse of "Thanatopsis" says, "So live,

that when thy summons comes to join that innumerable caravan,  
which moves to that mysterious realm,

where each shall take his chamber in the silent halls

of death, thou go not like a quarry-slave to his grave,

soothed and sustained by an unfaltering trust,

approach thy grave like one who wraps the drapery of his couch  
about him, and lies down to pleasant dreams."

[ Laughter and Applause ]

>> Couldn't get any better than that.

Could not get any better than that.

[ Applause ]

>> Thank you.

I am very pleased and excited to be able

to introduce the CDC Director, Dr. Robert Redfield,

who has been with us for not a long time.

He arrived in March of this year.

Dr. Redfield is the 18th Director of the Centers

for Disease Control and Prevention and Administrator

of the Agency for Toxic Substances and Disease Registry.

He has been a public health leader, actively engaged

in clinical research and clinical care

of chronic human viral infections

and infectious diseases, especially HIV,

for more than 30 years.

He served as the Founding Director of the Department

of Retroviral Research

within the U.S. Military's HIV Research Program and retired after 20 years of service in the U.S. Army Medical Corps. Following his military experience, he co-founded the University of Maryland's Institute of Human Virology with Dr. William Blattner and Dr. Robert C. Gallo, and served as the Chief of Infectious Diseases and Vice Chair of Medicine at the University of Maryland School of Medicine. Dr. Redfield made several important early contributions to the scientific understanding of HIV including the demonstration of the importance of heterosexual transmission, the development of the Walter Reed Staging System for HIV Infection, and the demonstration of active HIV replication in all stages of HIV infection. In addition to his research work, Dr. Redfield oversaw an extensive clinical program providing HIV care and treatment to more than 5000 patients in the Baltimore-Washington, D.C. community. He served as a member of the President's Advisory Council on HIV and AIDS from 2005 to 2009, and was appointed as Chair of the International Subcommittee from 2006 to 2009. He is a past member of the Office of AIDS Research Advisory Council at the National Institutes of Health, the Fogarty International Center Advisory Board at the National Institutes of Health, and the Advisory Anti-Infective Agent Committee of the Food and Drug Administration.

Please join me in welcoming Dr. Redfield.

[ Applause ]

>> Thank you very much.

Thank you very much for the kind introduction.

I also want to thank the co-sponsors, the Tuskegee University's National Center for Bioethics in Health, and the CDC's Division of Sexually Transmitted Diseases, and our Office of Minority Health and Health Equity.

I also want to recognize the 30th anniversary of the Office of Minority Health that works to advance health equities. And I want to thank all of you for coming to be part of this because some day, and sooner, because of the efforts of people like you, a health equity will become a reality. Life expectancy has come a long way in the last half-a-century and we need to do a lot to improve the lives of people over 65 for all Americans.

If you reflect back in 1900, the average life expectancy for all races was about 47.3 years.

By 1970 it had jumped to 70.8 years, probably one of the greatest achievements in public health and the advances in the 20th century.

Leading causes of death have changed just a light slightly.

In 1950, the top five causes of death were heart disease, malignant neoplasms, vascular lesions that affected the central nervous system, accidents, particularly motor vehicle and all other accidents, and early infant mortality and disease.



In 2016, you remain number one, heart disease, number two, the same, malignant neoplasms, number three now was unintentional injuries and accidents, and then number four was chronic lower respiratory diseases, and then number five, cerebral vascular events.

So very minor changes, obviously, with infant mortality being one that obviously got off the list and, unfortunately, pulmonary disease coming back into being one of the major causes of mortality.

But recently life expectancies plateaued.

If you look at since 2001, there's been an additional year gained in life expectancy. But between 2010 and 2016, really it's not really moved at all -- 78.7 years.

The National Council of -- and Institutes of Medicine report their study. Looked at some of the gaps, particularly in the people over the age of 50, and they highlighted that since 1980 Americans have the lowest probability, the lowest probability of surviving to age 50 compared to all other high-income countries.

Older Americans reach 50 now -- it's hard for me to say that 50's older, but I guess it is. I guess, you know, I'm kind of holding on to be 70 as older, but older Americans, which they said -- those of us who reach 50 now reach it in poorer health and face greater mortality from chronic diseases.

