COLORADO ADVISORY COMMITTEE

TO THE

U.S. COMMISSION ON CIVIL RIGHTS

Open Meeting

ACCESS OF MINORITIES AND WOMEN TO THE

MEDICAL AND LEGAL PROFESSIONS

THOSE PRESENT:

MS. GAY BEATTIE, Chairperson

COMMITTEE:

MS. MAGGIE ARO	MR. DON W. SEARS
MR. ROBERT L. FRYE	MS. LESLIE B. SPEED
MR. CASTELAR M. GARCIA	MR. MAX E.V. TORRES
MR. GARY JACKSON	MR. MINORU YASUI
MS. DONNA L. LUCERO	

STAFF:

DR. SHIRLEY HILL WITT, Regional Director

MR. WILLIAM LEVIS	MR. WILLIAM MULDROW

THE ABOVE ENTITLED hearing was held in Room 2330, Denver Federal Building, 1961 Stout Street, Denver, Colorado, on the 10th day of May, 1975, commencing at the hour of 8:30 a.m. on said day, and the following proceedings were had:

UNITED STATES COMMISSION ON CIVIL RIGHTS

MOUNTAIN STATES REGIONAL OFFICE
1726 Champa Street,
Ross Building, Suite 216
Denver, Colorado 80202
Telephone: (303) 837-2211

June 4, 1975

James E. Bouley
Bouley, Schlesinger, Profitt and DiCurti
187 North Church Avenue
Tucson, Arizona

Dear Jim:

Once again, thank you for a fantastic job. We have reviewed the May 10 transcript and find it to be excellent. Our office has made several minor corrections which should be noted for the record.

The fourth word on line 24, page 12, should be "professions." On line 16, page 18, the third word should be "except." On pages 24, 35, 46, 47, 48 and 87, the word "AMCAT" should be "MCAT." The third word on line seven, page 34, should be "organic." "AMCAP" should be "MCAP" on page 47, line eight. Dr. Prugh's first name on line one, page 112, should be "Dane." The acronym on page 118, line four, should be "WICHE." The fifth word on line seven, page 122, should be "obvious." It is my recollection that the percentage on line three, page 130, should be "6 to 7%."

In volume II, the next to last word on line three, page 158, should be "two." On line 13, same page, the second word should be "1967." The ninth word on line 18, page 159, should be "above." On page 162, line 12, the seventh word should be "has." The street on page 171, line 21, is "Yukon Court." The fourth word on line 16, page 175, is "admissions." The professor referred to on line 18, page 181, is "Alan Merson." On page 195, line eight, it should be "Krendl." The fourth word on line six, page 197, should be "women." The third word on line 19, page 198, should be changed to "past seven." On page 233, line seven, the eighth word should be "weakness." The street on line 22, page 243 is "Lipan." The eighth word, line nine, page 263 should be "students." On page 277, line 13, the fourth word should be "Defense." The fourth word on line one, page 303 is "torts." The last word, line 11, page 304, should be "Jarmel." On page 311, the fourth word, line 21, page 311, is "Holme." Line 18, page 315, is a question, not an answer. On line 19, page 326, and line 25, page 329, the name is "Reuler."

Again thanks for everthing. We hope to work with you soon.

Sincerely,

Bill

WILLIAM LEVIS
Regional Attorney

I N D E X

VOLUME I

PROCEEDINGS

THE CHAIR: Good morning. I think we may as well get started.

There are a few people still coming in from the hall, good morning and congratulationsto all of you that were able to get up this early on a Saturday morning.

This open meeting of the Colorado Advisory Committee to the U.S. Commission on Civil Rights will please come to order.

I am Gay Beattie, Chairman of the Advisory Committee.

Other members of the committee, and I'm not sure just who all is here yet from the committee, but let me introduce these who are here.

