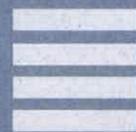


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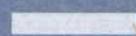
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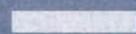
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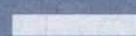
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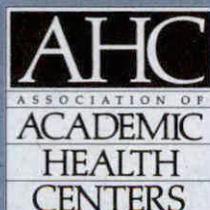
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**BUILDING THE WORKFORCE
FOR A DIVERSE SOCIETY**

Proceedings of the 3rd Congress of Health Professions Educators

Elaine Rubin
Editor

**ASSOCIATION OF ACADEMIC HEALTH CENTERS
1995**

The Association of Academic Health Centers (AHC) is a national, nonprofit organization comprising more than 100 institutional members in the United States and Canada that are the health complexes of the major universities of these nations. Academic health centers consist of an allopathic or osteopathic school of medicine, at least one other health professions school or program, and one or more teaching hospitals. These institutions are the primary resources for education in the health professions, biomedical and health services research, and many aspects of patient care services.

The AHC seeks to influence public dialogue on significant health and science policy issues, to advance education for health professionals, to promote biomedical and health services research, and to enhance patient care.

* * * * *

The views expressed in this book are those of its authors and do not necessarily represent the views of the Board of Directors of the Association of Academic Health Centers or the membership at large.

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PREFACE

The Association of Academic Health Centers (AHC) designed the Congress of Health Professions Educators to advance a new vision for health professions education for the future. The idea for this Congress emerged from several years of work on human resource issues by the AHC's Task Force on Human Resources for Health, by the AHC forums with individual Washington-based health professions associations, and by health professions educators at the AHC annual retreats for the deans and executive directors of the member organizations of the Federation of Associations of Schools of the Health Professions.

The first Congress in 1993 marked a milestone in the history of collaboration among the professions as it was a means to educate the educators about crucial questions confronting policymakers and to promote interaction among participants from diverse backgrounds and perspectives.

The goals of the Congress are to:

- Expose and educate faculty and administrators to an array of significant policy issues that will be confronting educators both now and in the near future;
- Enhance understanding of community needs;
- Encourage appropriate changes in health professions curricula to better meet community and population needs;
- Develop leadership and enhance team building among all ranks of faculty and in the administration of the health professions schools that constitute the nation's academic health centers; and
- To encourage educators to share the knowledge and information gained at the Congress with colleagues and students at their respective institutions.

With the theme *Building the Workforce for a Diverse Society*, the 3rd Congress of Health Professions Educators was designed to address a wide range of issues related to diversity. Diversity issues, particularly the expansion of minority participation in health professional schools, have been of concern for several decades. Although many successful educational initiatives were developed, they tended to remain isolated from the mainstream and therefore made only minimal headway in broadening minority participation and encouraging entrance and advancement of minorities into the ranks of leadership. In fact, current data show that minorities are more underrepresented today than 15 years ago.

As we move toward the 21st century, the issue of diversity in the health care workforce is ever more compelling. Demographic trends for the population of the United States reveal tremendous increases in minority populations. An increase in minority participation in the health care workforce, while not a guarantee, has been considered a significant means to ensure better access to health care services for these people. Health professions educators have long envisioned that the workforce would more closely mirror the make-up of the populace and they continue to look for new approaches to improve not only the educational and academic experiences but also the attitudes toward and environments for the delivery of services to this diverse patient base.

The papers in this volume span the spectrum of issues that must be confronted in addressing diversity. Together they present an overview of the social and economic conditions that will challenge the nation in the 21st century. The papers describe and analyze the implications of changing demographics for health care delivery and academic health centers, the responses of health professions educators to societal change, the perceptions about underrepresented minorities in the workforce, the roles and responsibilities of leaders in changing institutional cultures, the development of model educational programs, factors influencing the recruitment and retention of underrepresented students and faculty members, the impact of mentoring, and the commitments and initiatives still required to ensure success for the future.

Finally, these papers reveal the extent to which questions of diversity in the health professions are intertwined with the larger social and economic landscape of America. In addition, the papers point to the critical role that academic health centers, the institutions where a major portion of the education and training of health professionals occurs, must play in building and supporting programs to attract young people to careers in the health professions. In this regard, leadership and commitments to long-term strategies are required with community-outreach as one of the most important components of the agenda for the future.

We hope this book will serve as a useful reference for educators, administrators, and policymakers. The AHC looks forward to promoting further information exchange and collaboration among the health professions through the dissemination of these proceedings.

We would once again like to thank Congress participants and the contributors to this publication. Finally, many thanks to Elaine Rubin, Ph.D., AHC senior program associate, for editing the manuscripts, and Adrienne Lucke of ASL, and Joan Durgin, AHC administrative assistant, for their help in preparing the manuscripts for publication.

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Building the Workforce for a Diverse Society

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A DEMOGRAPHIC LOOK AT TOMORROW

Harold L. Hodgkinson

Tomorrow is in part an extension of today's trends. We can be very confident in predicting changes from 1990 to 2000, and a trifle less confident in predicting changes from 2000 to 2010. A first year graduate student in demographics can project the population of the United States for the year 2000 with less than a one percent error rate. A Nobel laureate in economics, on the other hand, would be in great trouble forecasting the Gross National Product for the year 2000 with a 10 percent error rate. The point of this brief paper is to use the 1990 census data as a jumping-off point to investigate changes that are very likely to occur during the 1990 to 2010 period. Our first task for this demographic look is to examine the 1980 to 1990 trend lines from census data.

The United States In 1990

Let's look first at some overall growth rates for various racial and ethnic groups in the United States. The nation increased by 22.1 million persons, reaching a total of 248.7 million in 1990. Different racial and ethnic groups increased at vastly different rates, as can be seen in Table 1. How the United States population in 1990 was made up by race and ethnicity can be seen in Table 2.

States and Regions

Just as the different racial and ethnic groups grew at different rates, so did the different regions throughout the U.S. Ninety percent of the growth in the U.S. happened in the south and west, while only three states got half of the *nation's* growth: California, Texas and Florida. Never in the 200-year history of census-taking have only three states had half the nation's growth. As a result, California, Texas and Florida picked up 14 seats in the U.S. House of Representatives; seats that were given up by Pennsylvania, Michigan, Ohio, Illinois (two seats each) and New York (which lost three seats) and several other states which gave up one seat each.

Growth in the U.S. was bi-coastal as well, with Georgia, the Carolinas and Virginia also making large gains in population. The heartland and mid-Atlantic states were the overall losers. By the next census, Texas will move into the second largest spot, and the Empire State of New York will drop to third. This decline will cost New York over one billion dollars in federal funds which are distributed to states based on their population. Map A shows the gainers and losers by state as a result of the change in population between 1980 and 1990.

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It is anticipated that the population growth rates will continue at their uneven pace through the next decade with concentrations in the southeast and west regions (see Map B -- Projections of the U.S. Population, 1988-2000).

Politics

By the year 2000, the Congressional Research Service has stated that California will have 50 seats in the House of Representatives, Texas will have 34 and Florida will have 28, for a total of 112 seats in the three states. That could be enough votes to defeat legislation introduced by any of the other states, regardless of party. (The U.S. Constitution requires us to hold a census every decade in order to revise the House of Representatives to accurately reflect the population.)

Concentration

In 1990, nine states made up half of the U.S. population: California, New York, Texas, Florida, Pennsylvania, Illinois, Ohio, Michigan and New Jersey. But as we can see from Map A, six of the nine states are not increasing much at all. The "new South" of Georgia, Virginia and North Carolina may move into the top nine states by the next census. State rankings by population are crucial to the amount of federal block grant funding they will receive. The larger a state's population, the more dollars it receives.

The states that are growing most rapidly tend to be states with a high percentage of minorities, especially minority youth. By 1995, the trend will be quite clear (see Map C -- Minority Public High School (Graduates)).

Prisoners and Dropouts

Some other key developments happened during the 1980 to 1990 period. The fastest growing group in the U.S. was prisoners, up 139 percent, from 466,371 in 1980 to 1,115,111 in 1990. We now have a higher percentage of our population behind bars than any other nation. A black male in the U.S. is seven times more likely to be in jail than a black male in South Africa. Black men, who make up just six percent of the U.S. population, are now three percent of college student enrollment and 47 percent of America's prison population. Prisoners cost the taxpayer an average of \$22,500 a year (as of fiscal year 1991), a very poor investment, as 73 percent of all prisoners released are back in jail within three years. Eighty-two percent of America's prisoners are high school dropouts. The best way to reduce crime rates is not to build more jails but to reduce the high school dropout rate, giving youth a "straight" alternative.

Family Shifts

The American family made some striking changes during the last decade. The "Norman Rockwell" family - a working father, housewife mother and two children of public school age - was SIX percent of all households for most of the decade. Data from the 1990 census are likely to show an even lower figure. The compositions of households in the United States have changed greatly. About 71 percent of all households in 1990 were family households, compared with 74 percent in 1980. The changes in household type between 1980 and 1990 is shown in Table 3.

These changes in households mean that 52 million households contain a married couple, and 41 million do not. By the next census, the numbers will be about equal. In 1990, according to data from the U.S. Census Bureau, only about one household in three contained a child (under age 18) and less than 20 percent of all households (17 million) had one or more children of school age (ages 6 to 17 years).

A few other notable changes which occurred during the 1980s are listed below.

- 82 percent of all children (under age 18) now have working mothers and six of ten mothers of preschool-age children (under age 6) work outside the home at least part-time.
- Women who are single parents are raising 13.7 million children with a median family income of \$10,982 (as of 1989). If the children are living with two adults, the median family income increases to \$36,872. Forecasters say that sixty percent of today's children will live with a single parent at some time before they reach age 18; in 1990, 1.2 million men were raising kids by themselves, compared to 6.6 million women; and over three million children are being raised by their grandparents.
- Over one million young mothers (age 20-24) could not work or look for work in 1986 because they could not find quality or affordable child care.
- In 1990, 13 percent of all children were regularly hungry, 25 percent were born to unmarried parents, over 20 percent of all children under age 18 were poor, about 350,000 children were born to drug-addicted mothers, 19 percent had no health insurance, and 166 juveniles of every 100,000 were behind bars.
- The number one goal of the President and Governor's "Education Summit" is to ensure that every child enters kindergarten health, well-fed and from a supportive home environment. Given the data presented above, it is no surprise that the cost of achieving this goal would be over \$40 billion.

- Most Americans now live in our 39 largest metropolitan areas, mostly in the suburbs.
- Sixty-four percent of all new jobs created in the last decade were in the suburbs. As a result, the most common commute is from a suburban HOME to a suburban JOB.
- In 1988, 57 percent of the nation's families and individuals could not qualify to buy a median-priced home in the area where they lived.

A Look Ahead: We Grow, But More Slowly

Looking out to the year 2000 and beyond, we can see some interesting shifts. The total U.S. population continues to increase, but at a slower rate, up to 267.7 million in 2000 (76.1 percent), and up to 282.2 million in 2010 (only 5.3 percent). However, America's youth population (age 0-17) goes up from 64.4 million in 1990 to 67.4 million in 2000, then **DECLINES** to 64.9 million in 2010, according to Census Bureau projections. This decline is already foreseeable in the decline in the number of females moving into the child-bearing years. Fewer women producing fewer children seems a safe hypothesis. The decline will be in the number of white youth particularly as is shown in Table 4.

A key rule of demographics is, if you were not born, you do not count. It is silly to mourn the loss of 3.8 million white youth. As pragmatists, we must ensure that the additional 4.4 million nonwhite young people get the best education and access to good jobs as we possibly can, for the nation's health, and also because they will be funding our Social Security's payments!

If the U.S. population is increasing all through the next two decades but the youth populations decline after 2000, it means that the nation's average age will go up like a rocket after 2000. The eldest baby boomers, now 46, will begin to retire in droves after 2000. The baby boomlet is now working its way through junior high, but half of this increase in youth is in California, Texas and Florida. There is no boomlet in most heartland and mid-Atlantic states as Map D makes clear.

"Minority" Peoples in 2010

By 2010, 12 states (listed in Table 5) plus the District of Columbia will have significant minority youth populations. About half of the nation's 64.4 million young people will reside in these 12 states. The question that arises from this situation from this situation is *what should we call "minorities" when they are more than half of the population?* In 26 cities in California in 1990, no single racial or ethnic group made up a majority of the population. As a result, no elections could be won by any single racial or ethnic group including whites. Coalition politics was the only winning pattern.

Concentrations of Nonwhite Youth

We normally think of "high minority" states as being in the deep south. That was true in 1940, as blacks were, for all practical purposes, the only statistically significant minority group. Since about 1970, the process has been one of making America more ethnically diverse. Looking at the list of states in Table 5, one sees many of our largest and most politically powerful states as well as some states in the deep south. In New York, California, Texas and Florida, each racial and ethnic group is expanding, beginning with the youngest portion of each group. By 2010, these FOUR states will contain 21 million of the nation's total 64.4 million youth, one-third of all youth (age 0 to 17) in the U.S. (New York is a special case. Although youth in New York will decline from 4.2 million in 1990 to 3.8 million in 2010, the decline is virtually among the white group. New York still remains a very large and powerful state.) As the nonwhite youth majority moves through the age range in these four key states, we will see first a majority of entry level workers, new households, new parents, promotions, voters, volunteers, semi-retirees and finally minority Social Security recipients, in that order.

Fertility and Class

It is hard to see what realistically would be likely to increase the white fertility rate in the U.S. (or in Europe). Given that 70 percent of all women of childbearing-age are in the work force, deferring fertility as late as possible in order to keep two incomes in the family (for those married women and one income for single women), the notion that vast numbers of women will give up their jobs, return to their homes and dedicate themselves to the raising of three or more children (or even one) is science fiction -- the loss of their income would be catastrophic for most households.

Indeed, as more minorities enter the middle class, we see a decline in their fertility as well. Middle class families have by definition some discretionary income, if that surplus is distributed among eight children, each share will be too small to do much, but if there are only one or two children, the surplus could change the children's lives. A report by the Business-Higher Education Forum indicated that in 1987, 36 percent of black families and 40 percent of Hispanic families are middle class - with incomes of \$25,000 or more. A 1991 report by the Census Bureau using a measure called "relative income" that takes family size into consideration found that more than half of all black and Hispanic persons had middle incomes in 1989 (51 and 55 percent respectively). Asian Americans also have a large middle income group, due to increased education and having several workers in each household. In Los Angeles, Washington, D.C., Miami, Newark and Atlanta, a MAJORITY of black residents were living in the suburbs in 1990, a clear indicator of middle class membership. Show me a minority child raised in a suburb and whose parents are college graduates, and I will show you a child whose educational performance is roughly the same as that of a white child raised in a suburb by parents who are college

graduates. For example, Figure 1 indicates the math performance of eighth-graders of each ethnic group, comparing the richest quarter of each group with the poorest. Much of what looks like race is really class.

Uneven Minority Distribution

We also need to remember that with this increased national diversity, 11 states in 1990 had 10 percent or LESS nonwhite in their youth population. Maine moves from 2.8 percent nonwhite youth in 1990 to 3.1 percent in 2010, Vermont from 2.4 percent in 1990 to 5.4 percent in 2010. Thus, states will become much more *unlike* in terms of ethnic diversity over the next twenty years. Youth will be more concentrated in a smaller number of states. By 2010, 32.6 million of the nation's 62.6 million children will be in only nine states: Texas, California, Florida, New York, Illinois, Georgia, Michigan, Ohio and Pennsylvania. Some will have little ethnic diversity - Pennsylvania goes from 16.1 percent nonwhite in 1990 to 18.7 percent in 2010, Ohio from 16.2 percent to 20.8 percent. Ohio and Pennsylvania also will decline in total youth during the 1990 to 2010 period, while California, Texas and Florida will gain 1.8 million youth. Over half of the youth population in these three states will be nonwhite well before 2010.

Implications For Education

Slums and Suburbs

Given that minorities are more likely to be in poverty than whites (most poor kids are white, although black and Hispanic kids have a much higher percentage of their total number poor) and given our look at the future, we might ask how schools are likely to fare with the clientele we have isolated. The best guess would be *reasonably well*. Although the conventional wisdom in 1991 was that ALL schools were terrible, the evidence for that view is very thin. The top 15 percent of America's students are world class on any set of indicators. The "forgotten middle" needs some work, but will graduate from high school and pay taxes. America's lowest 35 percent (in terms of school attainment) is truly awful, due to factors that were present when they first knocked on the kindergarten door. (Factors such as: poverty, out of wedlock, birth, teen births, cocaine-addicted at birth, short of food and housing, born premature, are only a few). America's best schools (and students) are located in the suburbs of our 40 largest metropolitan areas; the worst schools are located in the inner cities of the same metro areas plus some rural areas.

If one looks for the schools that most need assistance from state and federal governments, it is clearly our inner city schools and even easier to ignore rural ones. But now that MOST VOTERS live in the suburbs, it is easier for most political leaders to ignore inner city schools. (For example, *AMERICA 2000: An Education Strategy* announced by President Bush, never mentions reduction of poverty in inner city schools as a major educational task for the nation.) Many of these inner city

schools are performing heroically, against all the odds. However, if the suburbs continue to suck jobs, income, housing, shopping, churches, restaurants, colleges and corporate headquarters away from their core cities, there is a danger that inner city schools could become a real socio-economic dumping ground in the next 20 years.

It is also clear from our analyses that states will differ even more in the number of students and the diversity of those students, and perhaps even in educational attainment in the years to come. Coupled with the amazing changes that have taken place in the American family over the last decade, early childhood prevention programs like Head Start will be even more essential in the future. Yes, as of this writing Head Start programs are reaching less than half of all eligible children.