And this is driven by a number of factors. Obviously we still have a significant infant mortality rate.

We have significant mortality related to drugs. We have significant mortality related to diabetes and obesity. We have higher -- they say we have the highest, actually, for -- of diabetes and obesity among other countries. We have higher rates of heart disease. We have higher rates of injury and violence. And we have more adolescent pregnancies and STD's. And we have a high prevalence of HIV infection. There's not any one common thread that will explain. And obviously Americans with healthy behaviors still have higher rates of disease. There are a number of social determinants of health that play important roles. Obviously a very important recognition, the important of social determinants of health as predictors of health later on in life.

Americans' access to healthcare and behaviors greatly influenced by social factors and the environment. Obviously lifestyle, health policies, and social values. All of these can influence what one's health status is, particularly as one crosses the threshold of 50 and beyond. But there are some good news for older Americans. Higher survival actually for those of us that live past 75. There's really higher rates of cancer screening and survival in those of us that are over the age of 75.

There's better blood pressure control and cholesterol control which obviously is important as you saw that heart disease remains the number one, and there's lower rates of smoking.

But life expectancy still varies between populations. Life expectancy today in the United States for Caucasians about 79 years, for African Americans it's 75.5 years, for Hispanics it's actual 81.8 years.

And so there are differences in different ethnic groups.

It's important for us at CDC that we don't just study and describe, but that we actually put science into action and we try to explore the gaps

of healthcare among diverse older populations

with different social determinants

and different inequities so that we can begin to put science in action to improve a health outcome.

Some of the important determinants

of the diverse population over 65 from 2016 really looked at health-related quality of life.

We looked at fair or poor health conditions among different populations and including African American, American Indian and Native populations.

Clearly there's healthcare access issues that have been evaluated.

There's obviously the importance of staying engaged in regular medical care, particularly as you get older, and there are a number of areas where individuals end up missing those appointments because of financial concerns. Obviously there's health behavior issues, particularly that we need to be concerned about smoking and the use of alcohol.

Different ethnic groups have greater challenges here, obviously in some of the Native American populations.

I was kind of surprised to see in our recent MMWR that looked at smoking in different populations across the country by different age groups.

Actually it turned out that the Native American and American Indian population had their highest rates which may not have surprised people in this room, but what surprised me --

they had the highest rate across the board --

the highest rate for cigarettes, the highest rates

for juuling, which is a, you know, a --

highest rates for the alternative tobacco uses.

So clearly a lot to do.

And, again, this led to other issues.

They also had the least amount of exercise that were engaged in their daily lifestyle which may have some impact

on the complexities that we have with weight status and obesity.

But there are some good news, as we begin to look at some of the health inequities across in disparities and actually between 1999 and 2015, there's actually been a narrowing, at least of the life expectancy gap, okay [phone ringing].

That was the WHO, okay?

So we'll just put them on hold for a second.

We've got a little bit of an outbreak going

on in the DRC right now, but we'll get right back to them.

Should have turned my phone off.  
But I will say there has been a narrowing, you know,  
of two years in the last 15 years  
between the life expectancy in African Americans  
and Caucasians, which is, again, progress in the right direction.  
And really what has driven that is a decrease in heart disease.  
Can I give that to you and you figure what to do with that?  
Decrease in heart disease, cancer, and death rates.  
But, again, we need to be vigilant in trying  
to continue to improve that.  
We need to understand the unique challenges  
that face different portions of our population  
across the country and begin to confront the determinants  
that will affect life expectancies.  
For example, you know, across the board.  
I think we're going to see  
in every population there's unique health challenges.  
Obviously I look forward to talking to you about that.  
I'd like to sort of end with --  
to finally just ask you to do one thing for me which is  
to recognize that you should never underestimate  
the possible.  
And to realize that some day, and those of you who know me  
in my past life, you will know the biggest thing my wife used  
to tell me that -- I happen to be Catholic --  
she told me that the Bishops  
or the Cardinals were probably going to kick me  
out because I would argue with them that they need  
to spend their energy really focused on one  
of the greatest injustices that exist in the world,  
and that's health inequity.  
So never underestimate the possible  
because I do believe some day health equity will become a  
reality and we need to continue to recognize  
that that's what's required.  
Thank you very much.  
[ Applause ]  
They say I have a couple of minutes to --  
if there's any questions or anything,  
I do have about a couple more minutes if anybody  
who have questions, feel free.