Bob Frye, standing in the door over there; Max Torres; Don Sears; Min Yasui, next to Don. Other members of our committee -- Cas Garcia, I'm sorry I missed you, Cas.

Any other members of the committee here at this time? They will be coming in later. I'm sure.

Other members of our advisory committee are Maggie Aro, Gary Jackson, Donna Lucero, Marie Mendoza, Rachel Noel, Ernestine Robles, Myron Rush, Leslie Speed.

Also with us today are Isaiah -- Tony Creswell, is he here yet?

You see what happens when you start anywhere near to

time? Very few people here. But they will be.

Also, Dr. Shirley Hill Witt, who is the Director of the Mountain States Regional Office. Way in the back. William Muldrow up here in the front in the plaid jacket. William Levis, Esther Johnson in the back, Norma Jones, is Norma here? Maria Pares, is Maria here? Yes, there's Maria.

Those are the staff members of our regional office.

This meeting is being held pursuant to rules applicable to the state advisory committees and other requirements promulgated by the U.S. Commission on Civil Rights.

The Commission on Civil Rights is an independent, bipartisan agency of the U.S. Government, established by Congress in 1967 and authorized by Civil Rights Acts to: First, investigate complaints alleging that citizens are being deprived of their right to vote by reason of their race, color, sex, religion or national origin. Two, to collect and study information concerning legal developments which constitute a denial of equal protection of the laws under the Constitution. Three, to appraise federal laws and policies with respect to denials of equal protectionof the laws. Four, to serve as a national clearing house for Civil Rights information. And five, to investigate allegations of vote fraud in federal elections.

The commission has constituted 51 state advisory committees like ours here in Colorado, to advise the commission of relevant information concerning matters within the jurisdiction of the commission. And matters of mutual concern in the preparation of reports of the commission to the President and the Congress.

The advisory committee also may receive reports, suggestions and recommendations from individuals and public and private organizations, and public officials upon matters pertinent to inquiries conducted by the state committees. And also attend as observers any open hearings or conferences which the commission may hold within the state.

The session today is an informal meeting and not, and let me emphasize this, is not an adversary proceeding or a court of law. Individuals have been invited to share with the committee information relating to access to the legal and medical professions by women and minorities in Colorado.

Each person who will participate has voluntarily agreed to meet with the committee. Every effort has been made to invite persons who are knowledgeable about the area to be dealt with here today.

I think you will see from the program that you have, our staff really has done a superb job in trying to bring a wide range of people with in-depth knowledge in this field.

In an effort to get a well-balanced picture of the problems faced by minorities and women regarding access to the legal and medical professions, we've invited panels of faculty, students and administrators from the University of Denver, College of Law, and the University of Colorado, Schools of Law and Medicine, as well as other interested individuals.

Since this is an open meeting, the press, radio and television stations as well as all individuals are welcome. However, no participant will be televised, filmed or photographed during the informal hearing, nor shall any of their statements be recorded for broadcasting, if he or she objects to that and so I might particularly ask those of you who are going to be on the panel if you object to being recorded or filmed by the media, please so indicate before you make your comments.

We're very concerned that we bring out all of the information relating to the matter under inquiry. We're also concerned, however, that no individual be the victim of slander or libelous statements. As a precaution against this happening, each person appearing as a panel has been interviewed prior to this meeting. However, in the unlikely event that such a situation would develop, it would be necessary for me to call this to the attention of the person making such a statement and request that he or she

desist. I would also like to add that if any persons here in the audience here today, have statements or information that they would like to share with the advisory committee, both the staff and committee members are available to talk with you after the morning and afternoon sessions.

In addition, any persons wishing to submit documents, that is anything in written form into the official record of this open meeting, may do so within a 30-day period to the regional office here in Denver.

