CENTER FOR MIND-BODY MEDICINE
COMPREHENSIVE CANCER CARE 2001

CONCURRENT: Special Issues in Cancer Care for Minorities

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MODERATOR: LAUREN WOOD, M.D.

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P R O C E E D I N G S

DR. WOOD: Our first speaker is going to be DG Wilson-Davis, who is from New York City.

And she is going to be addressing issues of breast cancer survivorship, as well as programs, community-based programs, that she has developed specifically to address the issue of breast cancer within her local community, and communities of color. She is a native New Yorker who understands the issues of community health awareness. She was diagnosed with breast cancer in 1991, and she became one of the pioneers in breast cancer self-health awareness in Harlem and Washington Heights.

Ms. Wilson-Davis advocates comprehensive care and patient empowerment, and has focused her energies and dedicated herself to encouraging other women to discover their own spirit of survivorship. Ms. Wilson-Davis has significantly increased accessibility to services not readily available to Latino and African-American women.

And I think for all of us who are health care providers, issues of accessibility to traditional care or complementary and alternative therapies is a key issue for minority communities in the United States. Currently, Ms. Wilson-Davis is the community director of FORCE which is focused on rehabilitation and cancer education at the Harlem YMCA.

She is the recipient of the 2001 United Hospital Fund's Volunteer Achievement Award, is a board member of the Women at Risk Advisory Council at the New York Presbyterian Hospital, and has served as community representative on the Institutional Review Board at North General Hospital. Ms. Wilson-Davis also designed, with you in mind, a post-mastectomy center dedicated to providing quality and culturally sensitive services to breast cancer survivors.

She is also a member of the National Black Leadership Initiative on Cancer and has served as the former vice-president and co-founder of the Sisters Healthcare Coalition of Harlem. Thank you for joining us and agreeing to share your experiences with us, Ms. Wilson-Davis.

MS. WILSON-DAVIS: Thank you. It's my pleasure.

DR. WOOD: And welcome.

MS. WILSON-DAVIS: Thank you. And good afternoon to everyone. I am DG and usually I tell people DG stands for doing good, and I am. I'm a 10 year breast cancer survivor, and I'm a basic New Yorker, and I am an advocate for living and a warrior against breast cancer, period. That's just who I am. And my focus is on FORCE, which is Focus On Rehabilitation and Cancer Education.

I am an advocate in this battle against cancer and I work directly with the community. My form of communication basically started out as one-on-one. And the doctors kept calling me one-on-one, one-on-

one, which developed into a dozen, then to two dozen, and we decided to establish cancer support group services.

I had been connected with FORCE, and that's a young man named Jeff Berman who decided to bring an exercise, nutritional, stress management program to the community, because many people in the community did not have any knowledge about alternative cancer therapies. And basically, that's what we design and that's what we do. Our program is simple. It's directly to the public.

And it's about each one teaching one in the world of cancer survivorship. In our community, quite often, information is not readily available for a number of reasons. And the basic reason is just fear. People don't know where to turn. People don't know what to say. And they don't know how to communicate with their doctors.

What we decided to do is establish a patient navigation program where someone who is newly diagnosed with cancer is connected directly with a person to have them clearly have a friend, a breast health care friend, so they can have access to the proper ways of being treated within the medical facility. The FORCE program is a 13 week program. The first part of the program is yoga stress management and that lasts for 4 weeks. And then we have nutritional education and an exercise program.

At the Harlem YMCA they have a great facility where they have wonderful exercise equipment and also a swimming pool that's warm water. And we have an instructor there to give them direct -- to them give them direct physical therapy within the water. And this is really working out very well. And the warm water movement at the Harlem Y is really a great program.

The women come there excited and they shed fears. They don't worry about wearing their prosthesis in the water and we learn a whole new way of connecting with each other. When the women come to the program, a lot of them are very shy and very afraid to talk about their fears and concerns, because their most main idea that they really dwell on is death.

And within our program our energy is really going to life. And we designed that specifically for living purposes and the way that we do that is to have women connected with other women. We teach them all that they can handle anything that they need to handle once they have the proper tools.

So, we design a blueprint for proper tools for them to follow. And within that, we open up a one-to-one dialogue, basically with the social workers, the doctors, the nutritional counselors, and we have workshops geared just for that. We have a program that's based directly to the women and also their mates, whoever it is.

If it's the children in the family and they need additional information about how their parents are going to work through this cancer diagnosis, we have that, and we bring them into the workshop also. It's a place where it's -- cancer is directly a family affair, but we really open it up to community responsibility.

And within our community we have doctors who are really embracing new alternatives and new ways of going about sharing information, giving information, controlling information. So, for living with cancer, quite a few of the men and women in the community, they are learning a different direction. Their direction is about each one teach one.

And within that scope that's just what they do. They get information, they empower themselves with it, and then they share it on to another person. Their main focus is pulling another one in to expanding the program. The FORCE program basically works with 20 women at a time and is geared just for them.

This next session that we have, I have a man who has approached us to be a part of the FORCE program. And this is the first time we're really having a man come in with breast cancer. And the women were very receptive to bringing him in. But, his doctor wasn't receptive to bringing him in because he said he wasn't ready for physical exercise.

But, we did explain to him that it is more than just exercise. It's about nutritional counseling. It's about patient empowerment. And it's about stress management. Being stress-free for anybody, cancer or non-cancer, to be stress-free is a wonderful thing. Most of us don't even realize how we can become stress-free.

And in that program we have a dynamic instructor, yoga instructor, Asha -- and she's here -- Asha Gallagher, and she has developed a dynamic program to show the women in the program that it is something that everyone can attain. Within the scope of the Harlem Y -- is anyone from New York? Okay? Fine. So, you know about the Ys in New York City, and I'm sure nationally.

They have an ENCORE program which also focuses directly on education for cancer patients. This program at the Harlem YMCA has a wonderful program that goes beyond the cancer. It goes into belly dancing, rhythm and blues dancing, nutrition, yoga, karate, many different facets of the program.

And everyone takes advantage of that program. Our recruitment process is called Estelwess (phonetic), which is spirit of survivorship. And primarily, quite often, we hear the rumor that it is very difficult to get African-American women to come out to these different programs.

But, we have found that just to be the contrary. We have women waiting. I have a waiting list of people who are trying to join the program, wanting to be a part of the program. So, when we go out and retry to connect with the community, we go beyond the church.

We go directly into the schools, into the daycare centers, into whatever facilities that are major factors within the community. And we are working directly on a one-to-one basis and it's been wonderful. And the hospital has been able to collaborate with many other programs within the community to expand the forces of survivorship.

And the advocacy part of the program is that each of the women that comes in is taught to learn how to be part of the speaker's bureau, go out into the community, and share the information with other people.

So, if I have 20 women, and each one recruits at least one woman, I'm set for the next program. So, our program is just expanding two-fold. I mean, it's just amazing how things really happened there. The health and education for support group services is another dynamic factor to the FORCE program and the Harlem Y recruitment.

And that is because the education component part of it goes beyond the hospital and goes beyond "diagnosis" of cancer. Someone in the program had been told at one time before that they were only given a 2 year prognosis to live after they were diagnosed.

And in that, she became very, very angry, and decided to reach out and receive additional information. Because if you're giving a prognosis of living for 2 years, the doctor is limiting your medication. He's limiting your frame of thought, and everything in that capacity.

So, what we decided in an area like that is to become more knowledgeable, more focused, more determined on getting as much information as you can about that disease, and being able to work within that main frame, and, really, have a communication with your doctor. A lot of mis-communication is because there is no communication.

The doctor is not answering the patient and the patient is not asking the doctor. And a lot of things fall through the cracks when that happens. So, basically, within our program, we try to give an outline of certain questions, basic questions that you can ask your doctor and feel very comfortable with.

Our main frame now is in the community, because we're well-established there. We are trying to expand our services to men with prostate cancer. And so far, that list is also building up very quickly. We don't have the facility for it yet, but it's on our wish list and I'm sure it's going to come through for 2002. And we're really looking forward to running that program. As of right now, we have 11 men on the list. I only need 20.

And within that 20, we'll be able to really combine the forces and bring the men and women together. Because quite often they separate the support groups due to your illness. But, if you're diagnosed with cancer, be it male or female, there are many different issues that you can share together and learn from one another. And that's our main focus is really trying to learn, and share, and educate at the same time.