If not, I hope you have -- well, okay, go ahead.  
>> Sir, I have a question.  
I'm Frenress Truxson  
with the Diversity Inclusion Management Team here at CDC.  
And I would like to ask you, from your travelling's  
and discussions with some of the leaders of the world  
and of the state, can you tell us what you see right now is the  
biggest obstacle to us achieving health equity for all?  
>> Well, I think that's an important question.  
I think first what I would say is what frequently is the  
biggest obstacle  
for us achieving any great thing is what I asked you to do,  
which is never underestimate the possible.  
I do believe, when I talk about health equity, and I've done it  
for much of my career, many people think that I'm talking

about something that's not in the real world.  
So, first and foremost, we have  
to realize it's in the real world.  
Those of you who know me know that I'm a man of faith.  
I don't consider that a disadvantage.  
I don't think God intended us to have health inequity.  
I think health inequity is a consequence  
of man's choice, right?  
So it's time for us to first see it's possible.  
It's also important for us to see  
that it's not what was supposed to be.  
And since it's a consequence of man's choice,  
man's choice could go on a path to correct it.  
So I think, really, that's the biggest thing.  
The second biggest thing, truthfully,  
I think comes back to the individual.  
Health inequity is more driven by individual choice  
than I think some people want to recognize.  
You know, when my friend Dave Thatcher was Surgeon General he  
did a large report on health inequity as many  
of you probably know it and read, because many  
of us believed at that time that the key  
to health inequity was health access.  
And Surgeon General Thatcher's report actually came  
to the conclusion it wasn't access.  
So, again, I'm going to come back to our social determinants  
of health that have an impact on health.  
And the reality is, if you had told me  
as a scientist even 10 years ago that things that happened to me  
when I was young -- my father died when I was five.  
Life was pretty tough at the beginning --  
that that somehow had an impact on my health when I was 65  
or 67, which I am now, I would have told you there's no way  
that had any impact on my health.  
The reality is that science is showing that early events  
in life actually have major impact on health.  
So one of the more important --  
I was just arguing that I'd like to bring a death  
to what we call the fifth vital sign  
because I do think it helped set the stage  
for the opioid pandemic that we have today,  
that we overreacted to pain control.  
The real fifth vital sign we need is the social determinants  
of health so that we get people to start to focus  
on what are the social determinants --  
what the air filter situation is,  
what the food security situation is.  
You know, these are the things that are going  
to be really important.  
So I think to me those are the two things  
that I would say you've got to understand it's possible  
and it's what was intended,  
and it was our choice that it's not there.  
And then I would say to really underscore the personal  
responsibility to begin the path for each individual  
to move towards life's choices  
that gives them a greater shot at health equity.

Any other question?

Yeah?

>> Okay, I'm going to try this.

My question has to do with in -- when you say health equity, and based on what you were saying, does that include medical training of -- and my contention is especially for gerontology and stuff like that, is that the training of those persons in the medical and health professions tend to temper how this thing works. So does health equity also include education of those persons coming through the system that are providing services in the health fields?

>> Again, a very good question, and obviously my response would be yes. Again it goes back to whether people, the health system has to understand, the doctors and the whole system, has to understand that health equity is the goal line, you know.

There is a tendency I think sometimes to believe that certain health conditions in certain portion of the population are not moveable.

Obviously I think the experience that most physicians get in the training of geriatrics is highly inadequate.

So I would agree that health equity -- in order to get to health equity we have to have a highly educated medical enterprise that understands that the goal line.

I mean, obviously, to get health equity in different age group populations, in particularly the elderly in geriatrics, we have to get a health system of individuals that are trained in that.