And also, as I said, the staff really has done a superb job of bringing a wide range of individuals with knowledge in the specific areas in which we are inquiring now, but obviously with time constraints, you simply can't represent all points of view. If anyone here feels that they have information, experience, knowledge that is particularly relevant to the issues that we will be dealing with today, and if that is not reflected in what is being brought out, would you please just quietly slip over and contact one of the staff members or committee members that have been introduced to you and -- because of the particular federal statutes under which we are established, we have certain procedures we have to follow, so you would have to be interviewed, just very briefly, to establish the fact that what you wanted to say is relevant to what we're talking about today and within the constraints of our time

we'll make every effort to hear that point of view.

During the public meeting today, the advisory committee will examine the issues surrounding the crucial question of access by minority group persons and women to the medical and legal professions here in Colorado. We will explore the areas specifically of recruitment, admission and retention of minorities and women in medical and law schools, faculty hiring policies and practices, postgraduate medical programs, and the difficulties faced by minorities and women in passing the state bar examination.

As regards the bar examination, we will hear from an expert witness who will discuss the statistical validity of the test. In this area, we're proceeding with the cooperation of the Colorado Supreme Court.

This meeting will provide the basis for a written report by the advisory committee containing findings and recommendations about the issues raised today.

And I might add also that we will continue our study through the summer months and so the meeting today may help us focus on those areas in which we need to get more information.

As you see, we have a Court Reporter here, this fellow up in the front tapping away on his machine, to record the proceedings to assure that we will receive accurately all statements made by panel participants.

So, on behalf of the advisory committee, let me welcome you all today, and now, just for a few brief opening statements, we'd like to introduce some important people to you.

First, Harvey Deutsch, who is the chairperson of the Colorado Civil Rights Commission. Who is here representing Governor Lamm. Harvey?

HARVEY DEUTSCH

A. (By Mr. Deutsch) I can assure you that I do not intend to say anything either profound or slanderous this morning. So those of you who are still a bit drowsy need not worry that you'll miss anything.

When I received a call from the governor's office asking me to speak at 8:30 on Saturday morning, I concluded that for some unknown reason I had been placed on the governor's enemy list and that rather than audit my income tax he'd decided to ask me to speak early in the morning on a week end.

I do not, however, speak the -- the following remarks however, are not -- have not been cleared with the governor nor the Colorado Civil Rights Commission, nor my mother, they're solely my own for whatever significance or lack of

significance that they may have. Because the Colorado Civil Rights Commission has legislation before the general assembly, and because I was recently up for reconfirmation to the Civil Rights Commission, I have had occasion to discuss with the legislature and certain committees of the legislature, some matters of concern to me.

And I spoke with them last week about the emptiness of the promise of equal opportunity in housing under Colorado fair employment -- fair housing laws. When most housing in this state is beyond the reach of most of the people who reside in the state.

I heard some statistics yesterday that the average house is approaching, single family house, is approaching $40,000.00, and that a family needs an income of almost $20,000.00 to qualify, that puts housing out of the reach of maybe 70, 75% of Colorado citizens. And I spoke to them likewise about the emptiness of the promise of equal employment opportunity, under Colorado laws prohibiting discrimination in employment, in an economy where there are very few jobs open at this time.

We tell the young Black man, finish high school, learn a trade, go to college, it's rather meaningless when there are no jobs for journeymen, when they're sitting at the union halls looking for work, to talk about apprenticeships in skilled trades.

I think the analogy is valid with reference to opportunities to enter the professions for minorities, and women. If there are no seats available in medical schools, for more than 125 persons in any given year, there's a very limited opportunity for persons who have been traditionally denied access to medical school. I can't help but believe that in the State of Colorado there are 125 Black women and Chicano men and Anglo women and American Indians in each group that should somehow qualify for entry to medical school and entry into the medical profession.

I think what's going to be required of us is a commitment to expansion of certain of these facilities in order to accomodate the entry of a greater number of non-traditional groups into the professions.