If anyone has any difficulty in reaching out to the African-American and Latino community, there are direct routes that you can go. If you need that information, I'll be happy to share it directly with you. Just ask me after the session. I will give you my phone number and the number directly to the FORCE program. And if you need a FORCE program directly in your community, we would be happy to bring it to you if you have the space, and also the participants.

And if you have any questions about this, please, don't hesitate to ask. All right? Do you have any questions now? Yes?

SPEAKER: Do you have an E-mail address?

MS. WILSON-DAVIS: Yes. DG dgwilsondavis@aol.com.

SPEAKER: There was another question over on the left hand side in the back.

MS. WILSON-DAVIS: Yes.

SPEAKER: How do you -- what kind of mission are you giving the navigators and how does that work in terms of peoples' work schedules?

MS. WILSON-DAVIS: Okay. The patient navigation program was designed by a doctor named Harold Freeman. And he is now the director of the Cancer Center over in North General Hospital. He designed a program through the Harlem Hospital and Bill Clinton when he was in office. And they have recruited patient navigators and have trained them directly through the red tape of the medical facility. Because quite often they have different color tapes.

We have red, blue, and yellow within the hospital frame. In order to get your patient -- sometimes being diagnosed with cancer is not your biggest problem. Sometimes having a place to lay your head may be your biggest problem. If you have chemo, and no place to lay your head, you now have a double problem. And quite often this happens.

So, it's a problem like this that is beyond the social worker's job. So, the patient navigation also works directly with resources, housing, financial assistance, and child development for -- if a mother, she has two young children, she has to bring them in to get her chemo therapy, she can no longer handle her children and get chemo at the same time.

So, they have an in-house area for the children to be while the mother is receiving the chemo. And then, if she has to go home and she needs her home attendant, they also try to establish that for her. So, it's a real full circle of service established within patient navigation.

SPEAKER: --------

MS. WILSON-DAVIS: Well, they feel like volunteers sometimes, because they are so underpaid, but they are staff. They are staff, definitely. Yes. Yes?

SPEAKER: How often in the 13 weeks do the women meet together?

MS. WILSON-DAVIS: Okay. For support group services they meet weekly; for nutritional counseling, weekly; and for exercise management, they can go everyday if they like to. Okay? But, they have design exercise once a week also.

SPEAKER: Is there a minimum time that they have to go for exercise, or is it just all optional?

MS. WILSON-DAVIS: It's really optional because it's based on their diagnosis and their illness and what they can do. And all of the patients must have medical clearance from their doctors indicating that they are physically fit to go through exercise. It's not a strenuous exercise program. There's no main aerobics or anything like that.

And at the end of the program, they have a graduation process. Our first graduation we had 20 women graduate, meaning that they went through the majority of the program. And they decided that for their exercise for their friends and family they wanted to do something called the Electric Slide, which is like one of the hottest dances right now in New York.

So, now they added something called the Cha-Cha Slide. So, they have the Cha-Cha Electric Slide. And it was wonderful. The family, the friends, the children came. And it was really amazing to see the children respond to it because they kept saying, "Oh, mommy's okay." Mommy's okay. Because quite often we don't really sit down and tell the truth to the children to let them know that mommy can be okay. Don't be afraid. Because children hear what adults hear.

Cancer sometimes is a death sentence. And this is really what their little minds stay on. But, we had a wonderful first graduation. Yes?

SPEAKER: Do you ever run across people with a religious objection to either yoga or meditation and anything like that? And if you do, how do you handle that?

MS. WILSON-DAVIS: Well, you know, in reality, I did the first time. And I just asked the woman to please come to the program. Just sit on the side and see if she had any problem in participating in that. And she did, and she didn't have any problem in doing it.

Because we also found too, in being diagnosed with cancer, you become very humble. Humble in a sense that you can't imagine sometimes.

And you really start to fully understand that I need to bring something else into my life in order to give me some type of peace of mind, in order for me to understand what type of direction I need to go into in order to get this type of healing factor. So, I haven't had that as a problem yet. Yes.

DR. WOOD: I have a couple of additional questions.

MS. WILSON-DAVIS: Wonderful.

DR. WOOD: One of the questions I have is, are participants charged? Or, do they have to pay a fee in order to access the program? I know you say you have a waiting list now --

MS. WILSON-DAVIS: Yes.

DR. WOOD: Because of the popularity. And I guess that ties into the next question. And that is the constraints on funding, since it clearly seems it's been well-received within the community. There is a desire to have it expand to a different population, the male population with prostate cancer. And what are the constraints in terms of allowing that expansion to occur and to fulfill the need?

MS. WILSON-DAVIS: Okay. Funding is always a problem, no matter what program you are in. But, for our program, there is no charge. So, funding is always a major focus for us. But, there is no charge for this program. We accept all donations. You can contact us any way you like but we have no charge for the program.

DR. WOOD: Okay.

MS. WILSON-DAVIS: Okay? And also for the upcoming male program, we're also going to have that free of charge too. Yes.

DR. WOOD: All right. Another question -- I'm sorry. Were there other questions from the audience too? One of the second questions I had was, one of the principles -- and it seems like the very success of your group is each one, teach one.

MS. WILSON-DAVIS: Yes.

DR. WOOD: And you bring others in. But, that also recalls to mind the old game of telephone and how one person can say one thing and you -- as each one tells that, there is a version and a spin. And sometimes what comes out on the other end is very different from what went in. And how do you kind of insure a certain level of uniformity so that the same message gets across consistently that you want to reinforce in terms of the program?

MS. WILSON-DAVIS: Okay. That's a very good question. All right. When we run the support group program our main focus is letting everyone know that we are not physicians. Did you hear that? We are not physicians. Okay? We only give educational information, nutritional information. What we tell everybody -- whatever happens within that room, at that round table, stays at that round table. All right?

The women have developed such a telephone network support system, we cannot control what they say over the phone. Okay? But we can control what happens at that table and the information that we give out. We make sure that the information is clear, it's exact, and that they understand that before they leave the table.

If they have any questions, usually feedback comes back later within a week or two, in that somebody didn't understand something, and they're not comfortable bringing it to the table. Usually that sometimes comes up about their sexuality in dealing with their illness or something like that, and we may have a separate workshop on that issue later. Yes?

SPEAKER: After the 13 weeks, is there any kind of follow-up or aftercare? To have that intense good support, and then not have anything is hard.

MS. WILSON-DAVIS: Yes, what has happened with the Y -- they really were so excited about the program since it was such a major success, they decided to give the participants of the program a 50

percent discount on joining their facility. So, I've had at least 60 percent of the membership join the Y in order to continue their exercise program. And now we've developed a speaker's bureau for them to go out when it's necessary, and talk to other women who need that type of help.

SPEAKER: This isn't a question. I just wanted to point out that DG is incredibly accessible to everyone who participates throughout. So, that's partly the follow-up. It's partly what moderates the ones who want, is DG's own example, and her direct contact, consistently.

MS. WILSON-DAVIS: And then my contact has really forged over to other people being contacted. Because we always have to remember that we are survivors and a reoccurrence could happen. Someone can become ill again. So, we try not to directly focus on one person. Because if that happens, and something happens, and you're the person, then everybody becomes devastated all over again.

And they are realistic in understanding that they are fighting a disease. They have all been drafted into this battle of cancer and that we are all soldiers. And sometimes within a battle you lose soldiers. So, we do have a focus of everybody understanding on this issue of cancer. Okay, now. You had something?

DR. WOOD: There is a question in the front.

SPEAKER: Talking more and more about women with breast cancer and men with prostate cancer. And during this conference it's really beginning to hit home.

And I'm very, you know, somewhat skeptical as someone -- you know, being a woman, I spend a lot of time unpacking stereotypes, and removing labels, and you know, I'm beginning to recognize that at the very minimum we should be alert to this, and think about what that means and insure that we're not participating in removing the -- you know, as opportunity presents itself in an area, that we are adding to creating another way to segregate ourselves, women-men.

And I just wondered if you noticed that, if you had given any thought to that -- the gender language of cancer. You know, if you think about it, that's more like a thinking --

MS. WILSON-DAVIS: Yes.