One of my proudest moments as a physician, and I cared for prior to getting deeply engaged in urban AIDs, so I cared for a number of elderly individuals, and I was so proud when I finally got them almost, you know, off all their meds.

Some people come to like on 40 medicines, you know, from like 32 different doctors which they continue to refill even though they hadn't seen those doctors. And to try to go through and say, do you need this medicine. Well, here's three medicines, ma'am.

They're actually kind of the same medicine.

Okay. And to really get them down to maybe they're on two medicines or one medicine or even no medicines, a lot of times you got to get a guarantee if you look at an elderly patient population, a lot of times they're on lots of medicines.

And you really need to train gerontologists and physicians that can go through and take the time to understand exactly. I will tell you there's never been clinical studies that show the impact of the combinations of most medicines that most elderly are on.

If you take the average elderly individual and they're on 10 or 12 different medicine -- there's never been a study to show what those 10

or 12 medicines actually do when they're  
in the same person at the same time.  
So I take great pride  
in the answer is not necessarily a new prescription.  
But I would tell you there's a lot of healthcare professionals  
who have not been trained in geriatric medicine.  
So what you do and continue to do I think is very important.  
It's part of the solution.  
It's probably much more important  
than what I said immediately because it's more immediate.  
You're going to make a greater impact  
by training gerontologists and general internists  
and general medicine and family doctors in how to think  
about the principles  
of practicing medicine for the elderly.  
And the answer is not just more medicine.  
>> Well that means that their understanding and acceptance  
of holistic living -- eating well, exercising,  
to if not complement then maybe remove some of the pills  
and some of the medications for a longer healthcare life.  
>> Well, I think you raise an important point.  
And, again, I think unfortunately a lot of people,  
again, by different age groups that are  
in the medical profession, do have a tendency to think  
that the easiest answer is another prescription.  
I will say when I became CDC Director I was 235 pounds, okay?  
Let me just take a look.  
[ Laughter and Applause ]  
Now that wasn't because I came up with some great epiphany.  
But those of you who know me, I have a wonderful woman, Joy,  
I've been married to for 45 years -- 43 years, and she said,  
you're the CDC Director.  
You cannot go down there and stay at 235 pounds.  
You know, how can you set an example?  
So I will say today I'm 214, okay.  
Hopefully, if you come back  
in six months I'll be [applause] 200.  
And that's all based on really three principles.  
Eating properly, and actually my wife is pretty much a fanatic  
on that.  
She thinks we should have at least a 12-hour fast every day,  
so you've got to figure out when you eat.  
And actually there's a lot of truth to it.  
You can lose weight and will eat everything you do  
if you just don't eat for 12 hours a day --  
like from 7:00 at night to 7:00 in the morning.  
You do need to exercise.  
That exercise doesn't have to be strenuous.  
You can just walk, you know, 20 miles a week, you now,  
or a couple of -- three miles a day.  
And more importantly that a lot of people don't realize,  
you really do need to sleep.  
And if you can do those things,  
you can start creating a healthy lifestyle.  
I would say that most people in medical training  
that are younger than the age  
of 50 probably don't understand how important those three

elements are.  
And they need to have that reinforced.

>> I was wondering, as a physician  
and patient empowerment I think is --  
patient empowerment is extremely important.  
And I had written this book we made  
into a movie called *Doc Hollywood* and I came  
across a lot of doctors who I was able to interview for a book  
on symptoms that are life threatening.  
So people know when to go to the emergency room.  
And we got the rights of that back from Random House,  
and now it's a free app.  
And we'd just like people to know  
that if you have a headache, fever, and can't put your chin  
in your chest, then you don't take an aspirin and go to bed.  
And we're trying to figure out how to we get the word  
out that that's there.  
It's been published in a lot of other languages.  
And the other question I had real quickly is,  
I've been involved in medical research a lot,  
but we're working with some George Tech students  
on connecting people who live longer with a disease  
and see what they do in common,  
it might not be a patented drug.  
It could be something they're eating.  
And how could we get more groups to consider  
that type of research where --