Preparing for Diversity

We are already beginning to see the power of some of the nation's largest and most rapidly growing states in areas like textbook adoptions for schools, with the influence of California and Texas in areas like history, social studies and science. These two states represented almost one-fifth of all the textbook adoptions in the nation in 1991, and will represent more than one-fifth in 2010. Add Florida, and you approach one-third of all textbook adoptions. Yet, in all three states, the makeup of the legislatures is not yet representatives of the racial and ethnic diversity of the citizens. Neither is the makeup of teachers. While over half of all students in these three states will be nonwhite in 2010, about 19 percent of the teaching staff in California, 15 percent in Florida and 22 percent in Texas will be nonwhite. This is based on who is currently preparing to become teachers in schools of education. These three states also have among the highest high school dropout rates in the nation. *Who will assist new white teachers in discovering what their diverse students are like?*

Who Will Do the Work?

There is currently a major debate about jobs in the year 2000, but no debate about who the entry-level workers will be. (The NEW workers in 2000 will be 85 percent combinations of immigrants, women and minorities. About 15 percent of new workers will be white males, according to the Hudson's Institute's *Workforce 2000* report. That is a net figure.) The debate centers around the work to be done. Some analysis are insisting that in a high-tech age, MOST jobs will require a college degree. However, the most authoritative judgment, from an excellent Carnegie study: *America's Choice: High Skills or Low Wages*, is that in 2000, 70 percent of America's jobs will not require a college degree.

The best guess is that we are creating two work forces: one in minimum wage occupations that can be performed by high school dropouts, such as janitor clerk, fast food worker, hotel room maid, and the other in well-paid occupations in technical or administrative positions that need a college degree for entry. What has been declining

throughout America are jobs in the middle of the economic range. In 1991, for every new job created for a computer programmer, 11 new jobs for clerks were created or eight new jobs for food service workers or six new jobs for janitors. This leads to an "information-rich" and "information-poor" split in our society. These two sets of predictions (shown in Table 6) of jobs for 2000 makes the point. Health technology is growing most rapidly, but that number of jobs is dwarfed by the number of low-end service jobs. The service work force has a small "middle" and a large number of high and low paying jobs at the extremes.

Given that minorities are such a large percentage of the new workers in the next 20 years, there are three possibilities that can happen:

1. If more minorities graduate from high school and take some community college course training, 1.2 million new health technology jobs will be waiting.
2. If minorities drop out of high school, 4.2 million new service jobs will be waiting, of which three million are minimum wage and can be done by high school dropouts. (Minorities are now over-represented in this job category.)
3. If minorities go to college and graduate, 3.5 million new professional jobs (lawyers, doctors, teachers, accountants, etc.) will be waiting. (Minorities are now under-represented in these fields.)

Given the recent evidence from the Census Bureau confirming the increased number of rich and poor households in our nation, and the decline of middle-income households, it seems that the nation would benefit if more minorities opted for options one and three, with clear access to the middle class and the fulfillment of "the American Dream."

Mickey Mouse, Star Wars and Equity

Our three "megastates" of Florida, Texas and California have one thing in common: tourism is the biggest industry in all three, with "tech" a clear second. For every person who works for General Motors, there are about three people who work for McDonald's. Those in tourism hire clerks, waiters/waitresses, janitors and maids. Most new workers in these three states will be nonwhite. The equity issues involve access, through education and jobs, to a middle class status. It seems unlikely that these three states will be able to INCREASE access to the middle class for their dominant minority populations during the next 20 years. The result is likely to be social tension over the next 20 years based less on race and ethnicity and more on the combination of age, class and race. (Do we want to give every BLACK child a shot at a good education today, given that some black children have millionaire parents, or do we want to focus on giving every POOR child a head start?)

It may be time to take the issue of wealth and class head on as a major focus of our continuing debate about equity. Since the 1960s, we have been devoted to a single equity mission - the racial desegregation of schools. Desegregation of jobs and housing were afterthoughts during the 1960s with daily reminders that the task of desegregation is not progressing. Because large numbers of minorities (read blacks) were poor in 1960, desegregating schools meant equalizing access to the middle class. Today's strategy is different, as many minority families have moved into the middle class.

Thus, the courts have declared that the Kentucky educational system was unlawful, because poor small school districts were spending much less per child than rich school districts, resulting in the Kentucky Education Reform Act. Texas, Virginia and many other states have encountered similar suits. **If you are concerned about the scores of U.S. students compared to the scores of Asian students, try looking at the scores of U.S. inner city students compared to the scores of suburban students.**

How Do We Govern Metropolitan Areas?

The most obvious inequities in 1992 are those of the inner city and the surrounding suburbs. The difference in educational spending between these two areas are, if anything, more spectacular than those between states. The difference is that there is no governing body designed to deal with metropolitan areas where most American now live. Geographical distance leads to social distance. How do we get wealthy suburbanites to take seriously the problems of the city they fled to get to suburbia in the first place? **What would it take to get middle income people to move back to the inner city?** During the last decade the walls between city and suburb were built even thicker to insulate the suburbanites from any real contact with the problems of the inner city. During the 1990s and beyond, inner city problems like crime, drugs, poverty, youth violence, and family disruption will begin to move past the walls of the inner city into the suburbs. At that moment perhaps, suburban residents will realize that equity is a vital pragmatic goal and that their lives will improve if inner city residents have access to a good education and a good job.

Ask me to take you to a place where whites, blacks, Hispanics, Asians and Native Americans live together in peace and harmony and I can take you to any number of places. But if you ask me to take you to a place where rich and poor people live together in peace and harmony, I will answer that there is no such place. Much of what appears to be a problem between races is actually a problem between classes. It may well be that recognition of the need to make class differences more permeable for those who are willing to work hard and accept the challenge of the American Dream is the final and most difficult frontier of the equity journey for America.

A Scenario For The Next Two Decades

The population of the world moves past six billion, India becomes the largest nation in the world, eclipsing China, the West (U.S. and all its NATO allies) move from being 18 percent of the world's people to being less than 10 percent, Caucasians will be about 10 percent of the world's population. At this level, the West can "lead" the world, but not by military conquest. (It's hard to occupy the territory where 90 percent of the world lives.) In 1992, it became clear that the sperm count for Western men had dropped dramatically, meaning that about one man in five would be unable to become a father. This then would accelerate the decline of Western populations. The Newly Industrialized Countries (NICs) will have developed sizable middle class populations with discretionary income, which means that their fertility rates will go down while the large groups in poverty will continue to reproduce at a higher rate. This conflict between the better-educated middle class and the poverty groups will become a major source of tensions in these countries. While the number of HIV cases will continue to rise, the rise will not be exponential, and AIDS will not become the leading cause of death in the world, although it may be in Sub-Saharan Africa.

The U.S. will continue to grow, but at less than the 9.8 percent rate of the 1980 to 1990 period. After 2010, the population will begin to stabilize, and after 2020, immigration will become a major source of new human beings for the United States, and will be responsible for whatever growth occurs in the U.S. population after about 2030. The U.S. will continue to attract about two-thirds of the world's immigration, (particularly after Europe begins to stabilize). The U.S. will continue to get 85 percent of its immigrants from Central and South America.

Growth will be concentrated in nonwhite populations, in the south and west, and in the suburbs of our 40 largest metro areas. "Edge Cities" - self-contained suburbs outside the metro center - will become common, leading to further destruction of the inner cities as money, talent, education and jobs continue their move to the suburbs and Edge Cities. The problem of attracting middle classes of whatever racial and ethnic group back to the inner cities to live will prove a most intractable one. More black, Asian and Hispanic suburban populations will be seen. Some increase in growth will happen in the heartland states like Minnesota and Michigan, particularly after Michigan diversifies its economy away from auto manufacturing, as is already happening now.

Some of the "big nine" states that now contain half of the U.S. population will be eclipsed by the "new south:" Georgia, North Carolina, Virginia, adding to the racial and ethnic mix in our biggest states. New York will remain big and powerful but drops to third in size as Texas moves to number two by 2000. With all the increase in racial and ethnic diversity in the nation, there will be little increase in diversity in the New England states, which will remain 10 percent nonwhite. Thus, the states will become more UN-like in terms of size and diversity, creating a

concentration of power in the House of Representatives that will be uncommon - California, Texas and Florida will gain in clout.

By 2000, we will have almost as many households without a married couple as there will be with a married couple. In 2002, the oldest "baby-boomers", now age 46, become 55, and will begin to retire. (Many of them are planning to leave the work force early). As life expectancy increases, a large number of people will work for 30 years (age 25 to 55) and will be retired for 30 years (age 55 to 85) giving them one year of retirement for every year of work. That will put an impossible burden on the Social Security system. In 1950 there were 18 workers to share the costs of each retiree; in 2035, there will be only TWO workers to support each retiree. While the youth population (age 0-17 years) shrink from 34 percent of the U.S. population in 1970 to 25 percent in 2000, we move from 20 million people over age 65 in 1970 to 40 million in 2000 and 65 million in 2030.

Older people vote more often than younger ones and they are increasingly unlikely to support education or youth-related programs at state and federal levels. In 2030, the work force that supports the (still very white) elderly population will be about half white and the younger workers will be about 60 percent "minority" and female. Elderly minority populations will become more frequent, particularly in the middle class populations. Prisons will deal with more elderly prisoners on life support systems, as their life sentences are non-commutable.

By 2010, the job structure in the U.S. will be even more two-tailed, with about 30 or 40 percent of all jobs requiring a college education and paying very well, while 30 percent or more will continue to be "working poor" jobs for high school dropouts. We will continue to develop one new job for a computer programmer for every seven new jobs for clerks/cashiers. Tourism, our largest industry, will continue to grow and will contribute a large number of "working poor" jobs. As pointed out earlier, this separation will lead to "information-rich" and "information-poor" segments of our society, which is closely tied to wealth.

As the 40 largest metro areas continue to attract people and jobs, the viability of rural life will come into question shortly after 2000. (Almost half of U.S. counties lost population between 1980 and 1990. Over 90 percent of Iowa's counties did). The provision of medical and social services to sparse and declining populations will be as costly as providing them to inner city populations, and the "rural underclass" may rival the "urban underclass" as a problem area. However, the suburban majority, worried about the incursion of poverty and violence from inner cities, will try to keep the focus placed on the urban underclass.

The federal government will continue to find itself unable to lead the nation (it is too big for the small problems and too small for the big problems), allowing leadership to go, by default, to state and local governments and organizations. The wave of collaborative alliances (between education and health particularly) seen in the

1990s should continue for several decades, as local success stories begin to increase and people participate locally to further their self-interest. (Even in our earliest voluntary associations, the barn-raising benefited everyone eventually. Liberals and pragmatists both came.) More effort was placed on the local PREVENTION of social and medical problems, rather than their expensive and ineffective "cures".

By about 2010, most Americans should come to see that as the number of children continue to decline as a percent of the U.S. population, we cannot afford to throw any child away. (One cannot be a rising economy with a falling population.) The neglect of one-third of youth, common throughout the 1980s, will be seen as being contrary to the nation's interest, particularly the local community. Minority middle class groups will begin to apply pressure in these areas as well as whites. By the same token, metropolitan planning authorities should begin to increase in number and influence and begin to coordinate the interests of the increasingly affluent suburbs with that of the core city that spawned them in the first place. With such a new governing mechanism, some of the problems of an increasingly divided society may finally begin to be dealt with effectively. This may seem optimistic, but the only alternative is the destruction of America's core cities. Tomorrow is indeed an extension of today's trends.

Table 1. Percent Change in U.S. Population by Race and Ethnicity, 1980-1990

	<u>1980-1990 Increase</u>
Total, U.S.	9.8%
White, non-Hispanic	6.0%
Black	13.2%
Native American, Eskimo or Aleut	37.9%
Asian or Pacific Islander	107.8%
Hispanic (of any race)	53.0%

Source: U.S. Bureau of the Census

Table 2. U.S. Population by Race and Ethnicity 1990

	<u>(000) Number</u>	<u>% of Total Population</u>
Total, U.S.	248,710	100.0
White, non-Hispanic	187,137	75.2
Black*	29,986	12.1
Native American, Eskimo or Aleut*	1,959	0.8
Asian or Pacific Islander	7,274	2.9
Hispanic (of any race)	22,354	9.0

*Includes a small number of Hispanics

Source: U.S. Bureau of the Census

Table 3. Change in Household Type, U.S. 1980 - 1990

	1980-90 <u>% Change</u>	Number of Households <u>(000) 1990</u>
Total Households	+ 15.5%	93,347
Married couples, no children*	+ 15.0%	27,780
Married couples, with children*	- 1.7%	24,537
Single parent * - women	+ 21.2%	6,599
Single parent * - men	+ 87.2%	1,153
Singles living alone	+ 25.7%	22,999
Singles living with non-relatives	+ 45.3%	4,258
*Children under age 18		

Source: U.S. Bureau of the Census, Current Population Survey, Household and Family Characteristics

Table 4. Projections of the U.S. Population Age 0-17, 1990-2010 (in millions)

<u>Youth</u>	<u>1990</u>	<u>2010</u>	<u>Change</u>
Total youth*	64.4	64.9	+ 0.5
White, non-Hispanic	45.2	41.4	- 3.8
Hispanic (of any race)	7.2	9.8	+ 2.6
Black**	10.2	11.4	+ 1.2
Other Races**	2.2	2.8	+ 0.6

**INCREASE IN TOTAL NONWHITE YOUTH +4.4 MILLION
DECREASE IN TOTAL WHITE YOUTH -3.8 MILLION**

*May not add exactly because of rounding.

**Includes small number of Hispanics; "other races" are primarily Asian and Native American.

Source: U.S. Census Bureau as cited in National Center for Education Statistics, Youth Indicators 1991.

Table 5. Percent Nonwhite Youth* Projections for 2010 for Selected States

<u>State</u>	<u>Percent Nonwhite</u>	<u>State</u>	<u>Percent Nonwhite</u>
D.C.	93.2%	Louisiana	50.3%
Hawaii	79.5%	Mississippi	49.9%
Texas	56.9%	New Jersey	45.7%
California	56.9%	Maryland	42.7%
Florida	53.4%	Illinois	41.7%
New York	52.8%	South Carolina	40.1%
U.S.	52.8%		

*Age 0-17 years.

Source: U.S. Census Bureau as cited in *American Demographics*, May 1989.

Table 6. Fast Growing Jobs, 1988-2000

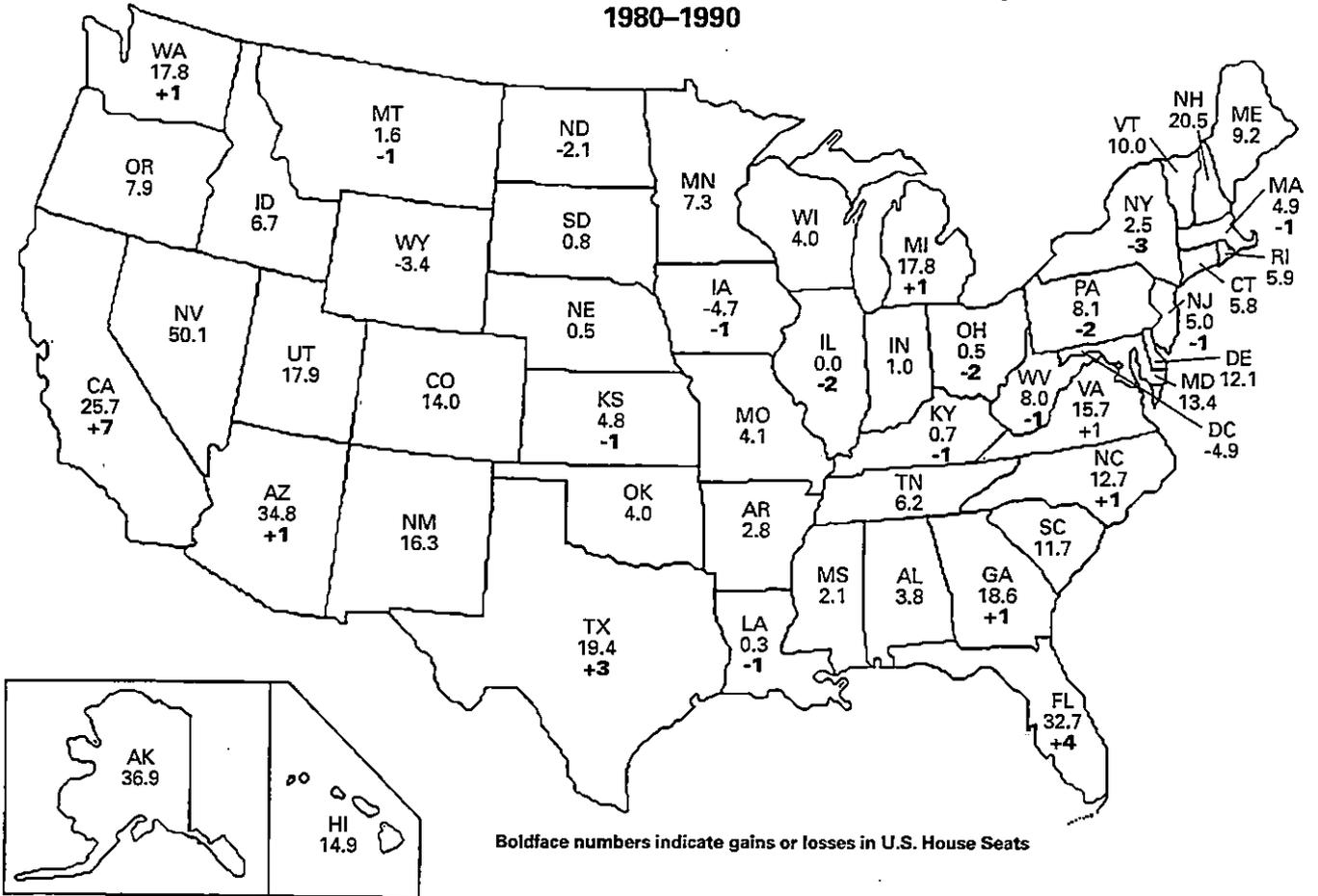
<u>Job</u>	<u>% Increase</u>	<u>Total Jobs In 2000</u>
Paralegal	75.3%	145,000
Medical Asst.	70.0%	253,000
Radiologic Technical	66.0%	218,000

Largest Number of Jobs in 2000:

Salesclerks	4,564,000
Janitor/maid	3,450,000
Waiter/waitress	2,337,000

Source: U.S. Department of Labor, *Monthly Labor Review*, November 1989.