SPEAKER: That just hit me.

MS. WILSON-DAVIS: And I'll think about it some more. I'll think about it some more.

SPEAKER: But, the other thing is in your work, I don't see anything specifically written about the spiritual component, the spirituality component. And I find, both again, as a Latino woman and someone who has been diagnosed with cancer, that -- I think that -- this is one of the most validating things that we can tap into in our own experiences and our knowledge.

And the spirituality component in racial minorities, American minorities, their experience, needs to be validated and brought out, especially --------. I'm just wondering if you in some way tap into that strength, and use it to empower that will to live.

MS. WILSON-DAVIS: Absolutely. I'll take your last part first. Absolutely. Spirituality is a major focus of the support group services, not just through FORCE, but in any of the support groups I've ever encountered. This last one that I have encountered -- when we're dealing with so many different types of women and religions, it's difficult to have a major component on what your spirituality is. Because

everyone believes in something different and they bring it to the table. But, within these workshops, all right? It is completely open.

We have what they call a prayer circle. And within that prayer circle, we will invite clergy directly from the community to establish a prayer circle for anyone that is in the group. Not just for them. But, for any of their family members who have fallen to this disease. We have women and men within the group who have brothers, and sisters, and mothers, and fathers, all within the same family, that will sit down at that one table to share prayer.

And quite often now, when you pick up a magazine or hear a program, you will see doctors validating spirituality and how good it is being able to connect. But, this is not just a thing within the community for an illness. This is a large part of the community. And being able to focus directly on it -- within the Latino community, you know, we have a lot of Catholic women coming in, and then we have Baptists, and then we some Muslims, and we have born-again Christians. Okay?

Within the survivorship, we all say we're born again because we're still here. All right? And when we focus on that, you can have "amen" in one corner, and "hallelujah" in another corner, and just people really giving praise to. Without the spirituality of it, I know for a fact, I wouldn't be here. Because I asked, I asked, please don't let me have any pain. Please let me live. Please let me be able to survive this. And everything I asked for, I received.

So, that's the only reason why I can stand here now and give testimony to being a survivor of cancer, because when you ask, you shall receive. All right? So, in asking, I also said, if you let me live and survive, I'll do whatever you want me to do. I didn't know it was going to be this. Okay?

But, I decided and I really felt that -- you know, sometimes hindsight is like way after the fact. And I find that, you know, when you're diagnosed with cancer, you always ask why, all right? But, now I really understand in order for me to do what I do I have to walk in those hills to understand when it's time to sit down, and talk to a woman.

And she says, well you don't understand. You don't know anything about cancer. And I say, yes, I do. Yes, I do. Stage 3A tumor, 7 centimeters, chemo -- aggressive, radiation -- aggressive, and loving aggressively. And that's how I made it. Okay? And that's the testimony that we give and we share.

And I think in just doing that, women connect with you right away. Not just women, men too. Men are amazing. They come over to me all the time and say, you know, I don't know what to say to her. I don't know what to do with her. I still find her beautiful, but she doesn't want to make love anymore. I still find him attractive, but he's scared to touch me. You know. So, these are the kind of things that we really have to focus in on. And that's the part of our spirituality also.

DR. WOOD: I believe there was another question in the audience? Was there? I had another question. And one of the things that I'm curious about is -- is that have you gotten any feedback from the healthcare providers of the women who participate in the program that they tolerate their treatments better, they are able to cope with the chemotherapy better, have less hospitalizations?

Have you gotten any feedback in that manner from the healthcare providers of the women who participate in the group?

MS. WILSON-DAVIS: That's a very good question. And I'm going to design a questionnaire just for that. And in reality, my program is so new, the answer is no. But, what I have received from the doctors is referrals and more referrals. So, that's a good thing.

DR. WOOD: That's good to hear.

MS. WILSON-DAVIS: Okay? So, that thing has really worked for us. But, as far as pulling the data together and seeing, how they are really faring? Not yet. Okay? We're just in our original --

DR. WOOD: That's a randomized study then.

MS. WILSON-DAVIS: Yes.

DR. WOOD: In terms of outcomes. Are there any questions for DG? Okay?

MS. WILSON-DAVIS: Yes.

SPEAKER: Back to that patient navigation program. You had mentioned that they were staff. What is the possibility or viability of having that be a volunteer program?

MS. WILSON-DAVIS: The viability of it is good. Now, going through the red tape is not. Okay? They do have -- like the American Cancer Society has a Reach to Recovery program. So, when a woman is diagnosed with breast cancer, she is automatically contacted within the hospital with a survivor. And they bring a little kit with a little fluff-puff, if they had a mastectomy, and they have a bra, and a exercise ball, and a little rope to show them how to work it. But, what's happening now in the hospitals when you have these surgeries, you're in the hospital for 24 hours. You don't have enough time to connect with the American Cancer Society. So, in order to have the volunteers there, the money is not really there to establish the space in the hospital. One of the major problems within the hospitals quite often is space -- being able to have an area for people to run their programs or to do their programs. So, also, within New York, they are combining a lot of hospitals together. Like you have Sloan- Kettering who is -- Ralph Lauren donated $5 million to North General Hospital to establish a first cancer center in the Harlem Community. Of course, the community is ecstatic. But, the -- it's the red tape. It takes awhile to put these things into place. So, when that happens, there will be more volunteers being able to work on a one-to-one basis with that. And I keep focusing -- I keep saying breast. It will be more than breast. Of course, I say that because I'm a breast cancer survivor so that always comes out of me. I can't help it. But, there will be many different volunteer projects going on. But, we have to have the training. You know. They're really, really adamant about that training. Okay? Yes, ma'am.

SPEAKER: I'm not sure I know how to phrase this question. I work in -------- inner city institute. And our struggle -- and I don't know if you have any suggestions -- in my experience or our experience, is that the spiritual life of the African-American women is so focused on God, and their relationship with God, and the Bible, that we have difficulty introducing alternative or complementary forms of treatment. It seems to be a very constricted relationship and we're having trouble entering that.

MS. WILSON-DAVIS: I understand what you're saying because I also have met women who will say, I'm leaving it in God's hands. I'm leaving it in God's hands. And quite often, they do. But, I tell them, it's good place to leave it -- in God's hands -- but, at the same time, you need to take the information that we're giving you, all right? Because, he wants you -- as they say in the Bible, God helps those who help themselves.

So, I try to find scriptures that relate directly to them, so they can understand a little bit better. I also try to connect them with an older woman or a woman of their same age, who may be able to relate to them better sometimes. I find quite often what happens is when we have certain programs, where we're trying to recruit people, they bring in a lot of college students or people in their internship programs.

And they're very, very young. They're very knowledgeable. But, when they come into the community, people will tell you, you don't have a clue. You're still wet behind the ears. Young whippersnapper and all that kind of stuff. And they're really strongly, you know, offended, by someone who is this young telling them about their body. You know. Or, not having a clue as to what the you know, religious connotations.

You have, you know, with the New York community, I have a lot of African women who are not about touching their bodies. Much less the Latino community, which is not about touching their bodies. So, when we really approach them, we have to approach them from a culturally sensitive way, that they know that I'm not here trying to get in their business as they say. I'm here to really share some information that will help you.

And this is really how we really focus. We have to connect directly on a one-to-one basis with them, spiritually, emotionally, and sometimes even financially. Sometimes even financially. If they're coming in and they don't have car fare to get back home and they just got finished taking chemo, well then you make those arrangements.

You go the step further. And that goes beyond the social worker. Social workers have so much caseloads that they cannot really handle the work of new patients coming in with this disease. And basically, right now, they're bringing a lot of clergy into the hospitals. Okay? And when a woman is diagnosed, they try to have a woman who is a survivor and the clergy close at hand. Because they know exactly.

By now, you already know if you give somebody a diagnosis of having cancer, no matter what kind of cancer it is, they usually will become upset. But, if they have somebody there who is a survivor, not necessarily of that particular cancer, but a survivor of cancer, period, and someone that is clergy, it's a little easier. It doesn't stop the blow.

But, it's a little easier. And then we have a direction for them to go to get the information and/or the insurance. They don't have the insurance. And that happens quite often also. Okay? Because if you give someone a diagnosis and tell them that they have it, and they don't have the insurance, then you're cutting them off at the knees. So, you have to have a lot of things in place before you can really start that treatment process. Okay?