>> Well, your second question is easier for me in the sense that,  
you know, getting big data  
on population health I think is really important.  
And continuing to stay, if you will, data-driven,  
open-minded about what it is that is associated in --  
with better health and better survival.  
You know if any of you have followed that one, one,  
you know, one decade coffee is bad,  
the next decade's coffee is good, one decade coffee's bad.  
You know, one decade drinking a glass of red wine is good.  
Two glasses of red wine is good.  
No alcohol is bad.  
Next year, alcohol is bad.  
I think the only thing that we've agreed on in medicine  
since we finally recognized the obvious  
with my friend Everett Koop, who I have great admiration for him  
because when we started with cigarettes,  
it was the cigarettes weren't the problem.  
You just needed low-tar cigarettes.  
You'll be all right.  
And then it was, well, no --  
it's filtered cigarettes was first.  
And then maybe it wasn't the filter.  
Maybe you needed low-tar filter cigarettes.  
And then Everett Koop finally came out  
and said, you know what?  
You don't need cigarettes.  
It's smoking that's the problem.

So I do think population-based studies that can have the robustness like the Framingham Study to help people look at. And they need to include parameters that may be they instinctually don't think should be concluded. I'm going to come back to that idea of just getting six to eight hours of sleep a night. I think people underestimate how valuable that is. And obviously how valuable it is to walk three miles a day. You know, I don't think that's been quantitated in a meaningful way . Your second question is I do -- you know, I think it's important to get the proper health information to people so that they can make their own proper informed health decisions, you know? We were just talking about that yesterday. We were having an exercise. If you've seen a lot of people around here -- there's a lot of people around here, about 400, because we're doing an exercise right now on a flu pandemic. So we're -- it's sort of a mock situation for the last three days that we started with day 35 into a major flu epidemic to a new strain of flu which was causing a pandemic and significant mortality and morbidity. And, of course, I asked a similar question when we had our guidance to the American public -- and, again, this is a mock guidance, right, because we're just going through it. But the guidance was if you're sick, stay home, because we don't want people with flu coming to the emergency room. But I said, but we need to put a little more guidance in there because how about if you're really sick and you're not going into respiratory failure? We don't want the person to think, well, CDC said we should just stay home, you know? We don't want you coming in with average flue, but we also know when your respiratory rate gets up over 22 to 25, we want you to come to the hospital. So same type of thing. Because they way I would have read the message -- the CDC told me to stay home, right? And then, you know. So I think you're right on how you get that proper messaging, the different things. There's obviously a number of people you can connect here. One of the important roles CDC has is in communication, in division vehicles that we communicate with the American public and the healthcare teams. They constantly get people to understand what our position is on how to improve health or how to minimize health risk, so I'd encourage you while you're here to interact and get in line for some of the people that do that for a living. That's okay. Two more questions and we'll finish up. >> Thank you very much.



My name is Sonia Hutchins, and I am a professor at Morehouse School of Medicine in the Department of Community Health and Preventive Medicine. I'm a recent retiree of the U.S. Public Health Service and spent 31 years at CDC.

And I was just curious to know what your thoughts are about whether you had an opportunity to look at the Health Disparities Subcommittee recommendations to the Director.

It's the Advisory Committee to the Director, and whether you had time to look at their recommendations. And the reason why I bring that up is because they look at success stories across the agency to see what we were able to do to overcome some health inequities by allocation of resources based on need.

And the good example of that is the child vaccination story. And so I was wondering if you had an opportunity to look at the recommendations from the Health Disparities Subcommittee of the Advisory Committee to the Director.

And what your thoughts, if you had a chance to look at those recommendations, what were your thoughts about that for the Agency?

>> First, thanks for your service.

Second, I haven't read those -- that document, but I will. I think there's somebody in here that's taking care of me. We'll make sure I get that document so I can look through it.

It's hard to put things into action if you don't do them. I remember one of the jokes that I helped my brother and I did as a cartoon in the 1980s was a picture of President Reagan

and he was saying his horoscope.

He was reading his horoscope.

And his horoscope said, your legacy will be determined by your response to the AIDS epidemic.

And then the President's --

you know, the cartoons that my brother drew says, he says, hey, Nancy, what's AIDS?