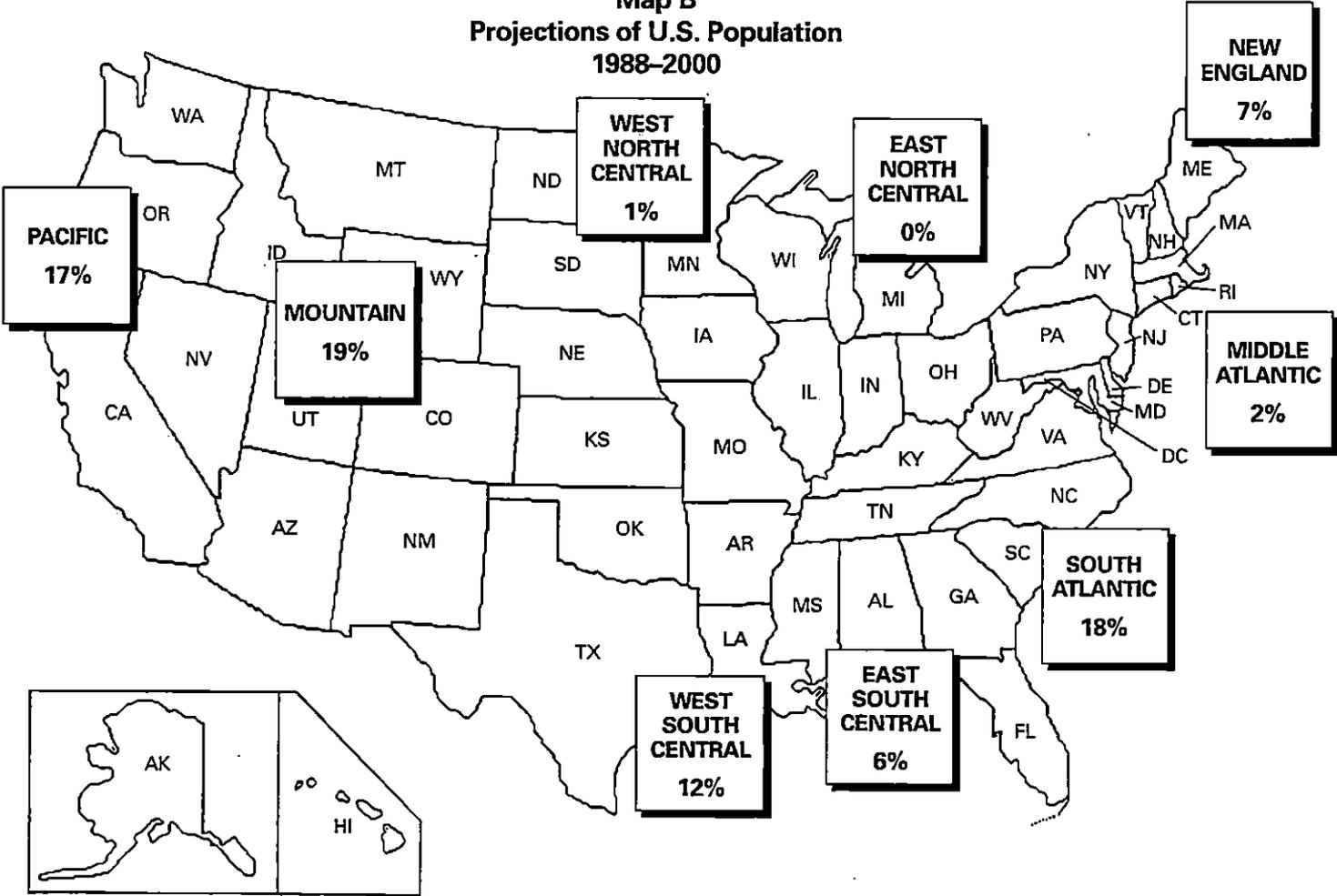
Map A
Percent Change in Population and Change in Congressional Representation
1980-1990



Boldface numbers indicate gains or losses in U.S. House Seats

Source: U.S. Census Bureau

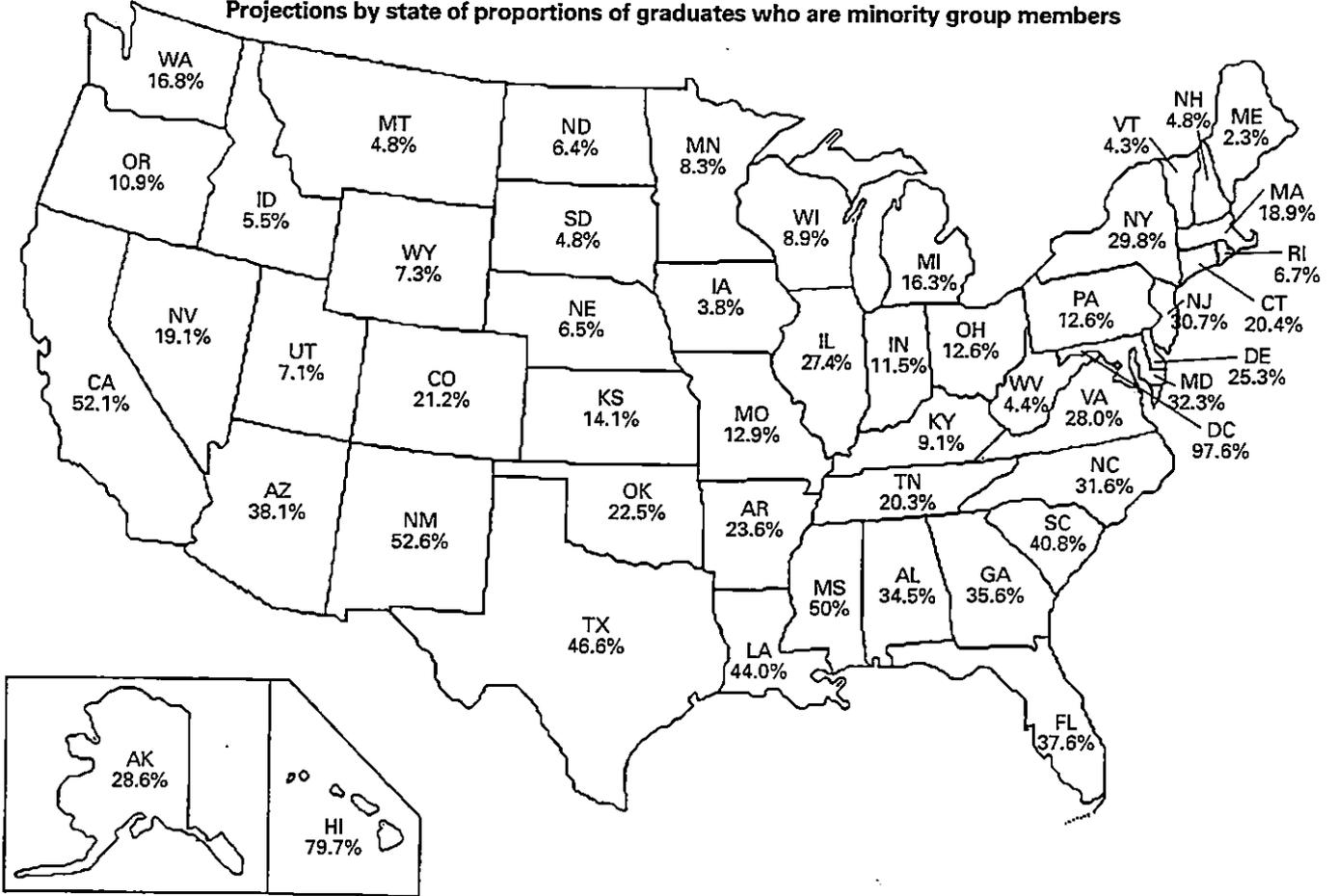
Map B
Projections of U.S. Population
1988-2000



Source: U.S. Census Bureau

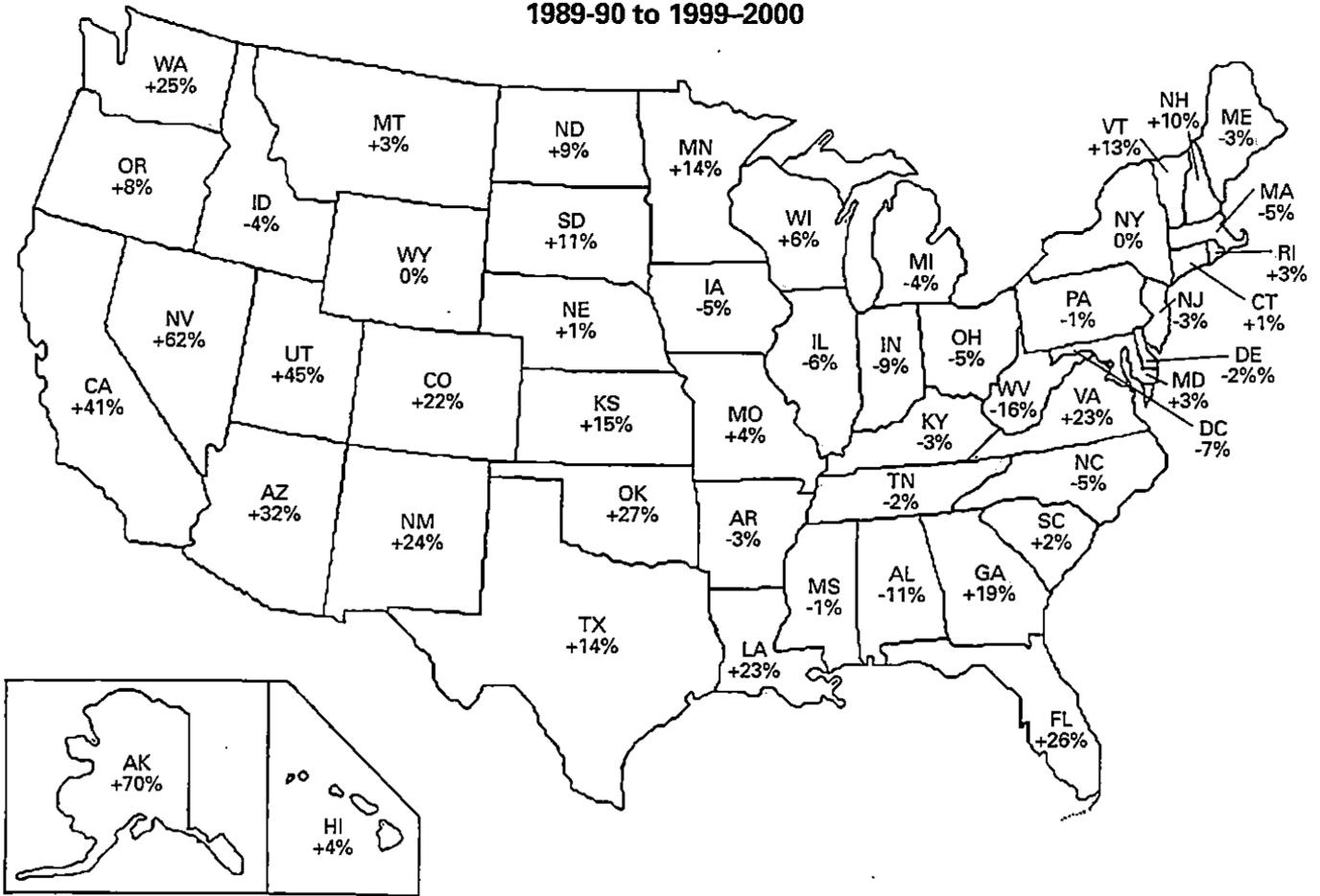
Map C Minority Public High-School Graduates, 1995

Projections by state of proportions of graduates who are minority group members

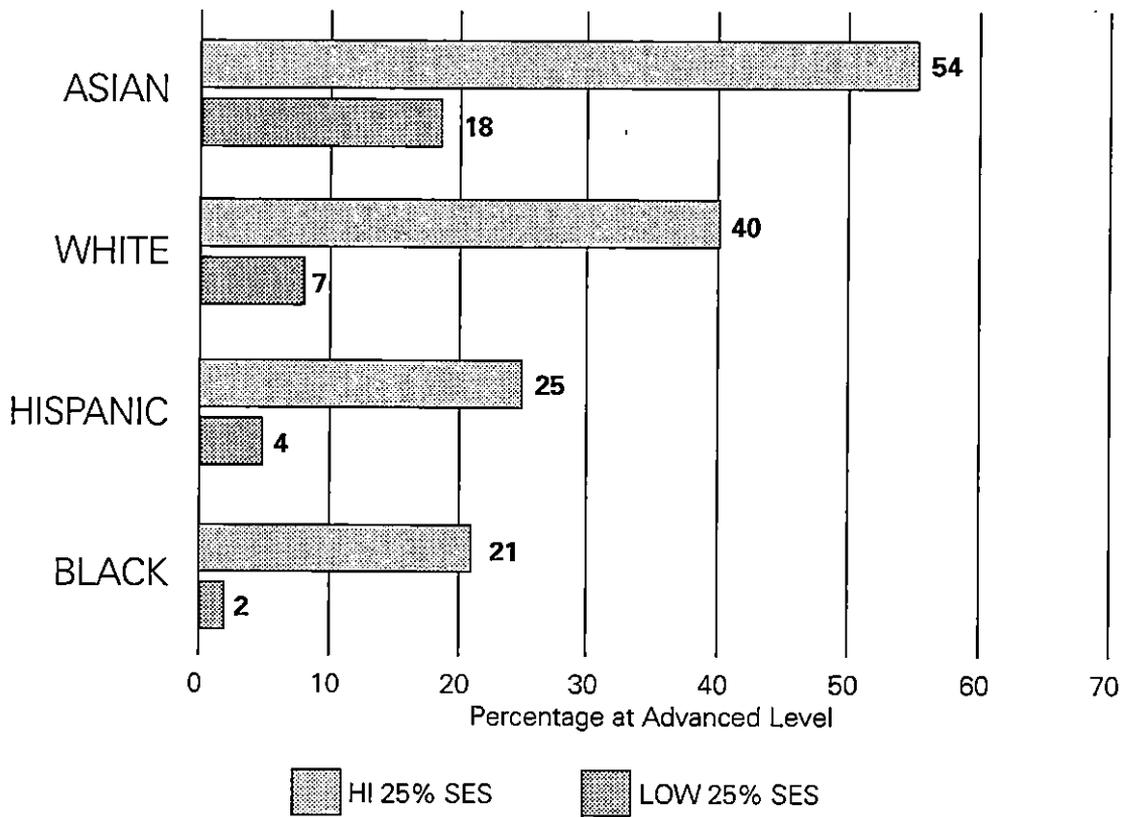


Source: Western Interstate Commission for Higher Education

Map D
Project Change In The number of High-School Graduates
1989-90 to 1999-2000



Source: Western Interstate Commission for Higher Education



Source: National Center for Education Statistics, *National Education Longitudinal Study of 1988, A Profile of the American Eighth Grader, 1990*.

Figure 1. Percentage of Eighth Graders in Low and High Socioeconomic Groups Who Are Proficient in Advanced Mathematics, by Race and Ethnicity, 1988

CHALLENGES AND OPPORTUNITIES OF DIVERSITY IN THE ACADEMIC SETTING

James H. Johnson, Jr.

Our nation is in the midst of an unprecedented demographic transformation. This transformation is radically changing the complexion of our neighborhoods, our schools, our places of work, and, indeed all walks of life. As a consequence of both the heightened immigration and high rates of birth among newly-arrived immigrants, non-white minority groups are projected to surpass non-Hispanic whites to become numerically the majority population in the United States by the first or second decade of the 21st century. At the same time, the American family structure is undergoing a dramatic transformation with the numbers of never-married single parents and unmarried dual careerists, and homosexual couples increasing rapidly. Their numbers in certain locations are increasing much more rapidly than those of traditionally-structured families.

Unfortunately, not everyone welcomes these rapidly occurring demographic developments at present; nor are these changes likely to be well-received in the future. The intolerance to population diversity has become so intense that in some states and cities, police departments are now required to record and maintain statistics on the incidence of racially, ethnically or religiously motivated violence, as well as on the incidence of gay-bashing.

Indeed, it has been argued that the failure of local elected officials to implement human relations policies which could mitigate the racial and ethnic antagonisms that have accompanied recent changes in the composition of the Los Angeles population was one of the root causes of the 1992 civil unrest in that city. In contrast to the black-white kinds of civil disturbances which occurred in the 1960s, the Los Angeles riot was a multiethnic rebellion.

Against this backdrop, it is necessary to heighten the public's awareness of the importance of effectively managing diversity in organizations in the 1990s and the years beyond. We must do this not only for social or moral purposes, but also for reasons of enlightened self-interest. It makes sense to be conscious of diversity.

The answers to the following four questions can enable organizations to initiate diversity training program or to evaluate the effectiveness of programs that are already in place. Why should organizations be concerned about workplace diversity? What is the nexus of issues of diversity about which organizations need to be concerned? What guidelines or strategies should be used to manage workplace diversity? Finally, what are the potential organizational consequences of failing to effectively address issues of diversity in the workplace? My premise is that competitiveness of the United States in the global marketplace is very much connected to our ability to manage diversity.

There are five reasons why American organizations, including institutions of higher learning, must engage in diversity training. The first one is the demographic imperative. The United States population is projected to grow much more rapidly, and to become far more diverse than was predicted in the late 1980s by the United States Census Bureau. In 1988, the Census Bureau estimated that the United States population would continue to grow until the year 2010, at which time it would peak at about 300 million people. Afterwards, it would remain relatively stable until year the 2050.

More recent projections, however, indicate that the United States population growth is not likely to peak in 2010. Instead, the nation's population is projected to increase by 50 percent over the next 60 years, reaching 370 million by year 2050.