It also seems to me that it's no solution to society's problem or to the problem confronting this group in its study, to be pitting a Black man against a White man or Black man against a White woman or, a White woman against a Spanish surnamed man and a Spanish surnamed man against the Native American woman in an effort to achieve some sort of, quote, proportional representation.

I think equal opportunity in education is meaningless if it inflicts an injustice upon an individual. I think the end of the road for proportional representation is a denial of the concept of individual merit and ultimately

a limitation on the opportunity rather than an expansion of opportunity.

It seems to me that it is not in society's best interest to force a confrontation between different persons of different races, sex, ethnic backgrounds. I'm well aware of the argument that, and it's an argument that has tremendous merit that as a result of past historical injustice, that must be corrected, we must statistically increase representation of minorities and women in institutions of higher education and in the professions.

But I think we have to balance that with an examination of the effect of certain policies on individuals. The corollary of that argument is when we speak to a minority person and we say look at the great strides that Black people or women have made in terms of representation and they say to us what the hell is the relevance of statistical data when I can't get a job, when I can't get into medical school, and when I'm in all respects qualified? I don't think we want to deprive individuals of opportunities because of their race, because of the color of their skin and therefore the only solution I see over the long haul to the problem, is two-fold. First the elimination of artificial barriers to admission to institutions of higher education, to the prefoessions, and an expansion of opportunities by increasing the enrollments in some of these

institutions if not most, if not all.

I'm an attorney in private practice, I'm not afraid that by increasing the enrollment in law school I'm going to be forced out of a job. I'm convinced that the more minorities that are admitted into the professions the more minority persons in the community that will receive, for the first time, the attention of these professions. The more people from rural areas that are admitted to medical school, the more people in rural areas that will receive medical treatment for the first time. I'm totally convinced that the more non-traditional groups we admit into the professions, the more non-traditional groups that will receive service by these professions, and it will result in an expansion of opportunities for all of us.

I've been listening to the governor and I've been listening to the joint budget committee tell us how in these difficult times, there is no money available for expansion of facilities, for new programs, for bilingual education, for many of those things that are very important.

If the money supply available to government is not increasing, I think we're going to have to examine our priorities and perhaps reorder those priorities.

I thank you for the opportunity to welcome you this morning on behalf of our governor, he and I look forward to

examining the product of the efforts of the state advisory commission.

Thank you.

THE CHAIR: Thank you very much, I'm glad I got up at 8:30 to hear those remarks, I thought they were very interesting.

I would like to introduce to you at this time, Maurice Mitchell, who is the Chancellor of the University of Denver and also is a former member of the U.S. Commission on Civil Rights.

Chancellor Mitchell?

MAURICE MITCHELL

A. (By Mr. Mitchell) Thank you.

Since some nights I never get to sleep, it doesn't make any difference what time it is.

It's a great pleasure for me to be here, and to participate as a citizen no longer associated with the Civil Rights Commission in the activities of one of the state advisory committees. Ive done that many times in the past, and just want to remind those who are here that it is the state advisory committees, the tentacles of the commission, if you will, in all of the 50 states, that enable the commis-

sion to expand its inquiries and to be sensitive to problems at the state and community level. And that seems to me to be singularly suitable in this particular kindof an investigation.

In all the time I spent at the Commission on Civil Rights, and in the time I've spent in work related to their interests since, the word poverty keeps cropping up. You find it at the root of everything. If a child is in a home where there isn't much money, a minor kidney or bladder infection often becomes a lifelong constraint on future success.

An individual can not be properly educated, an individual who has to live in parts of a community where neighborhood conditions are, well, inexcusable, these are people who suffer from the effects of poverty.

You can cure poverty if you can go to work. If you can get a job. The commission has always been interested, then, in how to strike a blow at poverty. And poverty is relative and poverty occurs at countless levels, one of them of course, one root of poverty, is in the opportunity to be properly educated.