And then right behind the President was about five Congressional reports that we collected on AIDS, like the first AIDS Commission, the thing -- they're all stacked behind his desk.

So it was sort of a the same comment, that if you have reports and you don't read them, and you don't put them in action, then what's the purpose of these reports?

So I'll take a look at it and see if there's other ideas that we can look at.

There clearly are actionable items that can make a difference.

I have learned in my career, thought, the biggest obstacle -- this is why I keep saying it over and over again, and some people think I say it too much -- is the biggest obstacle is people don't think it's possible.

And most people don't spend time on something they've already decided it's not possible.

So the first thing you've got to get people to understand is all things are possible. Okay? And I will say that when John Kennedy said he was going to put a man on the moon, 1962, right, I don't think a lot of people thought that was possible. But when Neil Armstrong walked on the moon in 1969, he did it. And I would say we didn't have the scientific solution. Those of you who know me know one of my aspirational goals is to eliminate disease when we have the capacity to do it. And so, first and foremost, is to eliminate the AIDS epidemic in America. We have the tools to do it. But most people don't believe it's possible. So it's hard to get a commitment to do something that most people don't possibly -- those of you who know me know I worked closely with President Bush on the PEPFAR Program where we brought AIDS therapy to Africa. I was one of the first to treat people in Africa along with Paul Foreman in Haiti, and most people thought it was impossible. But when President Bush sent his team to see what we were doing in Malawi and they saw what Paul Foreman was doing in Haiti, they found that, wait a minute, it is possible. So then the question is, do you want to do it? And then the next question if you want to do it, then how much is it going to cost to do? And then once you know how much it's going to cost, then how are we going to do it? And I think the AIDS Program in Africa was a great example of President Bush seeing the possible, leading the nation to John Kennedy man-on-the-moon, seeing the possible. Leading a national to act. So I would argue health equity seeing the possible. Unfortunately, and this is where I look for other organizations to get engaged in this battle, unfortunately health equity's probably going to be a longer battle than my lifetime. But you've got to get institutions committed to the possible. And whether that's government institutions, faith-based institutions, the ones that somehow seem to stay focused for the longer road, sometimes they're faith-based institutions. That's why I think they'd kind of see, you know, being the social conscience to get health equity as the possible independent of their denominations. I think that would really be a great effort, you know, because I do think it's hard for other organizations, whether it's a medical school, whether it's a health organization, to really stay on point as you're trying to do it. But we as healthcare professionals can go after incremental steps, you know, proving health equity and a decrease in health disparity. And I think what I said in my talk is we should be proud of the fact that we've made some progress, right?

We've still got a long way to go,  
but we've made some progress.  
But it's still true that your life expectancy is more dictated  
by what zip code you were born in in the United States  
than probably anything else.  
And that's a problem.  
Was there one last question?  
And that's it.  
Right there.  
Alright, we'll do two -- if it's quick -- is it quick?  
>> Basically.  
>> How you doing.  
I'm Kevin Williams.  
I'm an Assistant Professor  
of Healthcare Leadership at Mercy University.  
And I'm also, [inaudible] MPH Class  
at Morehouse School of Medicine.  
And I'm sitting in this room largely because I was exposed  
to the five sciences of public health through Morehouse School  
of Medicine, and also through a program,  
Regional Research Center for Minority Health working  
with the Office of Minority Health  
under Dr. Warren's leadership  
and Dr. Karen Bouye.  
And I just wanted to see what is your administration's commitment  
to training other workforce, the future workforce  
of public health practitioners,  
particularly minority public health practitioners,  
to look at these morbidities and mortalities from being --  
from the community actually [inaudible] the science  
and being able to practice public health?  
>> We just had a meeting this morning with some  
of my colleagues at CDC, and I was going  
through the five key core capabilities  
that need to be built.  
The third one on that list was, of course, was workforce.  
And we went through some of the great programs  
that were implemented at CDC -- the EIS Program, right?  
Then we looked at the next one  
which was the Public Health Associates Program  
which is a great one.  
The Laboratory Leadership Program.  
And I said, my challenge to them was, okay,  
what's the next great program because we clearly need  
to keep building public health capacity.  
What's the greatest gap that we need to try to fill right now  
with a historical program that will --  
EIS Program's historical.  
Tom Freedman, one of my predecessors,  
did the Public Health Associates Program.  
It's really making an impact across the country  
where we have people in all the health departments  
around the United States.  
He told me when, when he --  
he gave me advice and I took the job.  
He said, the one thing he asked me to do was  
to treasure that program.