These revised projections are based upon the Census Bureau's realization that the United States population will not approach zero population growth (ZPG) in the foreseeable future, as it had assumed in 1988 when formulating the initial projections. The 1988 projections were based, in part, upon the assumption that the population growth rates of non-white ethnic minority groups would approximate the non-Hispanic white rate (which is currently approaching ZPG) by the end of this decade. That is, the number of children per average white family (1.7) has remained relatively stable.

More recent analyses based upon the 1990 Census results and annual current population surveys, however, suggest that this was an unrealistic assumption. An unanticipated demographic development has forced the Census Bureau to change its assumptions undergirding the population projections: growth rates among non-white ethnic minority groups have been on an upward, rather than a downward spiral over the past five years. This is a consequence of continued high rates of both immigration and natural population increase.

In its most recent set of projections, the Census Bureau assumes that this trend toward continued rapid population growth among non-white ethnic minority groups is likely to continue well into the 21st century. The black population is projected to increase by 94 percent over the next 60 years. Over that same time, the Asian and Pacific Islander population will increase by 413 percent, the Native American population by 109 percent, and the Hispanic population by 238 percent. In contrast, the non-Hispanic white population is projected to increase only by 29 percent over the next 60 years.

Illegal and legal immigration combined will increase the United States population by an average of 800,000 a year for the next six decades. However, the annual increase could reach 1.4 million at some time. Each year over the next 60 years, 200,000 illegal immigrants will arrive in this country. That is twice the number assumed in a 1988 government report. By the year 2050, the United States population will include 82 million people who arrived in this country after 1991, or who were born to people who did. This group of immigrants and their children will account for 21 percent of the total United States population in 2050.

Whites will account for a declining share of the United States population. The non-Hispanic segment of the white population is projected to stop growing by year 2029, peaking at about 209 million. Over the next 60 years, the black population will nearly double from 32 million today to 62 million in 2050. The Asian population will double by the year 2009, triple by 2024, and quadruple by 2038. Overall, the Asian American population will increase from 8 million today to 41 million in 2050. Hispanic Americans will account for more than 40 percent of all population growth in the next 60 years. The Hispanic population will increase from 24 million today to 82 million in the year 2050 -- an unparalleled set of demographic transformations. In addition, childbearing rates for black and Hispanic women will continue to be higher than those for white women. The cumulative effects of immigration over the next 60 years, however, will be more important to people living in the United States than will be the number of births. What are the consequences of these demographic trends? There are three noteworthy consequences for businesses and other organizations, including institutions of higher education.

The first is that these demographic changes have enormous implications for the marketing of consumer goods and services, including services to students of higher education. The consumer market will be far more diverse by the first or second decade of the 21st century than it is today. This is due to the fact that non-white ethnic minority groups will constitute numerically the majority population in the United States. This is the reality for a large number of counties across the nation. In 1990, for example, non-white ethnic minority groups constituted 58 percent of the population of Los Angeles County, the fourth most diverse county in the United States behind San Francisco, Manhattan and the Bronx. Today, over two-thirds of Los Angeles' population is non-white. Radical economic, ethnic and demographic changes are not only occurring in major urban centers, but also are moving down the urban hierarchy into small and medium-sized communities.

The second consequence of these developments is the enormous implications for the future composition of the labor pool from which organizations will draw their employees. We will see a massive ethnic and gender diversification of those entering the labor market. One study estimated that minorities and women will account for 85 percent of the labor force growth between 1986 and the year 2000. Focusing upon workers, it becomes evident that the total labor force participation is likely to increase by 18 percent between 1986 and year 2000. Participation of women in the workforce is likely to increase by 25 percent. Black participation will increase by 28 percent; Asians by 71 percent and Hispanics by 74 percent. In contrast, the white male participation rate is projected to increase by only 9 percent during this period. It is notable that the estimates of these changes in the composition of the United States labor supply are based upon more conservative population projections than those released by the Census Bureau in November 1992. This means, therefore, that women and minorities are likely to account for an even greater percentage of new entrants to the labor force than is currently anticipated.

The third noteworthy consequence is that these shifts are occurring at precisely the same time as significant changes in labor demand in the United States economy. Due to de-industrialization, the massive decline in highly-unionized, high-wage heavy manufacturing employment, a bifurcation or polarization of labor demand in the United States economy has emerged. This change is characterized by the growth of employment in two broad economic sectors: low-skilled service employment, which requires little education and few technical skills, and high-skilled work in high-technology manufacturing and advanced services sectors of the economy. This type of work requires high levels of education and the ability to do "head" work, as opposed to hand work.

Superimpose on top of those structural changes in the economy the downsizing, re-engineering or right-sizing movement toward being lean and mean. What is emerging in American society is an enormous competition along racial, ethnic and gender lines for the "good" jobs. Defined as those with some prospect for upward mobility and benefits, a limited number of these jobs will exist. There is, however, a trend towards a contingent economy of temporary and part-time jobs. Even an education does not guarantee that a person may not end up in the contingent economy. Indeed, large numbers of well-educated Americans will find themselves in the contingent economy. A corporation, for example, may no longer keep a full-time attorney, but rather may contract out for services on a specified number of months or days of services. With this contingent economy on the horizon, as well as all of the emerging demographic changes, an enormous set of ethnic antagonisms is arising as more people compete for an increasingly fewer number of good jobs.

The so-called social imperative is the second reason for which organizations must engage in diversification activities. Recent studies indicate that new minority workers are less willing to conform to or assimilate into the existing corporate culture, and are more likely to maintain their own cultural identities. This means is that organizations must become more diversity-conscious if they are to avoid internal conflicts and to remain competitive in the 21st century marketplace.

The third reason to understand and accommodate diversity is the so-called personal imperative. Research in organizational psychology indicates that individuals who have learned to function in desegregated situations develop superior communication skills, tend to be better leaders, better coaches, better at influencing others, and better at giving and receiving feedback.

The fourth reason is the so-called legal imperative. Discrimination lawsuits are expensive and may prompt more than a slight reprimand from corporate stockholders, boards of directors, boards of trustees or boards of governors. Northwest Airlines, for example, settled a racial discrimination suit for \$1.2 million, and a sexual harassment suit cost K-Mart over \$3 million. Denny's provides one of the most recent examples of an organization found guilty of discrimination in terms of its treatment of minority customers, including African American Secret Service agents.

The fifth and final reason for which organizations must do diversity work is the so-called profit imperative. Heterogeneous work groups, when well-managed, can outperform homogeneous groups in both quality and quantity. The treatment of women, minorities and the disabled as a business imperative is the equivalent of a unique research and development product for which there is a huge demand. Diversity creates business opportunities. Failures to consider diversity create economic disasters, examples of which abound. General Motors failed at marketing the Chevy Nova in Mexico; *nova* (no va) means "won't run" in Spanish. Another example was Gerber's efforts to market its baby food in Africa. In African society, it is customary to put a picture of the item to be consumed, as opposed to the target consumer, on the container. By putting a picture of a black baby on the baby food jar, Gerber suggested that the Africans were cannibals. Both of these mistakes proved highly costly.

The second of the four questions which must be addressed relates to the nexus of diversity issues about which organizations need to be concerned. It is important to note at the outset of this discussion that diversity is not synonymous with Affirmative Action, nor is it about white male-bashing. Typically, talk about diversity makes white males nervous because they believe that it is going to degenerate into a male-bashing session, or that it is going to be about Affirmative Action. Managing diversity, however, is different from those issues. It is about maximizing the productivity of all workers. It is about creating an environment in which all workers feel comfortable, and thus are focused on the task at hand.

Historically, the image of diversity training is rooted in the evolution of the manner in which diversity training emerged. The traditional approach to diversity training was the notion of assimilation, Affirmative Action, and the melting-pot model. The idea of many of those hiring practices is that the worker must lose the expression of his/her individuality in order to fit in and be productive. This is not terribly diversity-conscious. The notion of assimilation is problematic because the new immigrants, as indicated earlier, are less willing to "assimilate" or "melt." Some people question that notion and argue that the melting pot notion a myth.

Understanding diversity is a second aspect of the diversity training movement. We can assume that much tension or difficulty in firms or organizations flows from a lack of understanding other people. The objective of understanding diversity is to enhance employers' ability to accept, understand and appreciate differences among individuals.

In the contemporary period, the third approach is managing diversity. The objective is to create an environment that fully taps the potential of all individuals in pursuit of corporate or organizational objectives, without giving advantage or disadvantage to any person or group of persons.

There exists a nexus of diversity issues out there with which we must concern ourselves if we are to manage diversity effectively. What does this nexus include? The diversity fabric must be concerned with the full range of employees in the workplace, and white males are an integral part of that fabric. White males are often concerned about double standards and being blamed for the existence of the glass ceiling. They, like any other group in an organization, have their own discomforts and dissatisfactions.

The nexus also includes family issues. Family structures are changing dramatically. The notion of the mommy-track, of child care, and of work flexibility for the increasing numbers of single-mothers imposes a series of constraints and role conflicts. Work flexibility for these women is a need of which organizations must be conscious, as the duties of a parent may not always conform to the nine-to-five schedule of the workplace.

We must include knowledge about the disabled population in terms of access and accommodation in the nexus. Understanding the rules, regulations and guidelines of the Americans with Disabilities Act is an integral part of the diversity fabric. The increased presence of females in the nexus makes it imperative to be cognizant of the rules and regulations regarding sexual harassment. An innocent look or certain body language might be misconstrued as a sexual overture, which may lead to accusations of sexual harassment. The importance of diversity training with respect to sexual harassment is that different cultures operate within different norms. We need to educate people about appropriate workplace behaviors.

Minorities are concerned about issues of access and fairness. The issue of diversity training revolves around looking at all employees in terms of individual development and identity. We want to move away from diversity training pertaining only to race and gender. This training includes a range of other issues which reflect the enormous demographic and economic changes that are occurring in society.

The third question to be answered is what guidelines or strategies should be used to manage diversity? There exist strategies for both organizations and individuals within organizations. This discussion will begin with strategies for individuals.

There are four key behaviors. First, an effective champion of diversity must be able to understand how one's own personal beliefs and values may affect others. One must realize one's own prejudices. There are a number of different techniques that can be used to facilitate this realization. First is a diversity awareness profile, which indicates a person's level of sensitivity to diversity. One outcome of this profile is the establishment of a set of interventions to foster sensitivity and diversity awareness among groups.

Second, an individual must take responsibility for championing diversity. One must be able to articulate the goals of diversity awareness training, and the goals of valuing and managing diversity. One must understand rules and regulations that govern workplace behavior and how they differ from managing and valuing diversity. One must be fully aware of the provisions of the Americans with Disabilities Act of 1992,

and the Family and Medical Leave Act of 1993. One must know the guidelines of Affirmative Action and the Equal Employment Opportunity Commission (EEOC). One must know the demographic profiles of employees and customers in one's business unit or region. One must understand the effects of company policies, systems, and practices on employees in the context of their ethnicity, gender, lifestyles, and cultural differences. And most importantly, one needs to know about how to communicate the exchange of ideas and knowledge in an organized, effective manner. One must know how to design training based on a particular unit's need.

The organization also shares responsibility for ensuring diversity. One component of this duty is the distribution of information. The organization should provide a firm understanding of the laws and regulations governing employment discrimination, how Affirmative Action and EEOC programs work, the demographics of the labor pool, and the demographics of the company's customer base. The company should develop its marketing strategies and day-to-day operating strategies according to this understanding. Another responsibility of the organization pertains to behavior in the workplace. Employees should be given specific guidelines about unacceptable behavior and should be educated about such issues as racial and sexual discrimination and sexual harassment.

Next is the emotional aspect of the workplace. There are exercises and quasi-therapeutic techniques that encourage people to examine and confront their own deep-seated prejudices and those of others in the group. One caution here, however, is that we need to be conscious and sensitive when we do these kinds of sessions; oftentimes we are asking people to rethink or relive very painful experiences in their pasts, irrespective of their ethnic, gender or racial background.

The systems component is one of the most important areas in which an organization has a duty to ensure diversity in the workplace. Companies or organizations that want to encourage, appreciate, and capitalize on diversity instead of just tolerate it will probably need to change some policies and practices. Performance appraisal systems, pay and benefit systems, coaching practices, mentoring schemes, management development programs, flex-time arrangements, jobs-caring, day care and affirmative action plans all need to be examined.

It is extremely important for the company to engage in organizational audits. Such as audit exposes barriers to diversity by examining different components of organizational culture. Tenure decisions provide an illustration of barriers to diversity. When a black person, for example, comes up for tenure, he or she may be required to have 18 outside letters of evaluation, as opposed to a white person coming up either before or after needing only six. Audits of organizational culture are important in identifying such major barriers to diversity training.

We must not avoid the issue of diversity. We must bring it out into the open and discuss it. We must act as intercultural ambassadors and create an atmosphere in

which differences may be used as stepping stones to facilitating greater understanding between ethnicities, races and genders. Leaders must be intercultural ambassadors and make tact and respect the rule for discussion of ethnic, racial, and gender differences. We need to stay within EEOC guidelines, despite the current antagonism towards programs such as Affirmative Action. We should not tolerate racial or sexist views. Talking about ethnic differences means that tact and diplomacy are that much more important.

We must educate employees in the broadest sense of the word. Mediating between personal and professional goals, the company must link employees to the organization's values, standards and norms. Helping them to match their styles and skills with corporate goals will insure that employees' personal and professional needs are fulfilled. This education includes explaining the unwritten rules of the organization. Employers must address such issues as rules concerning dress, hairstyle, acceptable language, how to express disagreement with coworkers or superiors, how to make requests from coworkers and how to approach superiors.

A potential employee should be referred to coworkers so he or she can acquire a well-rounded perception of the organization's culture. If a person of color is coming to a campus, he or she should be afforded the opportunity to talk to some other people about working in that environment. Failure to do this may result in the person finding himself or herself unhappy or uncomfortable in that environment. It makes sense to expose up front potential employees or recruits to the broadest body of coworkers in that environment.

The top management also plays an important role in ensuring diversity in the workplace. Without the firm support of the top management, promoting diversity may be incredibly difficult for a manager or chair of a department. Responsibility rests with the top management to write workforce diversity into the corporate mission statement or the university mission statement and to hold managers accountable for achieving diversity by setting quantifiable recruitment and retention goals linked to compensation. Doing so includes not only vocal support from the CEO and other top managers, but also the allocation of adequate dollars to workforce diversity efforts and the appointing of a manager to be responsible for supervising all diversity-related activities.

We must address the issue of stereotyping as one of the largest constraints on sensitivity analysis and diversity consciousness in American society. In 1992, the University of North Carolina at Chapel Hill did a survey on ethnic antagonisms in Los Angeles. The survey posed a series of questions which asked the various ethnic groups to evaluate each other along a number of dimensions, including intelligence, welfare dependency, and ability to get along with others. Results of the survey demonstrated that 63 percent of Asians and 40 percent of whites perceive themselves as being far more intelligent than the average black; 76 percent of Asians, and 61 percent of whites perceive blacks to be more prone to live off of welfare than to work everyday. And 56 percent of Hispanics perceived blacks as being difficult to get along with. That 56

percent is embedded in an empirical reality in that in Los Angeles blacks and Latinos often share the same residential communities, and there is an enormous tension in those communities in competition for housing, jobs, and scarce resources in those environments.

Asians, in particular, perceive themselves to be far more intelligent than blacks, at least according to the 1992 survey. Whites are second in their belief of intellectual superiority and Hispanics are a distant third. Hispanics receive the same proportion of negative ratings as blacks. Asians rate Hispanics negatively in terms of welfare dependency and intelligence. They believe that Hispanics are far more likely to rely on welfare, and are far less intelligent than other groups.

These stereotypes play a major role in the labor market. The University of North Carolina at Chapel Hill has just completed a study of 4,000 employers across four cities in which a pattern of negative stereotypes, especially those of black males, emerged on the employers' side. Black males are perceived as dangerous, having a poor work ethic, being unintelligible, being untrainable, as well as a range of other stereotypic views. The burden of these negative images can cause people to change their behavior for the worse, which only perpetuates the stereotype.

The last stereotype relates to how Asians are viewed by other minority groups. Whites, blacks, and Hispanics do not harbor negative stereotypes of Asians in terms of intelligence and welfare dependency although there is a belief among all groups that Asians are fairly difficult to get along with. This mostly positive perception of Asians is rooted in the high proportion of Asians in Los Angeles County who are engaged in entrepreneurial activities in minority communities. There is, however, much ethnic antagonism through interaction in the business environment between Asians and other ethnic minority groups. The Los Angeles civil unrest, was not about Rodney King per se, but rather it was about another case captured on video tape in which an Asian shopkeeper shot a high school honor student in the back of the head. While the jury found the shopkeeper guilty of felony murder, her sentence was as light as five years probation and six months of community service, causing much upset in ethnic minority communities. There is an enormous set of existing ethnic antagonisms that are going to make it very difficult to promote diversity training in society.

A successful business or organization in the 21st century will need to note certain trends. Everyone will belong to a minority group. By the year 2000, one out of four employees will come from a minority group. White men will constitute less than half of the labor force. Asians will outnumber Jews by a margin of two to one. Hispanics will lead blacks as the nation's largest minority. Immigrants will become more important to United States population growth than natural increase. The challenge here will be to target the diverse cultures, age groups and lifestyles with the right products and messages.

The structure of the family will be redefined. By 2010, married couples will no longer be the majority household in American society. By the year 2000, more than half of all children will spend part of their lives in single-parent homes. An increasing number of babies will be born to unmarried mothers. By the year 2010, about one in three married couples with children will have a stepchild or an adopted child, which is reflective of the high rate of divorce. Indeed, in some places in America, the divorce rate currently exceeds the marriage rate. Interracial marriage will alter the faces of the average family. Alternative family types will become more prevalent, including unmarried heterosexual couples, homosexual couples, and friends who live together. Advertisers and recruiters will need to be extremely tactful in depicting 21st century home life.