DR. WOOD: Are there any other questions for DG? One last one in the back?

MS. WILSON-DAVIS: Yes? Okay.

SPEAKER: If they don't have insurance, who do you do?

MS. WILSON-DAVIS: What do we do if they don't have insurance? They have emergency Medicaid. And basically any hospital, private or city, will have a social work department that will put that in place for you. And I know this for a fact because at that time I did not have insurance. I was that naive. I said I can't have cancer because I don't have insurance. It just couldn't even work. But, the doctor told me that was the last thing that I needed really to worry about. My focus was on healing and just to stay focused on that. And that kind of always like, stayed with me -- that this doctor was not really that concerned about my insurance. And I must say, and I said, well he must be a really good doctor if he doesn't really worry about where his money is coming from. I think I'll let him service me. Plus, too, his last name was Godfrey. So, I said, well "God" is in his name, and "free" is in his name. So, let me put that together. I said, let me put that together. Yes?

SPEAKER: --------

MS. WILSON-DAVIS: That's really been my hardest -- that's really been a hard row to tow. It really is because they're so afraid of being deported. My youngest client is 15 years old. 15 years old. And I think she may have had this illness for quite awhile. But, nobody would bring her in, until it became, really, at the latter stages. Okay? So, when her mother did bring her in, she brought her in under somebody else's Medicaid insurance. All right? And everything is computerized now, so you know what that means. Okay? But, the hospital really has a dynamic in-place factor where if you don't have that insurance, and you are an illegal alien they still have to treat you. Okay? They still have to treat you.

Now, your Medicaid may be denied later on. Okay? Within that treatment -- and they can really stop your treatment if your Medicaid is denied. But, you have to be referred over to someplace else. The bottom line is you can always get what you need. You just have to know in what direction to go. And you always have to find somebody else to ask -- somebody else to ask somebody else. And that's really what the problem is. They don't know where to turn. And if you don't speak English, you don't know what to say.

DR. WOOD: I think that's a wonderful segue into some of the issues that Dr. Heurta is going to address for us. And I want to thank you very much DG for your presentation.

MS. WILSON-DAVIS: You're very welcome.

DR. WOOD: Dr. Elmer Heurta is with us from the Washington Hospital Center. And he is going to be discussing his model of cancer information education programs, that he has developed for Hispanic communities, as a paradigm and a model that can be used and extrapolated to other ethnic minority communities. Dr. Huerta was born in Peru where he obtained his medical degree at the University of San Marcos in 1981. He was trained in internal medicine and medical oncology in Peru and then moved to the United States in 1987.

He subsequently completed a fellowship in oncology at Johns Hopkins University and then got his master's degree in public health there, as well. He completed a fellowship at my institution, the National Cancer Institute, in cancer prevention and control. He's currently the founder or director of the Cancer Preventorium at the Washington Cancer Institute in D.C. He is the president and founder of Prevención, Inc., a non-profit company dedicated to the production and dissemination of educational materials for the Latino community in the United States.

Dr. Huerta was appointed by President Clinton as a member of the National Cancer Advisory Board and is a member of the national board of directors of the American Cancer Society, the National Coalition for Cancer Survivorship, the Cancer Research Foundation of America, and the American Legacy Foundation. Dr. Huerta. Thank you.

DR. HUERTA: Thank you, Lauren. That's fine. Yes. Good afternoon. Buenos tardes, everyone. Thank you very much for coming to this session. And I would like to congratulate the organizers of this session for their success. These are hard times and as probably you are experiencing, many meetings, and many reunions are getting postponed. So, I think it is great that we are together, just to continue our routines. Because if there is something that these bad people want for us, it's for us to really go downhill, interrupting our routines. So, it's just great that we are all here. Keep working. What I'm going to be talking to you about is a model. It's a public health model. It's a public health model that uses media to promote behavior changes, that encourages people to think about health in different terms, and mainly encourages people to take action to go to see a doctor when they are healthy, before they get sick. That is the main thrust of this talk. As you heard, I am a medical oncologist. So, I used to give chemotherapy for almost 10 years of my life. And I started to get disenchanted with medical oncology. Not because of my patients at the time. They were most wonderful patients. But, because I realized that most of the cancers that were sent to me for treatment were either preventable or early detectable conditions, so that it was really heart breaking. Didn't you know that the checkup is necessary? Well, no. I didn't have any pain. Uh-huh. And did you -- do you know anything about health? And do you know that cancer can be prevented? Well, not really. Uh-huh. And have you seen the last soap opera on Channel 5?

Remember, I'm talking to Latino people. They say, yes, of course. Have you heard the last top 40 song on Radio Rhythmo? Yes, of course. So, that -- this type of conversation gave me an idea that all these people with advanced cancer were very knowledgeable in entertainment, on the light side of life, but they were not really knowledgeable in basic health education concepts. That was 1985. That was Peru.

So, I started to ask myself a couple of questions. And the answer to those questions is what you are going to see today. My first question was, given that all these people knew everything about soap opera, sports, and the entertainment, because of the media, would it be possible to sell health, using the media in the same way that they sell soap, cigarettes, alcohol, or cars? Would people buy it? That was one question. And the second question, seeing all those cases of advanced disease was, would it be possible to have some day a place, a facility, that only would have patients without disease? Healthy people interested in learning how to prevent cancer and desiring to have a cancer checkup so that we can pick up early cases, before they get advanced. So, that's what I started to question myself in 1985, 1987. So, when I moved to the U.S., the program developed, and I used media to do that. And this is what we are going to show you today. At the same time, that idea of having a place for healthy people evolved into this name, which is the Cancer Preventorium, which is a kind of new thing in how I see the fight against cancer should be in this new millennium. The focus of this presentation is the Hispanic, Latino population of the United States. This model can be easily applied, however, to other ethnic and racial groups. That's extremely important. So, when I'm talking about the barrier that I'm going to describe to you now, think on Native-Americans. Think on Asian-Americans. Think on African-Americans. Think on the Appalachian people in the Appalachians. Think about any under-served community -------- in the general population. Why not? These are fundamentally the barriers that were mentioned. Lack of information, for example. Lack of information -- the public is not aware of many, many things. I'm going to show you an example later on.

But, talking about Latinos, because they are linguistically isolated. 40 percent of Latinos in this country have been born outside of the United States, so Spanish is their primary language. When are they going to hear about Peter Jennings or the New York Times' Health Page or things like that? They are isolated. So, health information is very scarce for these people.

And we're talking here about 40 percent of 37 million people. So, we're talking about millions of people. We are not talking about 1 million, 2 million, no. There are 37 million according to the 2000 census data -- 37 million Latinos in the U.S. now. 40 percent -- almost half of them, were born outside of this country. They are linguistically isolated. Therefore, they are lacking health information.

They live in poverty. And when you live in poverty, as DG said -- by the way, wonderful program. I'm inspired. It's really wonderful, your program. When you live in poverty, and somebody tells you, listen you have to get a checkup. You have to stop smoking. You know why? Because you're going to die in 20 years, 30 years. And you say, what?

My God, I don't even know what I'm going to eat tomorrow, and you're telling me I'm going to get something 20 years from now? That's poverty. Because you are day by day. There is no -- the health insurance coverage for these communities, the Latino population, up to 40 percent of them have no health knowledge. And in areas, like my area here in Washington, D.C., up to 80 percent of people have no health insurance.

There are no programs which are culturally competent and ethnically sensitive for these people. They go once, nobody speaks Spanish. They don't want to go back at all. They call to one of those 800 numbers for one of those many organizations, and say, they call, they say, hi, how are you doing? Do you speak Spanish? Habla Espanol? No, sorry. Okay. Thank you. That's it. The hospital -- no bi-lingual signs. And they are in their communities.

So, what this causes is that people -- they don't want to go to the hospital. They kind of postpone their medical care. And they don't understand the medical system. They come from countries where the medical systems are very -- sometimes non-existent. Maybe one social security and one minister of health, and that's it.