I've gotten to know it.  
It's a great program, the Laboratory Leadership Program.  
So I would tell you that the Workforce Development is key.  
If any of you have great ideas  
where you think the greatest gap could be filled  
as we develop the next historical program to continue  
to enhance the public health workforce of this country,  
we're very open to it.  
I'm committed to try to understand what that is.  
You can't try to build seven different programs  
at the same time and think that they're actually going  
to ever make an impact.  
So I am trying to understand during my, who knows,  
tour of duty, you know.  
It's one of the realities.  
It's not fun that I left a lifetime tenured job  
that I could have until I was hopefully 100 years old.  
And you're here and you don't really know.  
But I do want to make sure that we make an impact  
on workforce that, like Tom, lasts beyond me.  
I haven't decided is that, you know, where that gap is,  
but I know that it's an important gap.  
Last question and then I got to run.  
>> Thank you.  
My name is Dr. Yep and I'm Associate Dean  
of Academic Affairs  
at the Claremont Colleges [inaudible] Colleges.  
I'm gifted with teaching Community Health,  
Health Inequities in California,  
working alongside immigrant refugee elders.  
And I appreciate your opening about an invitation  
for a paradigm shift which is what is possible.  
And my grandma lived until she was 102, and when she was  
in hospice care, the social worker asked her,  
what did you fear?  
And she said, that people will lose hope.  
And I think in many ways what you offered is to not lose hope.  
So what do you think is the biggest social determinant?  
We talked about social determinant of health,  
but what do you think are social determinants of paradigm shifts,  
because you're inviting us to do a paradigm shift.

>> You know, that's a --  
obviously a very good question, again.  
And, you know, I have to be honest,  
I'm not sure I know the answer right now.  
I think it is -- you know, I gave a talk.  
I have two children that are doctors.  
I gave a talk when they got their white coats.  
My son got his white coat.  
The Dean decided to let me give the talk.  
He didn't know what he was getting into.  
And I tried to decide, what do I tell, you know,  
all these 200 medical students, you know?  
And so I decided to, you know, to keep telling next  
to parenthood, I felt  
that medicine was the greatest vocation one could have,

and of course, you know, my son was in the audience.  
And then I went through a series of like four points.  
One was, you know, continue the daily commitment  
to self-education.  
And I went through how, when I was in medical school,  
there was not sonograms, CAT scans,  
there was no AIDS, you know.  
This is a profession that you've got to stay.  
The second was to never deny your patients the opportunity  
of the advice of one of your colleagues.  
And I would just never give an answer  
when the answer is I don't know.  
That's how I treated the story  
because I gave you the answer I don't know.  
Okay. And don't deny your patients the benefit  
of one of your colleagues.  
And please don't teach somebody something that you just have  
to teach because you don't want to say you don't know, so you --  
now you taught somebody something wrong.  
The third, which caused the Dean to fall out of his chair --  
not literally, but I did see him definitely posture  
and tighten up.  
I said, and the next thing you need to do is you need  
to learn to love our patients.  
And everyone said, what?  
And I went to the story how my first son died  
and how the doctors were really brutal to my wife and I.  
And how a number of my patients had taught me  
that they were no longer just my patients.  
They're no longer my friends.  
They're actually people I really loved.  
And then the final thing I told them is keep a journal  
about your enthusiasm of medicine as you're going  
through it because one day you're going to need to open  
up that journal and remember how enthusiastic you were.  
So I don't know the answer to your question.  
It's an important question.  
I think part of the theme of my answer is you've got to care.

And I don't think we teach that well, ironically,  
in a profession that is all about caring.  
All right?  
So maybe you'll come up with a better way to do it.  
Thank you all.  
[ Applause ]  
>> Thank you again, Dr. Redfield.  
Thank you.