Full-time homemakers are approaching extinction. Most children will never know a time when their mothers did not work outside the home. By the year 2000, more than 80 percent of women aged 25-54 will be in the labor force. Women will account for nearly half of the labor force. The fact remains that businesses and other organizations will be dependent on the skills women have to offer, which means that they will have to adapt to insure their job-satisfaction. Parental leave and flexible working hours will be the rule for all but the smallest businesses and organizations.

We are at a crucial period in our history in terms of our ability to interact harmoniously and successfully with one another, making it even more important to address diversity issues now.

CHANGING CULTURES TO CREATE SUCCESSFUL PROGRAMS: THE MEYERHOFF SCHOLARS PROGRAM

Freeman Hrabowski III

This paper focuses upon ways in which The University of Maryland, Baltimore County (UMBC) has been able to change the culture on its campus to increase the number of minorities entering and succeeding in programs that lead to careers in the health professions. It will highlight the impact of the Meyerhoff Scholars Program, an initiative designed to increase the number of minorities, particularly African Americans, in science.

The University of Maryland, Baltimore County is a young school. The campus will be 30 years old next year and serves about 10,500 students. It is a school with a diverse student population with minorities constituting slightly more than 25 percent of the student body. Of the 10,500 students, approximately 1,300, or nearly 13 percent are African Americans. Approximately 12 percent are Asian, and about 2 percent Hispanic. The emphasis at the graduate level is on science, engineering, and public policy. The university offers 18 Ph.D. programs. Approximately 65 percent of the students enter with an interest in the sciences and engineering and computer science and technical areas.

The university is evolving rather quickly. Ten years ago the level of research and training grants was under \$5 million. At present, it is \$30 million. Invention disclosures traditionally have been only two or three per year. This year the numbers reached 20, with eight patents filed. The university is heavily involved with companies and also works with a variety of universities, including the University of Maryland at Baltimore and Johns Hopkins University.

There were three challenges facing the university in 1987. The first was that only two African Americans per year graduated and went to medical school. Over the past 30 years, the university has been able to graduate large numbers of students who go on to graduate professional schools. Large numbers of African American students, however, arrived on campus with an interest in law, medicine, dentistry, pharmacy or other professional areas, yet very few were entering these programs. The second challenge was the discrepancy between the numbers of white students entering with an interest in science, and the numbers actually graduating. It was clear that large numbers of students, black and white, came to the university with an interest in pursuing a career in science or in technical areas. Reversing the school's negative reputation among both black and white students was the third challenge; many black students believed that the university was a racist institution. Many white students thought it a cold and unfeeling place.

There were several important issues at the root of these problems. The first was that the university focused on high-ability students, and took great pride in their successes. Unfortunately, many of the minority students attracted to UMBC did not have the academic preparation to do as well in the areas of math and science. A second cause of dissatisfaction among undergraduates was that more attention was devoted to doctoral programs because the university's Ph.D. programs were developing rapidly, and freshmen were left to fend for themselves. The school was investing to increase research dollars and produce Ph.D.s at the expense of the undergraduates who constitute more than 80 percent of the university. The poor performance of African Americans was merely one part of the problem. There was an issue involving the performance of all of our undergraduate students, and the amount of attention they were receiving.

To resolve these problems, the university examined the balance between the undergraduate and graduate programs. Second, it looked at special groups of students, particularly minorities in the sciences, and women in engineering and physics. Part of the study was an assessment of the study habits and amount of time students were spending on their studies. It also looked at the academic preparation of students before they came to the institution. Finally, the study was designed to examine trends such as one racial group doing better academically than another. The study showed that half of the black students were not doing well but neither were significant numbers of other students.

In the basic chemistry course, it was not unusual to have between 60 and 70 percent of all students earning below a C. Apparently, nearly 60 percent of students around the country may earn below a C in this course. Whether it is basic chemistry course, basic calculus course, biology, physics or engineering, more than half of the students are not doing well. This can be discouraging to students, regardless of color, and large numbers who enter college with an interest in health care or science, find instead that they do well in social sciences and humanities. They then change their majors.

The responses from different departments were that poor performance of students was due to either poor or mismanaged study habits, or an overload of courses which left them insufficient time to prepare thoroughly for each one. All of these answers were true. However, they did not touch upon the quality of instruction in those basic courses. Who was teaching those courses. In a number of cases, the basic courses were being taught by professors of low prestige or teaching ability. Freshmen students are the most vulnerable on a campus. Making the transition from high school to college is a difficult one. These students need special attention. In high school children are accustomed to having homework every night and being tested and quizzed on a regular basis. At college, however, the first calculus or chemistry exam is not until midterm. Most high school students, even highly successful ones, tend to wait until a test is coming to actually study the material. Likewise, most students will

make the same mistake when they get to college. By the night before the test, it is usually too late to do well.

The Meyerhoff Scholars Program was implemented to stem the loss of students from the areas of science and medicine and to increase the number of M.D.s and Ph.D.s in science. The program has grown from a grant of \$500,000 for the first group of 19 students to a current total of nearly \$7 million for 180 students. The average score on the Scholastic Aptitude Test is in the high 1,200s, with an average grade point average (GPA) for the group of about a 3.4 in science courses.

The program is to produce Ph.D.s in science. We recruit top students but top means many things. SAT scores range from 1000 on up. Encouragement and hard work with students mean a lot. A summer bridge program that focuses on a combination of math, science, and an African American culture is also important. Many of these students have never had any work that focuses on their history or their literature or an understanding of blacks in medicine and science. The program provides significant scholarship support. The best students get a full ride. At first all of the top students were getting a full ride. Now about half get a full ride--tuition fees, room and board. The others will get a partial ride.

The program places a major emphasis on study groups, with a lot of attention given to problem solving and study groups. Study groups are also important for students to connect with each other. We emphasize getting to know all kinds of students and working with all kinds of people, because that is the workforce. We place a strong emphasis on advising and counseling. Program values are very significant. We place a lot of attention on community service and giving time to tutoring and helping other students. All Meyerhoff students tutor math and science to inner-city kids. They also tutor people on the campus.

At UMBC tutoring is not for students who are trying to pass. Tutoring is for students who are trying to get A's. We changed the mind set about the concept of tutoring. There is a stigma in high school attached to tutoring. Only slow kids or kids who are really in trouble go for tutoring. We have been able to document and to highlight on our campus that A students spend a lot of time not only in labs but also in the tutorial center, either tutoring or being tutored or working in group study sessions. The work of the Meyerhoff students has spread to all segments of the study body.

A lot of faculty are involved and this is essential. We have a prestigious faculty involved with these students and serving as mentors. These students are working regularly in the laboratories of faculty members. Clearly, leadership from the administration is important as well as African American mentors, who are physicians and scientists, and other mentors in health related areas.

There is a lot of emphasis on family involvement. There is a Meyerhoff family association. We tend to think that when students go to college they are on their own, and they are adults. But it is not true. I do not care how big the guy is, or how sophisticated the young woman looks, he or she is talking with a mother. If there can be involvement with parents at the undergraduate level, it can be very helpful as students have a variety of problems. The issue of students succeeding in science is not merely a question of help with academics. It is an issue of emotional support and involves many other things that go on in that young person's life. UMBC takes a holistic approach.

Probably the most important part of the program is evaluation. We are documenting what works and how the students are doing in courses. They are doing extremely well. We have two different comparison groups. One is a historical group of test scores and grades. The other addresses students who do not come to UMBC. It is interesting that 95 percent of the students who start in the Meyerhoff program actually graduate with a major in science and engineering. And of that number, about 95 percent are going on to graduate and professional schools. They are in a variety of M.D./Ph.D. programs. This fall between 18 and 20 African Americans are entering medical school, and about that number will be going on for Ph.D. programs. Having brought in at least one African American faculty in the math and science and engineering areas has made a difference as well as having a black dean of the medical school at the University of Maryland at Baltimore.

There are a lot of wonderful things happening. Before this program African Americans did not get A's in courses like genetics. Now we have dozens of students doing that. But it was like breaking a barrier in a race. Once the first group achieved it, others quickly followed.

One example of what is the best about UMBC is the November issue of the *Journal of Molecular Biology*. The lead article was done by Mike Summer, who is our Howard Hughes investigator. The article deals with the three dimensional structure of the HIV virus type 1 matrix protein. It is significant that one of the authors on the paper is a young African American woman in the Meyerhoff program, who has been doing research with Dr. Summer for the past couple of years.

Hands-on experiences are critical and exciting parts of the program. We have more than 20 students in labs at the University of Maryland Medical School and about 20 at Johns Hopkins University, and 150 in labs all over Maryland in the summer. Such experiences excite students about the sciences, and make all the difference. It changes attitudes of faculty and administration. But most important it gets students succeeding in work and makes them determined to go on and become physicians, Ph.D.s, or health professionals. If we can have people as excited about research and science as they are about basketball, we can have more minority professionals.

GRADUATE ENGINEERING FOR MINORITIES PROJECT

Howard Adams

This paper briefly outlines the Graduate Engineering for Minorities (GEM) program, addresses its operations, some of the issues that the program has tried to resolve, and its successes. The program has been in business for quite a while.

Each year, minority men and women are entering undergraduate engineering and natural science curricula; however, a smaller percentage are continuing on to graduate studies. For most, the opportunities associated with a baccalaureate degree appear to be sufficiently attractive. They are not aware that an advanced degree in engineering or the natural sciences can open new avenues to challenging, responsible employment and future success.

The mission of the National Consortium for Graduate Degrees for Minorities in Engineering and Science, Inc. (GEM) is to increase participation and graduation of underrepresented minority students at the master's and Ph.D. levels. GEM does this by 1) programming activities that build alliances to secure financial support; 2) developing support mechanisms to enhance the academic and professional growth and success of underrepresented minorities; 3) producing materials and programs to advocate graduate education; and 4) influencing national policies that affect access and choice for graduate education.

GEM accomplished its mission by providing graduate fellowships to underrepresented minority students through three fellowship programs:

- The M.S. Engineering Fellowship
- The Ph.D. Engineering Fellowship
- The Ph.D. Science Fellowship

To realize its goals, GEM also produces printed and videotaped materials explaining and advocating graduate education.

For a long time GEM focused on engineering, so it was relatively easy to talk about graduate engineering for minority students. In 1989, the field of science was added to the program agenda. The program has expanded beyond minority education. In fact, many people have copied this model, including the National Physical Science Program that is for women.

GEM was organized in 1976 and incorporated in the State of Indiana. Notre Dame agreed to house the program. Over the years we have grown from a very small program with an annual budget of about \$200 thousand to almost \$5 million today.

There is a building on the Notre Dame campus called the GEM Center. Seventy-seven engineering schools participate in GEM and some of those also have science programs. All of the schools of engineering do not have science programs. About 60 schools offer the Ph.D. in science. GEM is sponsored primarily by government and industrial research laboratories. The universities kick in part of the cost of students' tuition. Funding comes from these sponsors, including Bell Laboratories, Microsoft, Boeing, Exxon and Mobil Oil. The NASA laboratories, the National Institute of Standards, the Bureau of Standards and the Argonne Labs of the Department of Energy are also among the sponsors. GEM runs the training program for the Environmental Protection Agency (EPA), which is a program dedicated to having students get advanced degrees in the environmental sciences.

GEM's major focus is preparing students for the master's degree in engineering. The program accepts about 225 new students each year at the master's level. These awards are totally portable; students can go to any school they want. With money in hand, perceptions about admissions change dramatically. If you have money, you can be admitted to CalTech. If you do not, then institutions start talking about GRE scores and other criteria. GEM has the money; the students get admitted, and they go to school and they graduate. If you want to have a program, make sure where you put the money. If you put the money in the hands of the institution, many barriers arise.

About 25 Ph.D. degrees in engineering are awarded each year to our students. That is a small number. We cannot find enough money to fund that part of the program. About 40 Ph.D.s in the physical sciences are awarded to our students each year. Most of those are in chemistry and GEM has been able to get the chemical industry to provide funding. GEM is looking for funding from the pharmaceutical sciences for instance. We have students who want to do pharmaceutical chemistry, toxicology, pharmacology, and similar areas. We have students who would love to do neuroscience and genetics but we do not have any money.

GEM has a database and is a clearinghouse. GEM can match people up. Schools write GEM asking that their materials be sent to students who are interested in going to graduate school for instance. GEM has a guidance counseling project. When we talked to students, we found out they did not know how people become successful. It is amazing, once people become successful, they do not tell anyone. You would never tell anybody you had trouble with freshman chemistry. It looks like something is wrong with you. Students think that everybody succeeds in chemistry. I come along and tell students that I struggled with freshman chemistry. In fact, it wore me out. I was not a genius. I passed chemistry just by the skin of my teeth, and I went on and received a Ph.D. After I started talking about it, I found out that other people would admit to the same problems.

GEM decided to walk successful people back through their lives. We take people from various walks of life, and do a film about their lives. For example, Ben Carson, the neurosurgeon at Johns Hopkins was one of our selections. GEM also has a

nationwide teleconference over PBS every fall, where we talk about some facet of graduate education. Last year GEM addressed the graduate internship and how internships can be used to develop theses, research and other interests. We talked about how to pay for graduate education and how to find money. The fact that nobody pays to go to graduate school is not known. In fact, when I first started this program I would visit various campuses and tell faculty members that we tell students it does not cost anything to go to graduate school. Now they might have to make some choices about where to go. They might have to give up something, but funding can be found.

We are interested in focusing on issues that impact students going to graduate school. Why is it that you have to have a certain score on the GREs to do a Ph.D. in engineering? We ask people that question. What are you looking for? Nobody knew what they were looking for. What is it that GRE scores will tell you that an A in calculus does not tell you? If you can pass thermodynamics with a B or better, physics II with a B or better, calculus II with a B or better, and chemistry with a B or better, you can go to any graduate school in this country and do a Ph.D. It is absolutely true. It will not make any difference what your GRE scores were. And just because you did well on GREs, if you cannot do thermodynamics, you cannot go to graduate school. So even if you sneak up and practice the GRE and pass it, if you could not do thermodynamics, you cannot go to graduate school. That is a fact in engineering.

We tell students why they should go to graduate school. We got rid of the notion that if you get a Ph.D., you drive a taxicab. People with degrees in business do not tell jokes about driving taxicabs. They would never tell that story. We graduate Ph.D.s and then turn around and tell people that they have a hard time finding a job and end up driving a taxicab. There must be at least one lawyer somewhere who was not successful. I have never heard of one. I never hear about a lawyer driving a taxicab. We promote graduate education by telling students how to use it. For instance in engineering a master's degree is worth \$600 a month or \$300,000 in a lifetime. A Ph.D. is worth about \$1,500 a month or \$1 million in a lifetime.

We deal partnerships with universities and we develop materials. We are actually a broker between the universities and the industrial partners. We promote the program and convince the employers that they ought to participate in the program because it is the right thing to do. GEM has fellowships and publications. GEM organizes conferences, produces videotapes, provides counseling, prepares speeches, and performs research. We have a database and we have opportunities for students. We provide them with an internship to better understand their field.

GEM opens up opportunities and provides mentoring. Students know that they can call us in the middle of the night. But that mentoring also involves a kick in the pants. We tell students that once they have money in hand, and the door open, they had better graduate. We expect students to get a master's degree in engineering in three quarters, or four semesters, without excuses. So when I go into a room, I say how are you doing? They say, doc, I'm on the three semester plan. I will finish in December.

And so last December, at the end of four quarters, I had 26 students get master's degrees at Georgia Tech, and 1 Ph.D. They were underrepresented minority students in one class.

We had 68 students in the master's program. At Georgia Tech, we had 10 working on Ph.D.s. We just had 5 students--all underrepresented minorities--pass comprehensive exams in the school of engineering at Georgia Tech and 32 at Stanford. These are some of the top schools. We have had 21 students graduate from Tuskegee (100 percent); 78 from Cornell (96 percent). We have 40 people around the country who are teaching full-time with Ph.D.s. They are at the best schools in the country. Three of them are at the University of Michigan. People are getting tenure.

We are 38 percent female; about 60 percent African American; about 22 percent Mexican American; 2 percent Native American; and whatever is left over, Puerto Rican. That pretty much mimics the application flow. We generate applications around the country.

We try to move people. We have to move people from San Antonio to New York City or to New Haven to do an internship. The parents often say no; they will not let the child go. They turn the fellowship down, and the student does not get a chance to go to school. That is one of the problems. The second is that students do not receive enough information to be able to go home and convince parents that they have made the right choice. We have to come along and give students very good information on why they are going to get a Ph.D. Students do not know the answer. We have been working on how to provide the kind of information that students need that will allow them to make these very good choices.

For such a program there needs to be continuity of support. GEM has been in business for almost 20 years. And the same people who kicked us off 20 years ago are still funding us. It is a long haul. You cannot have a program over night. People need to buy in. It is not something that can be put on paper without involvement. The program has to have ownership. You have to have people who make a case that this ought to be done. GEM maintains strong links with the students. We maintain they are not names on a piece of paper. And we do not turn this over to a secretary. I am not knocking secretaries. They do great work, but they do not make people get Ph.D.s.

We have high expectations. We would never give a student an award and then turn around and say, "I don't know why you are here." At many universities, even after the admission process, faculty turn around and tell students, "I don't know why you are here. We never had anybody like you before." That must be a devastating thing for a student. Schools have to change that attitude. Such things cannot happen.

And finally program costs have to be kept down. If you are going to do something for minority students, you have to get the money to the student. You have to make sure of that. We simply say that if you give us a dollar, we give 80 cents to a

student all the time. What is difficult about doing this? You cannot recruit a student that you cannot find. And so we look in the wrong places. You have to have a mechanism to identify the kind of people that you need.

Retention is a very important piece, and it does not mean that you give students some grades. It means enhancing the campus climate. What do you have to do as faculty? What does the administration have to do to make sure that climate is conducive to students excelling academically? Not just minority students but everybody.

Lastly, we have to reaffirm that the student has potential and value, and what we are talking about doing has value to it. When a student calls me and is troubled about some aspect of their program or career, I get on the phone with somebody else to say, "Listen, here is somebody who had the same problem you have. Let me let you talk with them about what their experiences have been."