And when they come here they are bombarded with sometimes Medicare A, B, and maybe K, CHIPS, FAMES (phonetic), all those programs that a lot of Americans, maybe, even they don't

understand. So, they don't understand. Or, they go to the hospital and they say, you have to go here to this office first and then you have to go to other office first. So, they get lost in the system, in the medical system, in the hospital.

So, those are barriers that prevent people from looking for early care or any care at all. This is an example of lack of information. This is very interesting this slide. This is the National Health Interview Study of 1992, published in 1997. This is not only for Latinos. This is whites, blacks, and Latinos, women, and men. They were asked the following question: Would you please tell me if you agree with the following?

Do you think the older you are, the higher your risk to develop cancer? Basic question, right? A lot of scientists, we all know, the older you are, the higher your risk. Right? Because cancer is in older people. This is usually bio-statistics. We know that. Women, white women, said for breast cancer, only 31 percent said yes, the older I am, the higher my risk.

Meaning that almost 70 percent, they don't know that simple fact. White women in the United States. If you go to Latinos and African-Americans, of course, yes. Because they are less informed. Go for colorectal cancer. Men the same thing. So, lack of information that the simple fact that the older you are the higher risk. Another example, this is fatalism.

Same survey: Whites, blacks, Latinos, women, and men. The question here was, would you please tell me that you agree with the following? If I find an early breast cancer in you, can I cure it? Can you be cured if I find a breast, colon, or cervix cancer on you, early? Among women, 81 percent of the white women said you can cure an early breast cancer. Meaning that almost 20 percent said, no, you cannot cure it.

Go for African-Americans and Latinos. 35 to 40 percent of them said, no, you cannot cure an early cancer. So, if they think that an early cancer cannot be cured, how are they going to go for screening. How can you convince them? Look for colorectal cancer. As you know, colorectal cancer, when found earlier is almost 100 percent curable. Okay? So, we're not talking like here 80 -- no.

Watch these numbers all across. Cervix: 100 percent curable. Watch 50, 40, 40. So, those are examples of this lack of information, lack of awareness of the American people regarding cancer. This triangulates to less screening for different groups. I'm going to do less fecal and occult blood for colorectal cancer. This is the worst thing, you know.

They say that the American people in regard to colorectal cancer are where they were 35 years ago in regard to breast cancer. Let me explain this. Nowadays, we are regarding colorectal cancer in the same stage of awareness, and et cetera, as the American people used to be 35 years ago, with regard to breast cancer. So, we do not talk about that. Screening? Very low. Mammograms are not optimal yet.

The consequence is that distant stage diagnosis or assignation is high for many different diseases. And there is this gap between whites and blacks for many of these diseases that we know. And of course, 5 year survival rates are different also for people. So, lack of information -- what it produces, is less screening. Less screening produces more advanced disease.

More advanced disease produces less survival. Well, that's what we see. So, we created a cancer preventorium based on the natural history of cancer. This is the natural history of cancer that you all know. This is a time when cancer hasn't started yet. It's called the pre-diagnosis, fighting cancer before it starts.

There is the time of diagnosis when we have to involve families and cancer prevention. There is the time of remission of this disease, sometimes a relapse, sometimes a terminal illness. And there are

some things we can do, all across this natural history. Usually cancer control programs in hospitals, big hospitals, they start here, with diagnosis, and they are all across here.

It's rare, the institution that focuses here in the time of pre-diagnosis, focusing their attention to the local community. We have created this cancer preventorium on this model, this public health model, using media. We have used the media following four principles, and this one here is probably the most important slide of this presentation.

I have used media, radio, television, Internet, newspaper, one-on-one presentations, using media consistently. What does it mean, "consistency" in the use of media? Consistency means to have a show every single day of the week, Monday through Friday. So, for example, we have radio shows that are every single day and they broadcast the show three times a day, 7:30, 12:30, 4:30, for 5 days.

We started this in 1989, so you can calculate how many times this show has been on the air, saturating the community with health messages. That means consistency, every single day. We are trying to imitate these very good friends of ours that are on the 11:00 o'clock or on the 6:00 news in your town --the weather guys and the sports guys.

Can you imagine your 11:00 news without sports? Everybody would say, what happened here? Right? When the anchor says, okay, now Joe, what's going on with sports? And the guy says, well, Redskins are losing 5-0, blah, blah, blah, blah. Every single day you have sports. Every single day you have weather.

My idea is that we have to have health education programs every day also. Number Two is that what is the point of talking only about cancer if people are interested maybe in high blood pressure, diabetes, and maybe heart attacks, maybe contraception, maybe whatever -- childhood diseases, maybe some spirituality. So, my shows, they touch on all those aspects.

We talk about cancer, AIDS, alternative medicine. I mean all sorts of topics are touched by the show. So, everyday, everything. Number Three, we use all the channels, media channels that are available for the community. So, we have radio, we have TV, we have Internet, and we write for newspapers, and we also go to church presentations, or these community events, just to give one-on-one talks.

So, and then Number Four, is that we have created trust in this community, trust by separating the business of medicine from the educational activities. All of our radio shows and television shows are not-for- profit, non-sponsored shows. We have no sponsors. We get some help from CDC, from NIH to develop our shows. And sometimes they are recognized. But, if they don't want to do it, we don't want to do it.

We get some help from the pharmaceutical industry, but we never let them present our show. What is the result? That when the community listens to these messages, they trust in what we are saying because they know that we are not trying to sell them any product. So, this is very important. Every day, every topic, all channels, with trust.

And why do I use media? Well, we are now, I think, all of us victims of media in some way with this anthrax scare. We are 285 million Americans. 285 million, that's a lot of people. 285 million. There are 4 cases of --6 cases of anthrax, 6. 40 some people infected. But, we think that anthrax is going to come under the door, or wherever. Media, media, media. Well, you know why?

Because of this: Media sets the agenda. They set the agenda. When they want to talk about this every single day, every single hour, this is all what we are going to hear.

Number Two, media legitimizes the issue. Where did you hear it? CNN. Oh my God, CNN it's true. Even though later on they say, oh we apologize, the report we gave you wasn't really accurate, whatever. No. But, when you listen, it was on CNN. It's legit.

Number Three, of course, it changes behavior. And this is what we want from health. That's what we want: Changing behavior. So, we are now having ample examples of these behavioral changes in the United States these days. People buying Cipro. People stocking up on masks, et cetera -- behavioral change. Because they set the agenda. Legitimization changed the behavior.

So, I want to use these same principles of media for health. I want the community to be saturated. I want the community to be bombarded with health messages so that they can change attitudes, they can change behaviors, and they can see it different. That's how I'll use media. So, we have two types of radio shows.

One is an national and international show. This is Taking Care of Your Health. I'm going to show you later the map, but this is a show which is nationally syndicated. We have 86 radio stations across the country and we are reaching approximately 20 million people every day with this little health show. It's on radio, every day. This is a one minute radio show. This is for driving time. You're driving in the morning? Coming back into Virginia?

The show is on 84 radio stations across the country. One minute of health. This one, is a different radio show. So, we have two radio shows. This is called the Community Clinic of the Air, and this is local in Washington, D.C. What we do here -- and this is the only radio show that broadcasts from a health facility -- is that they built a radio studio for me in my office at the hospital.

So, it is so nice because I see patients until 12:30, 12:45. Then I go onto the Internet, prepare my show. At 1:00 p m. I connect digitally -- it's high tech equipment -- with the radio station. At 1:00 p.m. I'm reaching the community. Hi, I'm here everyday. We talk. It's a talk show. I answer questions from the public for one hour.

At 2:00 p.m., I say, I'll see you tomorrow. Thank you very much. And then at 2:30 is the next patient in the afternoon. So, this is a health show. And this show is a wonderful window to talk to the community. And this really allows me to explore the possibility of the spirituality, and just really elicit all this spirituality that we all have.

For example, I read poems for people in my medical show. I get these wonderful poems from Latin American authors. And then I start the show with some music which is from Latin America, and then I read a poem. So, people do call and they say, Dr. Huerta, thank you very much for putting that poem that I haven't heard for years.

That is food for my spirit. And this is the message I give to people. It is not only, this is a show -- I tell them. This is not a show that we are going to focus on your kidney, your bone, or your uterus. This is also going to give some food for your mental health. It is going to give you food for your spirit.

So, people, they really -- I use music, poetry, and all of this cultural stuff, to make people like a show and with the intention of saturating them with knowledge, and then going to behavioral change. It's a very, very nice show. I really enjoy a lot doing it every single day. When I travel, wherever I go, I go to Europe.

I go to Latin America. I just take my little box. It's a digital box. And technology is so great now. And I look for a place, of course. I plug it in and the show comes live from London. Live from Brussels. Live from Bolivia or Lima, Peru. So, the community -- and we have like 300,000 listeners here -- they just love the fact that he's a doctor. He is wherever he is.

But, he is communicating with them. So, it's very, very rewarding. We also have a television show. This is one hour every Saturday on a local television station here in Washington, D.C. And this year, hopefully -- we are in very serious conversations -- we. are going to be nationally syndicated in this television show.

We are going to be in the dish network and Direct TV nation-wide. This is also live. Same format. But, it's television. So, we have to show pictures and we have to have educational material. So, we have stomachs, --------. We have a lot of visual aids to do this television show. Extremely popular. We have Internet. This is also Prevención.org. As you know, Prevención is the Spanish word for prevention.

If you change this "c" for a "t" that's prevention. Prevención means prevention. And we have here -- all of our radio shows are there for listening to. And we are revamping this page. And so, we are going to give more information about our programs, et cetera. We also have another page. It's called graciasdoctor.com. Or, thank you,doctor.com. We are doing it with some friends. And it's a very, very nice Internet page. It's graciasdoctor.com. So, you see it's radio, it's television, it's Internet.

We write articles for the EFE news agency which are syndicated on different issues. So, as some of my friends say, there is no escape to your messages. And this is what I want. I want that. If they are in the car, they have something. If they are at home, they have something. If they are in a newspaper, there is something. There is saturation. It's like Phillip Morris. This is our network.

We have 80 something radio stations in the U.S. and Canada, Puerto Rico. We also have shows in El Salvador, shows in Peru, and in Ecuador. And this is a national network. And now, for example, for this anthrax scare year, someone leaked that I am also in epidemiology and public health.

So, I did probably 60 radio and television interviews in the last 2 weeks. All over place, just to peace out people, and just don't get scared about this thing. This is a scare thing. The impact of this effort: As I told you, this is voluntary, so I don't get paid for this. It's just kind of weekend stuff.

But, we have some things, like, for example, like the breast and cervical cancer early detection program in Maryland, increased the number of women going for mammograms and pap smears from this number to this number. And 55 percent of women in this program currently are from -- are Latinas. So, they are over-represented.

And this is because these people listen, they give their number, and they just go to get free pap smears and mammograms in Montgomery County. We did campaigns for Johns Hopkins when Johns Hopkins had the contract for the Cancer Information Service. In one week we generated 346 phone calls looking for Spanish material.

This is cancer clinical trials recruitment. It's very difficult to recruit women or men for clinical trials, especially if they are prevention. So, we asked people, please get -- and they got this number of people asking information, willing to participate. So, when we talked to these people and we said, why are you coming here?

They said, well, I understood, according to your shows, that this is the way science works. So, we would like to see if really we can be of any help. So, again, the saturation kind of dissipates a little bit that concept of guinea pigs or fears, et cetera. Same thing for NIH. We did a campaign for NIH. In one month we increased to 1200 phone calls, just asking for educational materials.

And finally the sanatorium idea. What is this? I went to the dictionary to look for this word, sanatorium. And I went to the American Heritage Dictionary, 2000. And I found out that sanatorium is an institution for the treatment of chronic diseases -- this is the dictionary word -- or for medically supervised

recuperation. So, these two words, "treatment" and "recuperation" are telling you about sick people, patients.

They go there to get treatment or to recuperate, or as a result -- for improvement, or for maintenance of health, especially for convalescence. Okay? You go there to convalesce. So, this is the sanatorium. You remember the sanatoriums, of course. Remember? For tuberculosis or mental health. This is a picture of the first sanatorium, tuberculosis sanatorium in the United States. It was called Little Red. It was in New York. It was 1884. What are these people sick with tuberculosis -- this is winter time.

They were outside breathing cold air because the belief was that cold air would heal their lungs. That was the way the sanatoriums -- there was a time in the 1930s where 650 plus sanatoriums existed in the United States. It was a network. It was a big business of the sanatoriums. This is how they used to live. This little room, you know. These little things to spit. 1884.

So, I went to the dictionary to look for the word, "preventorium." It doesn't exist. So, I'm just borrowing the term. And I'm proposing that the preventorium is an institution for the prevention and early detection of chronic diseases, or for medically supervised patient education. Frankly, the opposite. Or, a place for maintenance of health, especially for people without evident illness.

And this idea came about when I found this article. Because this is not new. At the beginning of the 20th Century, for example, healthy children were placed at preventories to protect them from their parents' tuberculosis infections. That's what they called it. So, I found this article published in June 1975 in Preventive Medicine.

Dr. Shimking (phonetic) wrote: "People of the future" -- he wrote in '75, 26 years ago. He said, "people of the future will visit preventories to undergo cancer screening tests, receive health education, and even engage in community activism." So, when I read this certainly -- because this is what I'm doing. This is what the clinic is about. And the clinic is this.

This is the place that we have at the Washington Hospital Center, the Cancer Institute of the Washington Hospital Center. We have our community outreach program. As I described it to you, this is heavily based on the media. Radio every day. Television every week. Internet, community events, et cetera. What I'm doing here, I'm going with the natural history of cancer.

I'm trying to reach healthy people in the community to tell them, listen, you have to take care of yourself. And I want you to come here to the preventorium where you can ask me more questions. And I can give you a full exam to detect early cancer. The preventorium. We have -- the lady, she just went to the South, she got married.

But, we had a wonderful navigator. She got every single patient, and she befriended them, and she would guide them through the medical system, the bureaucracy, the hospital, the mammography unit, the whole thing. And then, that's the navigation problem. And then we were getting women with -- diagnosed with cancer from the community. And they were asking us questions.

That's why we decided to start a breast cancer support group which was the first in this metro area. We founded these groups. Now, they are independent. They have 501 C-3 status, so they are independent. But, we have -- they get in my hospital -- they get together once a month. So, healthy people, be aware, come here for the checkup, we will help you to navigate the system. We will help you if you have cancer.

That is the motto that we have developed at the hospital. Our preventorium, our clinic, started operations in July of 1994 when I was hired in this hospital at the Cancer Institute. We have seen, up to last month, 9,260 people. All these number of people have gone to see us since that time. 9,200 people. Who are they? 20 percent are males and 80 percent are females. And this is very rewarding to me -- 85

percent of these people have no symptoms. They are there just because they want to learn how to prevent cancer.

They want to talk to me. They want to get a cancer checkup. Now, you think these people are rich people, people from the embassies, or the World Bank? Yes, some of them are. But, the vast majority -- I have data on this -- 90 percent of these patients, for example, are people who work in services. They clean houses. They do gardening. They are waiters in restaurants. So, they are really poor people, recently arrivals. 80 percent have less than high school education.

So, how can you think that all these people are coming healthy? 96 percent of these people are Latinos. 80 percent have no health insurance and, of course, I have to develop a network of local physicians, Latino friends of mine. They get my patients when I ask them, if necessary. I have developed good relationships with the county hospital.

And of course, my own hospital had a corporate decision to support this program. So, if I ever get a cancer that cannot be placed in the community, my hospital is willing take it. That's an excellent, excellent help that I really am very, very grateful for from the hospital. But, these people have no health insurance. And this is important. They have no health insurance, not because they cannot afford it.

This is important. A lot of these people, I would say the majority of them, they can afford to buy the health insurance. What happens is because 85 percent of the Latino in this metro area are recently arrivals, health insurance is a foreign concept for them. Because in Latin America, there is not such a thing as insurance for anything. Nobody has car insurance. Home insurance like we have here? No.

So, when they are young, 35, 33, working, you know, strong people, and the employer says, listen you have to pay $400 a month for health insurance. They say, what? I'm fine. So, they prefer to keep the money and not to buy the health insurance. So, that's one of the reasons. And the community, of course, reflects the community here in Washington, D.C.