Students will say to me, "You know it is not true that you are going to give us a fellowship." GEM students tell other students, "It's absolutely true. I got a fellowship. I am now in school. This is what it pays. It takes care of tuition. I get my job in the summertime, and there are no strings attached." You have to give students that kind of affirmation about what it is they are going to do.

We do a very important job of mentoring students, because we assume that they know what to do. We make the assumption that the student knows exactly what he or she is going to do. When I say mentoring, I am not talking about baby-sitting. I am talking about providing students with resources, with information. And it needs to be written for the students. We took questions that students consistently asked and we answered them. For example, what is a graduate degree? What does it take to get one?

What do you mean by the titles? In the health sciences, titles do not make a lot of sense unless there are accompanying explanations. What do degrees mean? What's the difference between a Pharm.D. and a Ph.D.? You have to give students some information about these issues. Do not assume that they know what they are doing. A group from the health sciences, the academic health centers, could conduct a similar program if they decided it was needed and wanted to support such an activity. You have to focus on what it is you are trying to do.

And finally, when you talk about affirmative action, it boils down to talking about slots. The surprising thing about the sciences is that you cannot talk about it in terms of slots. The numbers are too small. If you are talking about women, other than in the field of biology, they are not doing very well in the sciences. In physics, chemistry, and engineering, there are also still less than 20 percent women.

If you talk about minorities, they are still vastly underrepresented. In fact, on the science and engineering side, the people who have taken the full advantage of

graduate education in this country primarily have been foreign students. In engineering, they represent about 51 percent of the students; in chemistry about 57 percent; and in physics about 50 percent. In math, it is 60 percent.

At Mississippi State, which is in the heart of the South, of the Ph.D. enrollment in engineering, 51 percent are foreign students. Only 2 percent of students enrolled in engineering are black. Most campuses have already made decisions regarding the distribution of places. You have some notion of what you want the class to look like.

There is a very prestigious school in engineering that has about 135 slots in electrical engineering for entering students. It is known automatically that 35 of those are going to go to foreign students. There are set asides. Ten are going to go to the National Science Foundation (NSF). If enough people apply, they are going to take 10 NSF students. So if you can have set asides for NSF students, I do not know why you cannot have some for women. If we can have 35 for foreign students, then you could have some for minority students. But that issue does not even come up in discussion.

In summary, we are very proud of what the GEM project does. We have made a critical difference. We changed graduate education in the country, not just for minority students. It is easier now for majority students to get into some of these schools, because we have changed the way schools consider students.

MENTORING OF WOMEN AND MINORITY FACULTY AND STUDENTS

Brenda Hoffman

In addressing mentoring, everyone assumes they are talking about the same processes. I will address what can be termed classic mentoring, and describe some myths about mentoring, new ways to look at mentoring, mentoring and diversity, and some variations on classic mentoring.

What is mentoring? Everyone is familiar with the story of Odysseus and his voyage. We know how he left his son, Telemachus, in the care of his friend, Mentor, from whose name the term mentoring is derived. Everyone knows about King Arthur and Merlin, and the apprentice-master relationship. In industry many people received their start because someone -- perhaps a friend or relative -- was given responsibility for their training. And in many trades a lad was not likely to make good progress and obtain a secure foothold unless he were able to work by the side of his father or some friend of his father's who would take the trouble to teach him. That is classic mentoring.

Mentoring is also illustrated by the jigsaw puzzle principle. It is easier to put the puzzle together if you can see what is on the box. Once a mentee can see what is on the box, the mentee knows how to do it. And that is what good mentoring teaches. Those without mentoring find themselves unable to get from point A to point B. Those without mentoring, for example, are like the woman who has a Ph.D. and is working in the lab, believing that if she works 150 hours a week, keeps her head down, and just does her work she is going to be successful. Another example is the black nurse who wants to get into an administrative position, does not see anybody like herself in administration, and does not think it can be done. Finally, there is the white male faculty member who has been a straight A student his entire life and cannot get funded. He begins to think it is because he is the wrong gender or the wrong color, when the problem may be that he is not applying to the right agencies for funding or that his grants are not well written.

In every organization there are two parallel organizations. The public organization is the organization that emerges from the image presented in promotional materials from the annual reports to the organizational charts. Parallel to that is what is called the shadow organization. It is hidden, but it is vitally important. It is here where the decisions about pay raises and about promotions are made. And it is here where a good mentor, one who is familiar with the shadow organization, can tell the woman in the laboratory there are political reasons for her to come out of the lab and begin to collaborate. The mentor can tell the black nurse that there is a way to obtain an administrative position. The mentor can tell the white faculty member that there are people who have access to grant writing agencies, and begin to show this person how to write grants well.

In addition, there are other benefits to mentoring. The mentee gets a knowledge set and targeting of skills that are going to be needed for an academic and professional career. The targeting of skills is key. All academics know they have to publish or perish. A young faculty member needs to know what skills are needed if he or she is having trouble writing papers. The mentee gets individual recognition and encouragement, honest criticism, informal feedback, and advice on balancing multiple career and/or personal tasks.

In addition, the mentee gains an increased awareness of the organization and the shadow organization. For example, the public organization is saying that a person should serve on committees for women and minorities. This is a problem, because women and minorities are always being asked to serve on committees. The mentor needs to be able to say to the mentee that committee work is important, but there are only two key committees on which service is required. It does not mean that the mentee does not need to serve on any other committees, but the mentee needs to know the rules of the game, which the mentor can explain. Mentoring is similar to health care reform. Everyone agrees that it is important and that changes are necessary. Everyone talks about having increased access. But doing it is much more complicated than it looks.

What follows are some myths about mentoring. The first myth is that the only beneficiary is the mentee. In fact there are some benefits for the mentor. The mentor gets to establish a legacy and to mold successors, to extend a power base, to get reinforcement of a professional identity, and to pass on some personal knowledge. Mentors get assistance with projects, and a sense of achievement and accomplishment, and some acquisition of new technical knowledge. If the new person is a whiz kid on the computer, it can be very helpful in upgrading one's own work. There are two functions for the mentor: career enhancement, and obtaining new intelligence and new information.

The next myth says that mentoring is always a positive experience for both the mentor and mentee. While there are good mentoring experiences, there is also painful mentoring. There is the passive mentor who feels that his job is just to function as a role mentor. There is the active mentor, and that sounds good, but a well meaning mentor who is misguided and does not have the experience and the knowledge to understand what it means to be successful in a particular field, then he or she is an inadequate mentor. This is someone who is not invested or respectful of the mentee's career growth, and has unrealistic expectations for the mentee that are only going to guarantee failure. Such a mentor is inaccessible or insecure.

And lastly, there is the negative mentor or the tormentor. This is someone who actively harms the mentee. This mentor can squelch initiative or enthusiasm, be disrespectful of the mentee's work or actually appropriate it or provide negative and

destructive feedback. Such a mentor may even be someone who is uncomfortable or harasses people of another gender or another race.

Another myth says anyone who wants a mentor can find one. A lot of senior people assume this is so because they see people being mentored, and they are mentors. But it is actually not so. Senior people need to make it happen. It is not bad people or abusive people who derail or ruin careers. It is the indifference of people who become so involved in their own work that they forget the junior people.

The next myth says that mentoring is mentoring is mentoring. This attitude raises the question of an analysis for the mentor and the mentee. The mentee asks, "What do I want from a mentoring relationship?" The mentee needs to assess what stage he or she is at in their career. It is important for a mentor and mentee to understand that if a mentee is at the very beginning of a career, the mentor should not be at the same stage. The mentor is not going to have the time, the experience, or the enthusiasm to deal with the mentee and his or her problems. But if you get a mentee who is at the very beginning of a career and a mentor who is further along, then there is a chance for a good relationship to develop between people who have the time to work with each other.

For a mentoring relationship to be successful there are some important issues that need to be agreed upon from the beginning, and be made clear to both parties. Some people suggest it should be done in a contractual arrangement. There are five areas to think about. First, what are the expectations for the relationship on both parts? Do both people agree on how to pursue the goals for professional development? Do they both agree on whether or how to look at issues of personal choice? Does the mentor want to deal with personal parenting issues, career issues in terms of lifestyle, and/or family issues? How deeply does each party care about addressing university politics and developing political savvy? How much time and work are the mentor and mentee willing to commit to the experience and is there agreement on these commitments?

There are also some risks to mentoring for both the mentor and mentee. After all is said and done, the investment in time and effort may not bear fruit. A mentor may not be able to think beyond his or her own experience, gender or racial background. Either of the two parties may end up feeling used by the relationship. The mentee may end up being seen as lacking independent stature. For example, after 15 years of working together, all of the mentee's work may be ascribed to the mentor. The failure of the mentee may undermine the mentor's status in the organization. The mentor has made a very public commitment to the mentee. The mentee fails. It makes the mentor look as if he or she lacks in judgment. Or conversely the success of the mentee may threaten the mentor. Some people have been in mentoring relationships for 10 or 15 years. They have become colleagues, but suddenly the relationship ends badly.

The next myth is that mentor relationships are the same in all organizations. The organization or profession, in fact, can have considerable influence on a relationship. There are two key factors within an organization. What is the culture of an organization? Is it a rigid hierarchy or does it operate cross functionally? Are the jobs in the organization structured to enhance the possibility that mentoring can occur? Are junior and senior people encouraged to work together on projects? Is there a requirement for such collaboration? The physical layout of the organization is important in this regard. Are all the junior people in one area, and the senior people in another? In one organization I found a junior person who for 12 years had been in his lab two flights down from the department head. That person has never been, or perhaps never will be promoted.

In a field or discipline does the professional organization encourage newer members to work with the established members on committees? Do they encourage junior people to come to conferences, to speak at conferences, to meet each other? Are mentoring relationships encouraged in that way?

The second major organizational factor is the reward system. Does good mentoring produce pay raises, promotion, or tenure in the organization? Is bad mentoring penalized? Is mentoring even considered at the time of promotions?

For the first time this year Harvard has instituted the first annual good mentoring award, and has asked all its students and faculty to nominate faculty whom they consider to be good mentors. There has been an overwhelming response. For the first time people were able to do something positive that in this time of cost effectiveness is relatively inexpensive. It is a way of rewarding people for good mentoring.

The next myth is that people only mentor people who look like they do. But the question is also who is getting mentored and who is not. Most people are not being mentored in the classic sense. Mentoring has a Catch-22 quality about it. To be chosen as a mentee a person must already appear to be a rising star who can enhance the mentor's career. These rising stars are often not women and minorities. First, they are not the traditional people who are being mentored because they do not resemble the mentor during his or her youth. Women and minorities are very visible, so they are scrutinized more carefully. It is more risky for the mentor to take such a person under his or her wing. The mentees have to work harder than others to prove themselves to the mentor. They are stereotyped as representing the entire minority group of all women, so the one woman in the department represents the views of all women everywhere.

And there is the anticipation that it is going to be complex to deal with someone who is different. There are issues specific to women--stereotypical roles that get played out--father-daughter, knight and damsel. There are male solutions that may not fulfill female roles in parenting or family issues. There is a possibility that

increased intimacy can lead to some sexual tension. There is the intensive public scrutiny and suspicion. Others may see the relationship as based on sexual involvement rather than on competence.

There are issues specific to minorities and unique pressures of being a minority in a majority profession and a majority institution. And there is also the collusion in reproducing the stereotypic viewpoint that minorities should only be interested in minority-related concerns.

It is easier for mentors to mentor a person who reminds them of their youth. Forward mentoring and backward mentoring should be considered. Backward mentoring is mentoring people who look like you did 15 or 20 years ago, and mentoring in only the classic way. Forward mentoring is mentoring things that you value today in a colleague, and thinking about ways of mentoring that are not just classic mentoring. It can be thought of in terms of going to the same restaurant for 10 years. You go every Friday; you know it. There is one thing that you particularly like, you order it, and you know that every time you go there it will be excellent and you will enjoy it. Or, one time you go to the restaurant and to order something different to see if you like it. You may be surprised that it is even better than your old favorite.

What are the qualities that I as a mentor would want in a mentee. Some of them are intelligence, ambition, ability to perform the jobs that the mentor assigns, loyalty, and similar commitments and beliefs about the values of the work that you are doing in the organization.

The final myth says that an exceptional mentor can guarantee promotion or success. But in fact there are responsibilities that the mentee also brings to the relationship. The mentee, as well as having intelligence, needs to be motivated to follow through on activities. The mentee needs to have initiative. Famous faculty members are often approached by people who ask them to be mentors. It is very flattering, but also very overwhelming, particularly if a number of people are asking the same question. One such person I know gives each person a task, and however far the individual goes with the task defines whom he will select to mentor. The mentee must be willing to grow, must be willing to collaborate, and must be willing to put time into the relationship.

For the mentee there are some things to look for in a mentor. What is the mentor's past experience with mentoring? And has it been successful? Is this person a known advocate for others? If the person is very famous, but does not mentor people, there is no point in having that person as a mentor.

What is the potential mentor's standing in the organization? Does he or she have power or influence or standing in the field or discipline? Does he or she have a base of knowledge that the mentee needs to acquire? Again, it is important to know the mentor is at in his or her career. Finally, does the mentor have a broad collegial

network? There are probably at least 10 more roles a mentor can play, including sponsor, counselor, coach, boss, advisor, teacher, protector, advocate, and role model.

But can classical mentoring, as I have defined it, meet diversity needs with current changes in the health care and business environment. People are busier than ever. The ability of people to mentor in the classic sense is going to be more limited. And should someone looking for a mentor wait for this perfect mentor?

People tend to have two beliefs about mentoring, and it is an either/or situation. Mentoring can be either structured/facilitated or it can be done naturally. And the analogy for naturally is like falling in love. Two people see each other across the room, their eyes light up, music swells, and they know the chemistry is going. This is going to be the perfect love relationship, the perfect mentor/mentee relationship. It does not happen very often.

I would like to suggest that there are some alternatives. There are the individual initiatives and institutional initiatives. In individual initiatives I mean one-to-one relationships or new kinds of relationships. For example, peer relationships and the sharing of information among peers are important. Career strategizing is part of this sharing as well as understanding that two junior professionals or academics do have a limited amount of information. But they can provide each other with job-related feedback. There is also an organizational sponsor. This is somebody who can advocate for the mentee and recommend the right committees. The problem, of course, again is if the sponsor loses power or influence.

Peer relationships and organizational sponsors are one-to-one relationships that I urge people to be careful about because it can be risky to have one person meet all needs. In terms of relationships, I urge networking, limited or short-term mentor relationships, or multiple mentor relationships, where one person is not expected to meet all needs.

Among the variations and alternatives to classic mentoring that can be helpful are information meetings. At such meetings the junior people learn the rules of the organization, including tenure and promotion guidelines. That does not address the issue of the shadow organization, but if mentees can probably find an older established person who is willing to talk a little bit about the shadow organization.

Junior faculty should also be educated about the use of networks. You need to begin to educate your senior faculty about mentoring. Having mentored is not enough. They may have been mentoring two stars or not mentoring very well. Institutions need to select people who are very good at mentoring all kinds of people. A mentor-to-mentor support network should also be established. Informal mentoring is another option. Informal mentoring using alumni, retired professors or members of professional associations is also important.

Finally, formal mentoring programs. This is an idea that has generated a lot of excitement. A lot of people are thinking about it and starting them. There are a number of caveats to that. First, they are expensive and very labor intensive. Organizations have to decide if a formal mentoring program is suitable for them. Careful thinking is required. Safeguards need to be attached to the mentor-mentee matching process, and results should be measured and evaluated.

In conclusion, to increase diversity mentoring can be used now to retain and promote women and minorities who are already in the system. To increase diversity, mentoring can be used for future recruitment to attract and interest students from K-12 to the graduate level. There are organizational and professional imperatives. The patient population is changing. There needs to be more professionals who are intimately aware of the needs of the new people in the patient population, and the needs of this new workforce. In the end, each person in the workforce is looking for the same thing--opportunities for advancement. Affirmative Action is currently being deleted in the legislatures and the courts. The legal impetus for creating diversity may be changing. But so is the workforce. And mentoring a diverse workforce is mentoring toward a future that is already here.

INCORPORATING CULTURAL DISTINCTIONS IN HEALTH CARE DELIVERY AND EDUCATION

Arthur Kleinman

Why are we interested in culture and other forms of diversity? First, the population of the United States is changing rather rapidly, and it is the most diverse portion of our population that is changing most considerably. Second, the most recent era of American immigration is just about as impressive as the immigration story early in this century, which recast the entire notion of what our nation was about. We have not really begun to address the implications of this new period of immigration.

In addition, there are push factors which make it clear that we are going to see large numbers of people of other nationalities, ethnicities, and cultures enter the United States for years to come to increase our diversity. These people will come because of developments throughout the world. There are more than 100 political conflicts in the world today that are increasing the number of refugees; the figure is now 23 million worldwide. There are about 100 million internally-displaced people, that is people who do not leave the confines of their nation but are literally refugees within their nation. These people are traveling as immigrants to places throughout the world, and changing the nature of many societies that were never regarded as multicultural. Our society has dealt, at least passingly, with multiculturalism for many years.

Those are reasons why we take culture seriously. Culture also has potentially dangerous side effects and problems, including racialism and stereotyping. Stereotyping is a very big problem. It is such a big problem that one has to be constantly on the alert to avoid it, lest with the best of intentions we have the worst of results.

A few years ago in New York City a recent immigrant from the Peoples Republic of China discovered that his immigrant wife was having an adulterous affair. He returned from work and, with a meat cleaver, chopped her up into small pieces, disposing of the body parts around the city. He was eventually found and brought to trial. An eminent group of physicians, anthropologists, and other defenders of the cultural concept tried to explain to the court why in Chinese society his actions made perfectly good sense. The court pointed out the danger of the cultural defense, meaning that in an authoritarian patriarchal society this defense could be instated to obscure or to remove certain voices such as those of women, from the society. One wants to be very cautious in the way that culture is understood.