This is a very different Latino community. Central and South Americans as opposed to the Southwest where there are Mexican-Americans primarily. Here are Central Americans and South Americans. Very different community. 90 percent of course, are my listeners and viewers. So, this is what I said. Saturate the community, but be careful not to mix your business. I do not announce, for example, the telephone number of my clinic every day.

If I do it twice a month, it's a lot. I only do it when people ask for it. Why? Because I don't want the community to perceive that I want to lure them to my place. That's extremely important. So, if someone wants to do this, please don't tell people that you're the best, and call your 1-800 number. No, no, no. Do it very subtle -- very, very. People, they are very smart.

And of course, they come from all over the metro area: Virginia, Washington, D.C., and Maryland. Women, they are a little bit younger. Men are a little bit older. And this is what we found so far. We have found 16 cases of cancer among almost 9,300 people. Of these, 13 cases are early cancers. Early breast, early cervix, early prostate. And these 3 were cases that we picked up during the exam: A mass in the ovary in a woman, another mass in the bladder of another woman, and a gentleman with larynx cancer.

But, all these cancers were placed, were treated, were early. So, when I showed these to some people, they say, wow, only 16 cancers and you examined 9,200 people. Is that cost-effective? That's what they asked. My answer is, well, imagine you are going to get a new house. And you're going to buy a house, they are building it for you.

And you say, well, I like this house. And the constructor or the builder says, well, how many members are in your family? I say, four. Okay. For four members, we can give you running water for

three days. And for four people, I can give you sewage for four days. If you want extra, you'll have to pay me more.

The point is that water, running water and sewage, are public health issues that are givens. Nobody discusses the cost effectiveness of having running water and sewage. But, there are some people that still discuss the cost effectiveness of prevention programs. HMOs -- they don't want to mess into this thing. Why?

Because these guys, they have to see a return for their investment, as they call it, in a very short period of time -- a maximum of 3 years. And when you do these kinds of things -- you are doing it to measure it at 15 or 20 years. So, when you are an HMO guy, and you have to give an account, and you say that you have spent a certain amount of money to screen people and do promotion of activities. They say, Oh my God, are you crazy?

How much percent of clients did you lose this year? 10 percent Where did they go? To the competition. So, you're screening for the competition, huh? Where's your business sense? But, the point is that it would be great if we somehow considered health promotion, disease prevention, all these activities, as a given, basic given for people, like water, running water and sewage.

In such a way, it doesn't matter if you are in an HMO, but they screen you very well, they give you these kind of activities. And if you move to another HMO it doesn't matter, because you've got already a healthy group. And the big move? Okay, fine. They are moving from one place to another, but all of them are kind of maintained in their health. We haven't gotten to that point yet.

So, this is the last slide. This is just for you to think when you have, for example, mass media. Here in this column are the CNNs, the CBSs, the NBCs. And this is the public health objectives of people who use media to promote health. They want to entertain or to inform. We want to educate. They want to cover certain events. We want to conduct long term campaigns.

They want to deliver salient pieces of information and try out little things here and there. We want to create understanding of complex information. They want to reflect the society. We would like to change it. They want to address personal concerns. We want to address the societal concerns. They want to make a profit on anything they do. We want to improve the public health. So, it was funny.

I was the other day at a round table with Rhonda Rowland from CNN and she really made fun of this profit. She didn't like the profit part. She is from CNN. Well, in summary -- oh sure. In summary, the two questions that I told you at the beginning of this talk that I asked myself in 1985. Would it be possible to sell health to the public, using media? Yes. I have proven it. We have many surveys and proved that people are buying health. They buy it. They are interested in buying it.

And Number Two, would it be possible to have a place for healthy people to go? That's the Cancer Preventorium. Our clientele, they are healthy people, going for cancer checkups. So, in the same way that in the 30's we had 650 plus sanatoriums, all over the U.S. -- like a museums of sick people. This is wild dream. But, would it be possible to have a network of preventories across the country? Like a MacDonald's?

You can go, get your checkup, get out from there, and have basic checkups. You can pick up hypertension, diabetes, cancer, AIDS. That's my dream. That maybe a network of preventories can be placed in many, many places. So, this is the last slide. And this is probably a little of self-critique for all of us. We are scientists.

This here -- this thing here is the ivory tower of science. Maybe it is NCI where I was trained. Maybe it is the American Cancer Society where I am a board member. Maybe this is the county hospital, whatever. The ivory tower of science. Maybe this one conference, this same conference. Who is here in

this tower? This guy. A scientist thinking a brilliant idea, talking to whom? Who else? Another scientist interchanging brilliant ideas. To do what? What do they do?

Well, they do the main objectives of the work -- reports. There is going to be a report on this conference, I bet. What else? Books. I'm not saying that this is no good. I'm just saying that this is the reality. Papers, of course. If you don't publish papers, you perish. But, this is the focus. The focus. What else? Guidelines. Don't we have guidelines for everything?

For every single thing we have guidelines. What we forget, all of us, is that sometimes we are isolated. We are above the crowd.

Isolated from this family, from this other family, this group of people who work, living in the cities, people who -- they don't understand this language. They don't know how to make these discoveries useful in their daily lives.

So, the challenge is, how can we put all of this stuff for these people, so they can really take advantage of our work? We think that one approach is the use of media, as I told you. Of course, that's not the only answer. But, I think that is a model that can be applied in other communities. So, I really thank you very much for your attention. If you have any questions, I would be very happy to answer them.

DR. WOOD: Since, I'm the moderator, I'm going to jump in with my question first. And we will allow everyone to ask Dr. Huerta questions. And thank you, very, very, much for that very informative presentation.

I think one of the critical issues -- being an investigator in the NCI, we do a very good job of understanding and in incredible basic discoveries about disease pathophysiology, and then coming up with large Phase III clinical trials and determining which diagnostic screening tests are the best.

But, then, we're not very good at successfully implementing them. And your entire presentation focuses directly on that. One of the things that I was interested in, was you have the saturation. But, one thing that struck me was the fact that out of the individuals who had visited your clinic, only 22 percent were male, and the remainder were female.

And so, one of the questions that I had is, what do you think that difference is due to? Do you think it's due to lack of exposure? Or, do you think that the males are hearing it, but they're still not coming in and seeking medical attention?

And then the second half of that question would be what would you specifically do to enhance the distribution so that you get more males coming into the preventorium system?

DR. HEURTA: Well, first of all, this is not unusual. This is not pointed on the Latino -- all men are like that. We all know that we think there is something in our brain that is not working well to see prevention, to see things right here. And I can maybe picture this, telling you the anecdote of the two types of men I see in my practice. It's so funny.

When I go into my room and there is a man there, a patient, there are two kinds of guys. There is the guy who sees me and I say, Hi, I'm Dr. Huerta. And the guys says Hi, Dr. Huerta. Comes das? How are you doing? Shaking my hands. How are you doing? I listen to your shows, da, da, da. I'm here to have my checkup. I'm kind of uneasy, but please do it. And whatever. Great.

The other guys -- I would say 30 percent of those-- is the guy who is not even looking at me when I get into the room. I say, Hi, I'm Dr. Huerta, what can I do for you? The guy barely shakes my hand and says, listen Dr. Huerta, would you please do what you have to do quick?

I'm losing my day's work here. I say, excuse me. Okay, fine. Besides that the woman outside, she doesn't really want to feed me, if I don't come here. You see. So, I think we need more work to really -- -- patients to a cancer prevention is very significant. Definitely, we need more. But I think we need to develop better programs that are differently shaped to them, and I think that's a wonderful area for research. What are the determinants that make these guys go there, and the difference between the guy who is looking at me, and the guy that is not.

SPEAKER: Are there other questions?

SPEAKER: --------

DR. HUERTA: It's very, very much so. There are some studies on this. The nurse, the female nurse in the Latino community has a special aura. They are kind of the good mom in contrast with the bad news that the doctor can say.

The doctor is a nice person, too. They're respected, or whatever. But they are afraid of going to see a doctor, because they may get something, whatever. And the nurse represents the hand that is going to kind of guard them.

It's very important. I wish you can search and you can find a female nurse.

SPEAKER: --------

DR. HUERTA: Um-hum. Yes. I think the female -- they should work with the doctor. In my little preventorium, we have -- we are only three people. It's the nurse assistant. She is Latina. The secretary. She is Latina also. And myself.

The three of us are bilingual, so we can see the clinic. It's terribly important. Yes?

SPEAKER: Go ahead.

SPEAKER: I love what you're doing. I'm just fascinated --------

DR. HUERTA: Thank you.

SPEAKER: A question, though. You said you spend a lot of your time getting -------- saturate them with information to get them to the point of diagnosis.

But what exactly is the information that you are giving them, though, that -------- them? I mean, certainly you want the early diagnosis -------- But are there viable methods --------

Are you bombarding them with that? And then at the point -------- diagnosing -------- do you continue giving them, providing them with information --------

DR. HUERTA: The first question. The focus of my work in the media is health promotion, disease prevention and early detection.

For example, I don't comment on the -------- or on the laser things unless I turn around and I ended up doing some kind of preventative advice.

So, when I do all these television and radio shows, all the material that I comment on, are articles from medical journals. -------- the JAMAs, the New Englands, the MMWRs, they are the Journal of the National Cancer Institute.

But I pick up themes that are of course peer review, all that stuff. But that they have some -- what is the word? -- they have some interest, not only interest, but are relevant for the Latino people. That's what I'm really looking for.

So, hemorrhoids. I do stories on hemorrhoids. -------- Listen, be careful. Not every single bleeding through the rectum is a hemorrhoid. It could be cancer.

So, the message there is don't wait, see your doctor, because you can catch up something very early before it gets bad, without control.

So, what I'm trying to say is that all the messages that I give, all the messages are graded to prevention, detection, health promotion. That's the bulk of my work.

SPEAKER: -------- a question here? In the back, and then I've got another question.

SPEAKER: I just wondered --------

DR. HUERTA: What kind of issues?

SPEAKER: Mental health.

DR. HUERTA: Yes. Wednesdays are a mental health day for my radio show. I have a psychologist, and she is there every Wednesday, and we talk about depression and mental health. That's extremely important.

And also, on the television show, I have frequently psychiatrists and mental health people. And we have a list of all these places where people can go. We refer them to community places -- that's important, an extremely important chunk of my work. Mental health. Yes.

SPEAKER: The other question that I specifically have, in terms of -- I think it's really an outstanding model, because I really do believe that, in addition to your work specifically, we already have very good evidence of how the media campaigns specifically can be used to effect behavior in a societal manner.

You know, it's why everyone fastens their seat belt, in addition to the law. I mean, when it first started, everyone got the saturation message, that you now have to fasten your seat belt.

But in terms of using this as a model and a paradigm to potentially adapt to other communities, which experience extreme disparities in health care, such as African-American communities, Native American communities, one of the major issues and concerns that I have is, is that one, there's problem with there being a lack of information out there.

But then there's a separate issue that is intensified within particular communities, and that is not believing the information that's out there, because of historical distrust of literally a well- documented history of not being able to trust the information that was put out there from medical journals, from the public health service, from scientific communities, and so forth.

And how do you overcome that barrier, when it's not just about lack of information, it's also about not trusting the information that's out there, and having good historical reason to do so?

DR. HUERTA: I think that's an issue of the messenger and the characteristics of the messenger. If the messenger is a person who relates to the community, is one of them -- is one of them -- looks like them, talks like them, and -- is a person who is not selling anything to the public, I think that's slowly but surely you will overcome those resistances.

I think that is what I think. For example, in certain communities -- Asian American communities, or Native American communities, he put a program that this is going to take 1, 2, 3, 4, years.

When I opened the preventorium in 1994, I had already 4 years on the air every day. So when I presented my plan to the hospital, some of the administrators, they were kind of um-hum. You want healthy people paying out of pocket? Who's going to come?

In 2 weeks in July, in August, in 2 weeks, we filled all the appointments until the end of the year, because the demand was so huge.

So, I think that is the thing -- that message that we need to kind of give a -------- to the messenger, of course, the messages need to have the consistency. But I think those barriers can be overcome.

SPEAKER: Another question in the back -------- Go ahead. You were first. The young woman in the front -- you can go ahead.

SPEAKER: Can you tell me what tests that you actually do -------- walks in, what type of things do you provide?

DR. HUERTA: Sure. Very good question. As you know, they calculated that 75 percent of cancers are either detectible or preventible. Lung cancer is 30 percent. There are diseases related to -------- 30 percent.

And then come the list of the cancers that you can see, you can touch. So, what we do is we have developed a questionnaire, which is kind of targeted towards cancer prevention. -------- on cancer areas that can be affected, family history, behavioral history.

So, long questionnaire. After that, the patient is completely disrobed for a complete medical exam, and they do a complete check-up. So, it's from -------- to -------- A complete physical exam. I teach every single woman how to do their breast examination with the plastic model. And this is amazing. I'm seeing more and more African-American women now, because we are now providers of the breast and cervical early detection program for Washington, D.C.

So I have now the opportunity to compare, for example, the attitudes of women when they touch that breast cancer model.

I wish I can show you a picture.

-------- women, they would touch the model, the breast cancer model, and they feel the lump, and they react.

But what I see, is that the reaction of some of my African-American patients, is like an electricity. They just take their hand out of the model. What is that?

Well, just to show you that they do the complete breast exam, teach -- -------- teach them -------- self-examination -------- we do the Pap smear, we do the pelvic, the rectal with some patients, the little -------- they can send from home.

So, that is the check-up. After the physical exam, we go to the office, and we discuss. I put together the questionnaire -------- the physical exam, and that's when we discuss the risks, the empirical risks.

There are some women with family history. I run the NCI breast risk assessment program, -------- model. So I kind of show them how does it work.

So, it's very -------- talking a lot of instructional. Forty percent of people come back next year. They come back.

SPEAKER: --------

DR. HUERTA: That's a good question, again. I think I'm very fortunate last year, that this hospital has allowed me to do that. Because I have at least 30 minutes for each patient.

So I see a maximum of 20 patients a day. And I see 20 patients, three times a week. So, like 60 patients a week -- it's, like, 240. Each one pays $84, which are Medicare rates.

And because they pay cash, and -------- kind of seeing with good eyes this program, because this is probably one of the very few cash revenues for this hospital. And at the end of the year, my dollar is $1, whereas my medical oncologist colleagues, they only -------- for the 2 cents out of each dollar they bill.

So, it kind of pays by itself. It's not a money-making program. I am not millionaire, the hospital is not going to be a millionaire with this program. But it pays by itself, and allows me to have time to talk to people. That's very important.

SPEAKER: The young woman, and then you. The young woman was first, and then you can go next.

SPEAKER: --------

DR. HUERTA: Yes. Well, this is a very closed community, the Latino community here in Washington, D.C., is kind of closed. They're, like, 800,000 now.

And because 85 percent are recent arrivals, they depend on certain media outlet, like the radio stations I work with, a couple of television stations.

So, because it's closed, the doctor is kind of also -- I'm a frequent participant in the soccer roundtable. So we talk about soccer. So they see the doctor also talking about soccer, doing this.

So, when I participate in this soccer show, for example, they have their soccer players and celebrities, and I take advantage of that, because they allow me to do. And they say, Do you smoke? Do you do that?

So, I take advantage of those moments just to talk to these celebrities about health. And that's what people listen to.

But I haven't done marketing campaigns of this program using celebrities. It's --------

SPEAKER: One last question, since we're a little bit over.

SPEAKER: --------

DR. HUERTA: Well, if you call a celebrity -- I don't know how to define it.

SPEAKER: -------- on that popular soap opera --------

DR. HUERTA: Well, there's a show called Don Francisco (phonetic). It goes to 185 million people all over the world. I've been there nine times. They elected me as -- well, the personality of the year for -------- in the state in the front of 40,000 people -------- restaurants. Here in this hotel, for example, they just recognized me. And the thing that really strikes me is that -------- no cigarettes. Yes, no cigarettes. -------- mammogram, huh? No mammogram. So, that is the kind of -- really, that makes me very, very happy. Exactly. It's a message for --------

And now, for this anthrax scare, as I told you, I've been doing interviews on radio and television for 60 places in Europe, all over Latin America, of course locally here, but also nationally.

And people listen to what I have to say.

DR. WOOD: Well, thank you very, very much to both of you, Dr. Huerta and DG for your excellent presentation.

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