Today, we know more about culture, ethnicity, and nationality than in the past. We know, for example, that race makes no biological or scientific sense; we share as much in the way of genomic genetic endowment across the major racial

groups in the United States as within those groups. We are not closed breeding colonies. The original idea of race as we understood it biologically in the form that came to be most notoriously associated with Nazi medicine is simply unscientific. However, race is a very important element of social world, and descriptions of race in response to racial characteristics are a fundamental way that we work as a society.

We know that ethnicity in our society and in most societies around the world is not just about the identification with groups that link their origins at a certain point, usually mythically, and have strong interconnections around rituals, religion, and other shared identities. But ethnicity is a political category. Whether or not a person identifies with ethnicity on an application or government form may have a lot to do with the politics of a community or the political issues in a nation. For example, when the State of Maine had a major lawsuit about 15 years ago which would have resulted in 50 percent of the state being turned over to Native Americans, 75 percent of the people in Maine declared that they had American Indian ancestry. We do not have to look very far to understand the political dimensions of the issue.

Similarly, the very concept of culture is changing radically in our time. More than 50 percent of anthropologists are uneasy about the way that the concept of culture has been used. The use of the term culture has passed through three phases. There is a demographic phase in which we examine how different ethnic groups differ in rates of illness, in use of health services, and in both biological and psychological responses to treatment. That demographic utility is still significant, but there had been a deeper understanding of culture for about 20 or 25 years, which holds that people in different groups share understandings about the body, the person, interpersonal interactions, resources in the community, and illness, including the description of symptoms and where to go for care. While this is generally true, it tends to obscure the degree of intracultural diversity that exists. There are other forms of difference which somewhat limit cultural effects, and may in fact exert a greater effect than culture in any given setting. Therefore they should be examined with culture.

What are these factors? Class is one. The United States is the only society in the world in which it is not allowed to ask questions about class. Class in our society is so important it is that which cannot be spoken. We can speak about ethnicity, but it is very hard to speak about class. We know that class is a powerful dimension of our society. Indeed, the economists tell us that in the last decade, and particularly in the last five years, the gap between the lower and higher socio-economic classes has widened more than at any time in our history. The gap is greater in the United States than in any other developed society in the world.

There is gender, with its powerful effects. There are also age cohorts. Clearly we have seen a global shift in popular culture, in the major forms of communication and transportation, and the very nature of life in the decades since the 1930s.

At age 50, Michel de Montaigne, the great 16th Century French essayist who wrote in a very active century of change said that the age that he was born to was gone forever. Many people could say the same. The age in which we were born is gone forever. Since an age cohort carries with it many of the identifications of its early development, differences in the way culture is understood can emerge based solely on different age cohorts. For example, a recent study of television program preferences of adult African Americans showed that the groups only shared preferences for two programs out of 10. Adolescent African Americans and adolescent Caucasian Americans share a preference for nine out of 10 programs. And the two programs that were most interesting to Caucasian American adolescents were programs that were particularly aimed at African American adolescents. They focused on African American themes. The study demonstrates an extraordinary difference across age cohorts.

We are seeing a major shift in politics in our society. The liberal/conservative divide and the orientation to political values are significant differences that have emerged. Sexual orientation is increasingly recognized as a crucial dimension of experience that is related to medicine. Finally another factor that we do not usually think of as crucial to culture, but one that I have come to believe is the most important part of culture, is the culture of biomedicine and biomedical and health institutions. Health professionals are the bearers of culture as caregivers trained in medicine or the other professions.

Health care institutions are radically different. For a doctor or a nurse working in a veteran's hospital, the idea of service may have an entirely different meaning than for health professionals in an academic health center. The institutional structure can influence and create the practice of care, and therefore is a form of culture.

A respect for difference is the single most important element to take into account in dealing with culture. The issue really is what information and knowledge about cultural effects on health, illness, and health care are available that go beyond simple respect for alternative perspectives and alternative practices. The first thing that culture teaches is that the biomedical professional organizations--medicine, nursing, the allied health professions--occupy a relatively small portion of the health care system in our society and in all societies. This is very important to recognize. (See Figure 1). This is reflected in the health care debate in which most people have played a very small role. The single largest arena of health care for most people is not the hospital, not the clinic, and not the alternative practice of medicine. It is the family. The family setting of care is where 90 percent of illness episodes are identified and treated. Americans have symptoms on the average of 1 every 7 days. That is the average in national surveys. Very few of these episodes are ever seen by a health professional; most are normalized or taken care of in the context of the family setting.

It is important to recognize that both the professional and folk sectors are also complicated and when looked at from the cultural perspective, very different. For example the folk sector of care is an immense sector in our society that is used by one-third of Americans. There is evidence that as much money is spent on alternative practice as on the rest of professional health care.

What is folk healing? What is the alternative medical sector? It has a lot of traditional forms of care that might involve the religious system. It is very important, especially for severe illness and includes all kinds of traditional practices from herbalism through dietetics through various kinds of massage treatments.

This sector is part of health care, and this is what patients engage in and do not report to health professionals because they know that medicine and nursing and the allied health professionals generally regard such an alternative as inappropriate, less important, or maybe even dangerous.

But folk or alternative medicine can have an extraordinarily powerful effect on treatment. For chronic illness, the single most important management problem is compliance. We know that for most chronic illnesses noncompliance rates are greater than 50 percent. That is, most of the time patients do not comply. Hypertension is a very good example. Hypertension noncompliance rates are greater than 75 percent, meaning that this is the single issue in the care of hypertensive patients. Most of the time patients do not take their medicines, do not follow diets or do their exercises. Patients cannot or will not tell health professionals or health professionals do not ask.

The response is to ask, to open up this area, to examine this much broader sector of health care, and to realize that from a cultural perspective the locus of responsibility in care is not the professional, but the patient and family. They are making the decisions, no matter what health professionals think they are doing.

It is significant that this year for the first time, the Diagnostic and Statistical Manual of the American Psychiatric Association (APA) listed a cultural formulation that every psychiatrist, psychologist, and other mental health professional in the country should use with every patient they see. The APA believes that this can be transferred from psychiatry and psychology to the rest of health care virtually without change. The following are the elements of what a cultural formulation requires. It is based on a considerable amount of science. (See Figure 2).

The first thing is the cultural identity of the individual. What are a patient's ethnic and cultural identifications? What is the identity of the person, and how serious is the identity? How serious are the cultural and ethnic identifications?

Cultural explanations of an individual's illness are very important. Very few patients know medical terminology. Even the most sophisticated use it in a strange and unscientific way, because they are not trained in it. But they use local terms.

Those local terms are absolutely crucial for care. And that is where we see the culture of our society generally: the culture of common sense of American society as seen on the videos, as learned in school yards, as bantered back and forth in engagements. This is where local idioms, that is the words people use to talk about a sickness are crucial. Understanding how to discover local idioms or what key symptoms mean in different local settings for different groups is very important. It is easy to teach, and there is a huge knowledge base for it. And most health professionals do not have the slightest idea that there is such a knowledge base.

There are cultural factors related to the psychosocial environment and levels of functioning. This has a lot to do with what might be called the ethnographic setting of illness and the caregiver's need to take a kind of mini-ethnography, to ask how the family, workplace, local community institutions affect the illness and in turn are affected by the illness. Culture elements and the relationship between the individual and the clinician are obviously very serious, and range from communicating with the patient to learning how and when to use and work with an interpreter.

Health professionals are familiar with the key reason for understanding this area: It is called the "five-minute no." It occurs in a clinical interaction with a patient and an interpreter. The patient and the interpreter talk for five minutes. The interpreter turns to the health professional and says, "She says no." We know that something crucial has taken place in that five-minute interaction, including heated discussion or even arguments. Health professionals have to find out what occurred during the interaction. There is a systematic way of doing this. But there are many other more subtle dimensions of interactions with patients that relate to the fact that culture is not just about beliefs. It is about practices and habitage, including the way we hold the body, our gait, and our dress. It is about what are regarded as appropriate actions in patient interactions. It is about the nature of relationships and how they are regarded.

One of the most powerful influences is the notion of the relational self in a variety of groups in our society. For example, recent migrants from Southeast Asia as well as Chinese Americans who maintain a traditional orientation frequently identify the family, not the person, as the locus of responsibility for making crucial health care decisions about treatment, or life support systems at the end of life. The nature of the doctor/patient interaction changes because the doctor is not engaging with an individual, but with a family.

Cultural assessment for diagnosis and care includes going through a series of elements that affect both the diagnostic process and care and are listed in the DSM. All of this can be done in about 10 minutes, and can be effectively taught and learned to be carried out in a clinical interaction in about 10 minutes. The bad news is that in our managed care settings the follow-up interaction between doctor and patient takes 11 minutes. It is very unlikely that this kind of care is going to be easily applied in

those sort of settings. And how that will be negotiated and worked through is one of the chief issues for the future.

The disease process, the pathophysiology, the biology, and the crucial knowledge that health professionals possess are very different from the illness experience. The illness experience is the way people have learned to hold symptoms in themselves, to talk about them, and to feel them. We know that responses to pain vary systematically across ethnicities. The very way people sense a symptom, evaluate it, talk about it, and respond to it is deeply embedded in the cultural setting. How does a health professional get this knowledge? Where does it come from? I introduced the explanatory models technique about 20 years ago, a technique that is now used in many health care settings around the country. It is a simple technique involving about eight questions that ask people for their knowledge and understanding of their experience. Basically there are three questions, which are asked in a respectful manner and preceded by the statement, "It's important for me to understand what's wrong with you, and what you think is wrong in order to give better health care that is tailored to your needs." The questions are: what do you think is the problem? What do you most fear about this problem? What kind of treatment do you want? (See Table 1.)

I introduced the questions in order to make the doctor-patient relationship and the relationship with other caregivers more psychosocially sensitive, and more involved in the patient's life world. I have been astonished and somewhat depressed over the last few years. When I travel around the country as a visiting professor and have cases presented to me by doctors and nurses, I frequently discover that they will present a case as follows: Here is a man who is 54 years of age. He is a member of X ethnic group and has the following disease category. Here is the serum hemoglobin. Here are the electrolytes, and here is the explanatory model. The explanatory model is presented as if it were a "thing" or the same as the hemoglobin or the electrolytes. Nonsense. It is not a thing. It changes when you tell the story differently to different people. It is meant to be an entre into the patient's story.

The engagement with culture requires an engagement with stories--patient stories describing illnesses. A story can be broken down into four different kinds of meanings that I have written about in my book, *The Illness Narratives*, and in many other articles. I have noted that there is a systematic way to take those stories apart in such a way as to make them useful in clinical care. It is very simple and direct, and spans the spectrum from the way a metaphor or a key term like an idiom of distress is used, interpreted and related to help seeking, noncompliance, the way health professionals look at what is most at stake for people with a serious illness and how that becomes the central moral component in clinical practice.

This is meant to convey three things: (1) there is an enormous knowledge base on the cultural side; (2) some of it but by no means all has been distilled into clinically useful strategies; (3) the real problem lies in projecting that knowledge base

into our training programs. It is lodged there as a problem in two ways. First, we do not translate this knowledge very successfully in our training programs. And second, there are institutional obstacles within medicine, and I would argue within the rest of health care, that make it very hard to get this knowledge across, and to have it used.

That relates to the culture of our institutions and our professions, which have traditionally looked at patients as if they were homogenous, and looked at interventions as if they could be generalized across all patients with the same disease category. We have failed to see the heterogeneity and pluralism central to clinical care. There several reasons to take this information seriously. One is the simple fact that we live in a pluralistic, multicultural society in which these issues are the bread and butter of everyday clinical care. It is in the interests of health professionals to address these issues, because the more we get training in addressing them. the more effective we are in dealing with them. The better we are as health professionals, the more successful and cost effective our care.

I want to end on a moral issue. There is a moral core to clinical practice. It has very little to do with the high ethical abstractions that ethicists talk about. It is not about justice, not about equity, and not about beneficence. The moral core is the engagement of a human being with another human being. That moral core is based in the care provider stepping into the space of illness with its fear, threat, and sense of loss, and being able to moralize, engage, and deal with the other person. Increasingly institutional structures interfere with the ability to engage the other person. Culture is perhaps the most powerful wedge we have today to get at moral issues and to increase the capacity of health professionals to care for patients.

Table 1. Explanatory Models

1. What do you call your problem?
What name does it have?
2. What do you think has caused your problem?
3. Why do you think it started when it did?
4. What does your sickness do to you?
How does it work?
5. How severe is it?
Will it have a short or long course?
6. What do you fear most about your sickness?
7. What are the chief problems your sickness has
caused for you?
8. What kind of treatment do you think you should receive?
What are the most important results you hope to receive from the
treatment?

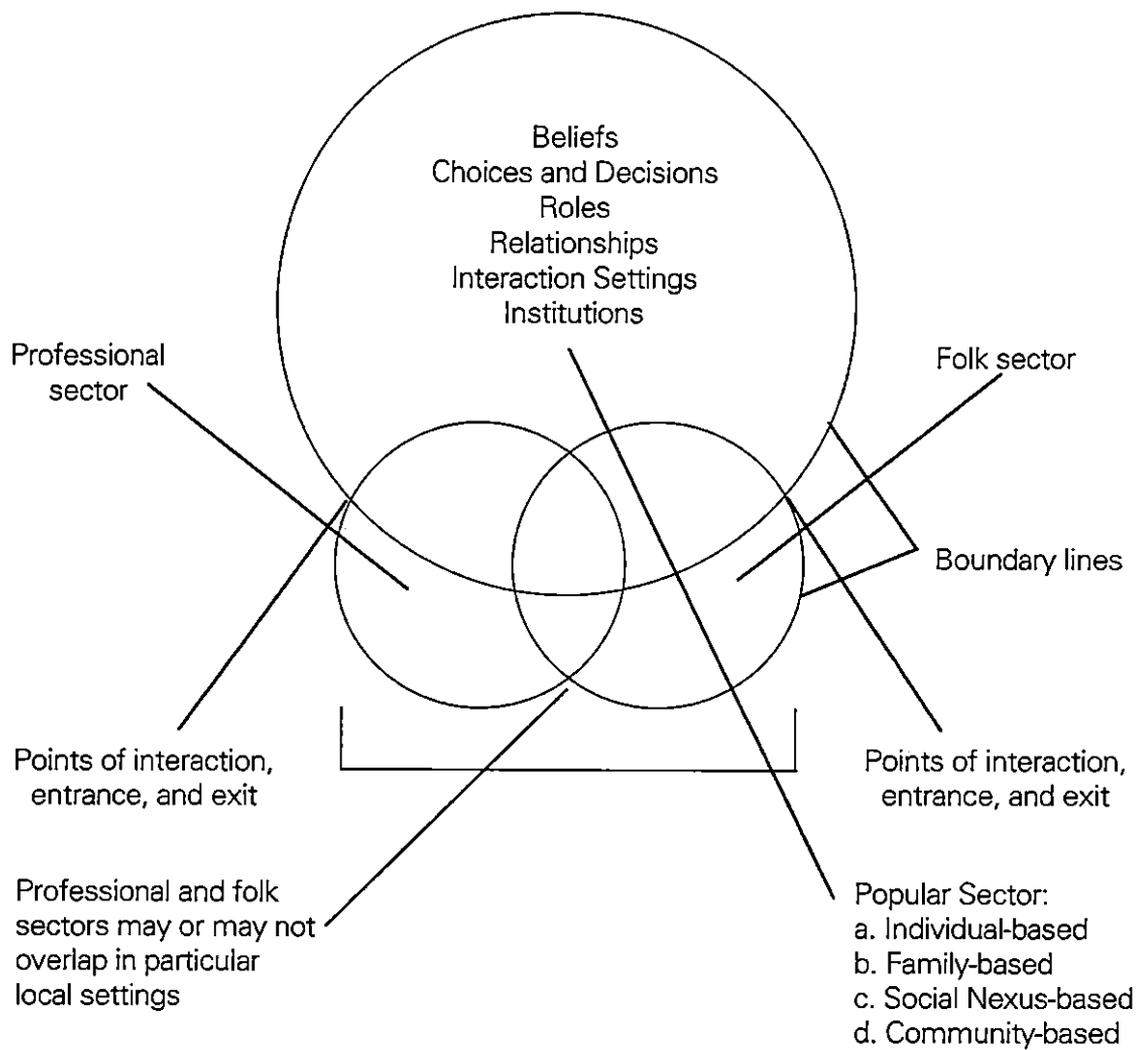


Figure 1. Local Health Care System: Internal Structure

The following outline for cultural formulation is meant to supplement the multiaxial diagnostic assessment and to address difficulties that may be encountered in applying DSM-IV criteria in a multicultural environment. The cultural formulation provides a systematic review of the individual's cultural background, the role of the cultural context in the expression and evaluation of symptoms and dysfunction, and the effect that cultural differences may have on the relationship between the individual and the clinician.

As indicated in the introduction to the manual (see p. xxiv), it is important that the clinician take into account the individual's ethnic and cultural context in the evaluation of each of the DSM-IV axes. In addition, the cultural formulation suggested below provides an opportunity to describe systematically the individual's cultural and social reference group and ways in which the cultural context is relevant to clinical care. The clinician may provide a narrative summary for each of the following categories:

Cultural identity of the individual. Note the individual's ethnic or cultural reference groups. For immigrants and ethnic minorities, note separately the degree of involvement with both the culture of origin and the host culture (where applicable). Also note language abilities, use, and preference (including multilingualism).

Cultural explanations of the individual's illness. The following may be identified: the predominant idioms of distress through which symptoms or the need for social support are communicated (e.g., "nerves," possessing spirits, somatic complaints, inexplicable misfortune), the meaning and perceived severity of the individual's symptoms in relation to norms of the cultural reference group, any local illness category used by the individual's family and community to identify the condition (see "Glossary of Culture-Bound Syndromes" below), the perceived causes or explanatory models that the individual and the reference group use to explain the illness, and current preferences for and past experiences with professional and population sources of care.

Cultural factors related to psychosocial environment and levels of functioning. Note culturally relevant interpretations of social stressors, available social supports, and levels of functioning and disability. This would include stresses in the local social environment and the role of religion and kin networks in providing emotional, instrumental, and informational support.

Cultural elements of the relationship between the individual and the clinician. Indicate differences in culture and social status between the individual and the clinician and problems that these differences may cause in diagnosis and treatment (e.g., difficulty in communicating in the individual's first language, in eliciting symptoms or understanding their cultural significance, in negotiating an appropriate relationship or level of intimacy, in determining whether a behavior is normative or pathological).

Overall cultural assessment for diagnosis and care. The formulation concludes with a discussion of how cultural considerations specifically influence comprehensive diagnosis and care.

Figure 2. Outline For Cultural Formulation

Source: Diagnostic and Statistical Manual IV: American Psychiatric Association

CHANGING INSTITUTIONAL CULTURES: THE LEADER'S ROLE IN COMMUNITY OUTREACH

Thomas Chapman

Being a hospital administrator, particularly in a teaching hospital is very strange and often difficult in this changing health care environment. Clearly the health care environment is undergoing the most fundamental and irreversible change that has occurred in the health professions and the health care industry in the last 100 years. The impact of the change that occurred in medical education with the publication of the Flexner Report is probably similar. It is a fundamental and irreversible change that will occur as any natural, economic cycle.

As obvious as that fact is, it is important, because it will shape the future environment and will shape the nature and types of opportunities and challenges that everyone needs to face and deal with. People coming into the health professions, particularly minorities have to understand that a basic shift in power has occurred that has made our environment very different. Health care has changed from being an environment where accountability was very limited and resources were unlimited to an environment where resources are limited and accountability is high. These factors will determine, define, and shape the kinds of future opportunities that will be available.

The *Opening Doors Program* is a very important and interesting program based on ideas that were generated both at The Robert Wood Johnson Foundation and at the Henry J. Kaiser Foundation several years ago. As we moved into the era of health reform many thought the financial barriers to care in this country would be resolved. Many people were very optimistic that everyone would have a health security card and there would be equal access to health care in terms of financial coverage. The thinking in both the foundations and other health professions circles was that people should start thinking about social and cultural barriers, and other kinds of barriers that arise that impact whether or not people get care. Access had to be defined in a meaningful way. Access has to be viewed in terms of the experience with and the process of getting care and the outcomes that result from that process.

With that perspective, *Opening Doors* was developed. Generally, the foundations conceive programs and put out requests for proposals; they get a lot of responses but receive very little input from people. We decided to do it differently about two years ago. We decided to go on the road--to go across the country to different communities and sit and talk with people about what their understanding, definition, and experiences with regard to social and cultural barriers in health care.

We spent a lot of time in six communities, talking with individuals, civic groups, and people in community-based health organizations, and other organizations representing a broad spectrum of education, religious, and social interests. We also spent time in these

communities talking with people in the provider systems, with both large established and community-based health care institutions. We talked to individuals who were experienced in those communities in caring for people, and we benefited from their understanding of and experiences with regard to social and cultural barriers to care.

Constant factors emerged from these discussions across the country. The consumers would describe the difficulties, the hurdles, the obstacles, the inability to get care or to get appropriate, timely care, and a variety of other concerns. The providers would describe the most comprehensive, seamless, cost beneficial, effective health care delivery system in America. This paradox said something about how individuals perceive experiences with one another, how health professionals and health care institutions perceive the health care experience, and how the receivers of care are interpreting the experience.

After the road trip, we developed the request for proposal. On the first round, we had 900 applications for this program; we were completely overwhelmed. The Robert Wood Johnson Foundation informed us that it was the second highest response they had ever had to a request for proposal. On the second round of funding, which occurred about three months ago, we received about 750 responses. There is still a lot of interest in the program. Unfortunately we only had the capacity to fund 21 programs. But they are very interesting and very diverse, both in areas of research and demonstration projects.

The projects vary. A few are in collaboration with community-based organizations and others with major institutions and organizations. One of our major issues was to change cultures. We felt it was critical to expand and amplify the fact that institutions must begin to think about changing their environments and their cultures. It was disappointing during the first round to review so many applications that focused on doing something to improve and break through social and cultural barriers that were community-based but never addressed the social and cultural barriers that are institutionally-based, and very imbedded within the institution.

Some of the projects link community hospitals to community-based programs. The University of Indiana, for example, is working on ways to improve the introduction of cultural issues into the medical school. Case studies based on real experiences in community clinics in central Indianapolis are being developed. Other programs are focused in the Native American community and Hispanic community.

Certain themes repeatedly emerged during the early site visits. One was the barriers created by perceptions about caregivers in terms of male/female, patient/caregiver relationships. Other issues emerged in the area of reproductive health services and family planning. There are many sensitivities with respect to the role the family plays, and in particular the role the male in the family plays with regard to how these health services are organized and provided.

Another very important factor was public perceptions of institutions. There really is a cultural gap in the way health care is organized. We forget that health care institutions

have developed their own language and have particular environments that are not always clear or easily understood by the public. In the Cincinnati area we spoke to people from the impoverished coal mining areas of Kentucky. These people had to cross the river and go to the big city to receive care. We found many fears and concerns about seeking care in the city; many of the fears were based on myth as well as knowledge of the negative experiences other people had encountered. It was enlightening to hear this perspective and to realize that these beliefs about health care had been maintained over decades.

Finally, in talking to people in Miami and Southern California, we learned about differences in definitions and values with regard to medical care. We made the assumption that preventive care and primary care are important and good. We have assumed that everyone believes that fact. But not all people understand or accept primary care in the same way. Health professionals have to understand why these differences exist, acknowledge these differences and not criticize or penalize people if there is disagreement between providers and the community in terms of the values, cultures, mores and the interests and priorities that have developed over the years.

These experiences demonstrate how important it is for institutions to have some sense of community focus and community linkage. Institutions, whether academic health care providers or public institutions, cannot exist in isolation. One of the fundamental and basic challenges in the nonprofit world today is to fulfill the nonprofit mission and to link with the community. How does the institution's or organization's activity or product relate to the community?

I chose health care administration quite by accident. I began my career in education, then moved to special education, and then moved to health education. And I became frustrated, because I did not like how I saw things working. I did not like the way I saw institutions behaving. I wanted to have much more influence over how institutions behave, and how they set priorities and focus on basic objectives in the community. Along the way I have spent a lot of time learning about how communities and institutions work. Can there be energies that come together which complement each other? Yes. Can there be common objectives and purposes? I believe there can be.

I have been somewhat disappointed because I do not think we have made nearly as much progress in encouraging diversity within the health care environment as we should have made over the last couple of decades. I think the pressures upon health care institutions to make even more progress in community outreach will increase because of the rapid rate of change that our communities are undergoing. Institutional leaders must continually examine what their institutions stand for, their institutional missions and how leaders can shape a sense of greater community responsibility within their institutions. It is not only the right thing to do, but it is good for business. Institutions are not going to survive or necessarily succeed as businesses unless they begin to relate to their communities and their marketplaces in more effective ways. This is even more critical in today's health care environment. In the past health care providers were in an open environment; they operated as they wished and were reimbursed for their services.

Today reimbursement has changed. Cost containment has stopped the flow of funds from all sectors. Today's health care environment is unpredictable and complicated. And almost everything that is done is in the spotlight. Institutions are held accountable for the cost effectiveness of services; this is a relatively new concept for many academic health centers.

One of the keys for the future in terms of achieving a more diverse workforce is to look at the relationship that young professionals and young trainees must have over the long term and to build mentoring relationships. There has been an enormous amount of energy well spent in developing more opportunities and increasing the number of minorities in academic environments. We have not had an equal amount of emphasis and effort put into the whole area of mentoring. And I mean lifetime mentoring, not mentoring for two or three years or five years, but lifetime mentoring.

I have a lifetime mentor. I have worked with a number of young people over the last 15 years, and I hope to continue to work with them. And I think it is the mentoring element of nurturing and developing relationships that is so important and so critical to help move people through and help guide them through very difficult and complex decisionmaking about their careers, their professions, and their chosen fields. I would encourage everyone to think about mentoring and how resources can be used more effectively to do it better. The educational efforts have been good. They could improve, all of them, and become a lot better. I will continue to put my time to help in the educational arena and to particularly help institutions evolve in this changing world to ensure that they are relevant from a social and cultural point of view.

A FEMALE VIEW OF LEADERSHIP AND INSTITUTIONAL CULTURE

Charlene G. Stuart

I have a very different perspective as a female hospital administrator from Charleston, South Carolina. In spite of being a woman with a Southern drawl and blonde hair, I believe I have succeeded. In reflecting on my career, I realized how very different I am today than 27 years ago. And I realized how very different the women with whom I work and to whom I am a mentor are different from me.

I think about how old I am, because I am old enough to see the differences, and that is good. Age gives me credibility. And I am pleased with those experiences. I remember the 1970s. My colleague and I were asked by the executive director of the hospital to give a very important and prominent physician in South Carolina a tour of the hospital. My colleague was head of operations; I was head of finance. When the physician returned to his home and wrote a note to our executive director thanking us. He mentioned Mr. Smith, my colleague, and said, "Would you please also give your very competent secretary my thanks." This is an interesting insight into what it was like to hold a fairly important position as financial officer in a state university in the South. It was necessary to have a good sense of humor.

I then can reflect on the 1990s. My most recent experience was in Seattle at the Council of Teaching Hospitals meeting. My financial officer is a very competent male. He and I were in the lobby of one of the finest hotels in Seattle. When the proprietor of the jewelry store walked out and said, "Oh, don't you make a handsome looking couple. Are you out for a night on the town? My male colleague said, "She's my boss." The proprietor said, "Women are like that. Blondes are always bossy." I am not sure much has changed from the 1970s to the 1990s although I know that I have.

I do not think for a second that my gender has kept me from being very effective in my own organization. I believe the confidence I exude sometimes gets me in trouble, because women are not supposed to be as confident as I am. I sometimes have to compensate for that confidence because it can be a deterrent to accomplishing some goals. I am not going to try to be something that I am not. I have never been very successful at that, and at this late age it would be a shame for me to even try.

It is still very tough for women to succeed today in the workplace. As a hospital director I am very interested in a diverse workforce, because diversity is the key to pleasing the customer. My customer is a very different customer from the customer of 20 years ago. And if health care providers do not understand diversity, they cannot have a patient focus or a customer oriented type of health care delivery system. The two things that we are learning

these days is that cost is important and the customer can evaluate. We stress both factors with our management team.

Although health care tends to have a higher population of females than in some other fields, it is important to note where those people are to understand how best to operate in the health care environment. Of the 19,000 CEOs and general administrators in the nation's labor force, men account for 72 percent; 16 percent of these people are non-white. Women make up 28 percent, with 26 percent of those being non-white. Hospitals and hospital directors work a lot with physicians. Of the 586,000 physicians in the United States, men make up 79 percent; 14 percent of these are non-white. Women make up 21 percent, with 23 percent being non-white. Of course the opposite is true for registered nurses. Men make up 6 percent of the 1.8 million nurses. Seventeen percent of these males are non-white, 94 percent of registered nurses are women, with 15 percent of those being non-white.¹

Recently I reviewed *The Gender and Careers in Healthcare Management*, the findings of a national survey by the American College of Healthcare Executives, which was published in 1991. The survey was conducted in cooperation with the graduate program in hospital administration at the University of Iowa. The goal of that study was to compare the career attainments of female and male affiliates of the American College of Healthcare Executives. This sample group consisted of 1,108 affiliates of the college, roughly divided between females and males. Accordingly to the study, females are less likely to have achieved the CEO status.

Females are less likely to have general management or financial management responsibilities. I was different because I have an undergraduate degree in accounting, and I have a master's in business administration from the Citadel. Females who entered health care fields from 1971-1975 are significantly less satisfied with their pay, co-workers, and chances for promotion than males who began their careers during that same time period, according to the American College of Healthcare Executives. At the Medical University of South Carolina, we are pleased that we have a program that promotes health administration. To be supportive of that program, we take residents from the program and provide a lot of mentoring. We have seen over the past decade that 50 percent of those students who are now enrolling are women. This program is helping to change the potential for women to succeed in the future.

As a woman, I am expected and required to do things differently. I think that often translates into doing a little more. It takes a little more to be recognized, but fortunately in my environment that has not been extremely difficult. I have tried to do is work very hard to make sure that the objectives of my institution are met. I believe that I have always been held a little bit more accountable than some of my male colleagues. I have tried to understand that, accept that, and to use that as a motivator and not to dwell on the negative aspects of the situation. For instance, my institution has just completed a major change

management process in which during the past 12 months we have saved somewhere near \$25-40 million in cash expenditures. In other words, our cash expenditures in the hospital are that much less than they were the previous year.

When the institution started the process, there was a great deal of skepticism from external sources. There appeared to be a concerted effort on the part of the media to dwell on what a mean witch I was for having to lay off people, rather than the fact that in by downsizing we were actually preserving the jobs for our hospital employees and preserving the Charleston economy that has been adversely affected by the pull out of the Navy. I also believe that I feel a pressure every day to represent women. It is not enough that I am female, but I have to carry the banner. And I have never been good at carrying banners or burning my bra or demonstrating. I have always felt a little uncomfortable with that role, because I feel that I am an individual. It does not feel right to me that I have to represent an entire gender. It is important for all of us to be individuals.

I have looked forward to crises in my institution. I have many male mentors. I have learned that crises make great women. Crises are opportunities--opportunities that should be looked at with a positive attitude without dwelling on the stress that is related to them. It is important to keep the communication flowing. I think I am a good communicator, and enjoy communicating. I have tried to do take my female characteristics and use them to hone my managerial skills. I have to confess that I have adapted and adopted a lot of male characteristics. I think that is because I came along at a point when there were not a lot of women mentors.

What I found is that I very much emulated what I saw in the board room. I dressed in a very austere manner, so as not to call attention ever to anything that I wore; I was not very stylish. I am enjoying watching the women with whom I work now, who are very competent, and can dress in a stylish manner and feel comfortable with fashion. These are some of the things that may make some people think that I sold out. I think it was necessary at that time in order to have the credibility and to be appreciated in my institution.

The diversity of the hospital workforce is a priority issue for the management team at the hospital. We have incorporated that principle into the job requirements for members of the management team; it is a part of their evaluation also. Diversity issues are emphasized repeatedly throughout the hospital.

I did not walk into my CEO job. I started in my institution right out of college, which was an advantage in a Southern state university, because I was able to mature in my organization. People there are very comfortable with me. I am not a foreigner thrust upon them, and I think that has helped me in getting the job done. My work in Washington for the Health Care Financing Administration in the early 1980s also helped me grow. Growing professionally helped me to understand that I could make contributions, and improve the

work environment for the women with whom I worked when I went back to my institution. I have never been reticent about making my male colleagues, even my superiors, understand the importance of the environment and the need to take an interest in making women feel comfortable in that environment.

There is a different level of career aspirations for men and for women. The study by the American College of Healthcare Executives showed that more males aspired to be CEOs. I wonder if this is the result of childhood socialization, perhaps competing non-work interest, or a reaction to what people believe is the perceived discrimination. There are few women moving up the ranks of administration in hospitals. Women feel they are stuck in the lower and middle management rungs. I think there will be opportunities opening for them in the future, and I believe that we are gaining ground there. It is significant that we recognize that fact. During my career I sought opportunities to increase my value to the organization by looking for opportunities and by looking for more additional duties and responsibilities. And I think sometimes women and minorities have to go out and look for and seek out such opportunities. Opportunities are not just thrown our way.

The hospital is a wonderful place to see the competency of females. Females, in my opinion, generally have more nurturing and caring skills. It is gratifying to see women with these nurturing skills becoming managers in hospitals. It is important things to keep in mind that most women are the decision makers with regard to where the health care is purchased. Women hospital managers are able to relate to much of the decision making taking place there. Women are naturally intuitive.

I have some of the toughest, roughest chairmen who chew up hospital administrators and spit them out. They come into my office and frequently share their fears, feelings, and maybe even a few tears. That shows that women are breaking down some of these barriers. And I just cannot imagine that happening if I were male. I believe if women combine their inherently female characteristics with good business sense that there will be a logical progression that will make women very effective health care professionals.

We still have stereotypes. It still hurts when people think that I should settle for earning less money, because I have a husband who can take care of me: Many people do not understand that women work as hard as their male counterparts. Men have characteristically used the organizational chart or the formal power and authority structure much more than women in managerial positions. Women are learning to engage in transformational leadership. We are able to transform the objectives of the institution and to get individuals to relate to and buy into transformation. Communication has been and is a key element for women in leadership positions. Interactive leadership will work to the advantage of women as we interact with this changing environment. I believe that women encourage participation. They share power and information, they enhance an individual's self worth, and try to

develop and have a learning environment where they work. And I think that results in excitement about the work.

I am a person who embraces change. I like change. I move fast and I am very decisive. The male side of me is very well developed. I emulated my male mentors. So perhaps all of that is locked in my psyche. I find working in the hospital very fascinating, because I work with some of the most challenging personalities. And I like complex organizations. I know that I had to earn the respect of many people with whom I work, particularly the physicians. They have been very good to work with and for the most part I enjoy the support of my medical staff. I have paid my dues and I feel good about where I am in my career. Throughout my career I have been willing to take risks. It is very important for women and minorities to be willing to take risks because that characteristic differentiates them from others and makes it easier to move ahead of the pack.

I have dealt with child care issues and I know what it is like to have such responsibilities. Therefore, as an employer, I am very understanding of child care burdens. I understand that a woman or a man who has a child care problem is having difficulty. And so I am very accommodating in trying to work that out. My own experience made me want to defend the right of those mothers who do not wish to work outside of the home. And I think it is very important that we do not pigeon hole people and push people into careers or responsibilities that they do not want.

My career perhaps illuminates many of the problems and barriers for women and minorities in addition to highlighting the potential for success. As the health care industry continues to undergo change, women will continue to make a major contribution to that evolution and to the future.

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