If you can't afford to send a child to school, if you must ask a son or daughter to drop out to become a wage earner before they should, if there isn't support for professional education, if there is hostility at the gates

of professional education, then women, minority men and women, ethnic minority representatives, people who suffer from poverty, are never going to be able to have the same expectations as people who don't. Poverty, then, is a -- almost inseparable factor in civil rights.

Another consideration that one always sees is that it is the affected person, the ethnic minority person, frequently a woman, who -- for whom the remedies are made available but who are the least likely to be able to use the remedies.

In, any minority community suffers when there are remedies available because no one has the professional competency to show them how to use those remedies and when that kind of professional competence is demonstrated, it is often denounced, the storefront lawyer, the informal medical clinic, which doesn't sit behind the safe and secure marble front of the established hospital. Or the -- snappy office building with a pile of law firms laid one on top of the other and the law library in the basement. These are not available to minority people.

And so, getting them an opportunity to be professionally trained, to become people who can trace the problems of a minority society to the available remedies and do so professionally, and do so with the respect of their contemporaries, seems to me to be terribly significant.

Now, if I'm not mistaken, what this hearing is going to show today, what these discussions are going to show today, is reasonably predictable. I wish it weren't. I wish that since the day in 1968 when I joined the Civil Rights Commission and the years before then, one could have said that great progress has been made.

Well, I have no strong conviction that it has. And here's what I think you're likely to see. First, the federal bureaucracy itself, the federal agencies themselves unwilling to comply, by and large, with the laws of their own government, and serving as disgraceful models for outside organizations.

Now, one has only to walk through this building, one has only to look at the size of the compliance force, the number of people who are around to see whether the law is being enforced. And one has only to look at the practices of the federal agencies themselves, including many of those who are involved in today's discussions, to see that they are not in compliance.

This is the shame of the government and the Civil Rights Commissions are really the conscience of the government and one of their functions is to point to this inadequacy. Inadequate compliance, inadequate enforcement of federal civil rights organizations within the agencies themselves, you're talking about two major activities in

which vast amounts of federal funds are spent, medicine and law, and in which highly honored professional organizations exist and what you will see if you are perceptive, is that they are equipped with conversation and that their dialogue is highly sophisticated, and that the action represented by that dialogue and that conversation is abysmally inadequate.

The second thing you're going to see is that institutions of higher education are implicitly anti sex and anti ethnic minority. One of the shocks to me in my lifetime has been to discover that a university is a far more bigoted place than almost any other institution in society. And the fact that our universities show very little successful compliance with civil rights requirements, with affirmative action requirements, is evidence of that.

I do not accept my own. Although I think we have made some strides in some areas, we are far from where we should have been and we have consumed millions of dollars in federal funds while we have played our own little games, --we're always willing to hire a Ph.D. to teach in the law school except, of course, you can't find any Black Ph.D's. There just aren't any Hispano Ph.D's. We make do with White MA, male. And one finds this riddled through the surface of the system of higher education.

Not necessarily just higher education. But all

education, public and private in this country and you'll see this demonstrated here.

You will not see a high percentage of minority people in medicine or in law, you will find the greater professional societies in those areas relatively hostile, whether they are open and truthful about it or whether they are evasive about it.

Well, I could go on. All I'm really saying is that this hearing strikes at the heart of vital needs for women and people in the ethnic minority community. It is absurd to assume that those needs have been met. It is absurd to assume that there's vigorous enforcement of the law. It is ridiculous to assume that important progress has been made. It has not been made. We will not solve the problems of denial of equal opportunity in our society by making believe we're solving them or by reading the bottom lines of meaningless statistical studies.

We will solve them by identifying them, by making the deficiencies public and by identifying those who have accepted the responsibility to do something constructive about them. And that is what I hope you will be doing here today.

And I hope that everyone who sits on a panel will be asked the tough questions, and will be asked about future commitments, and that a record of those statements will be

kept and that there will be a return to them. It must be now eight years since the Federal Civil Rights Commission studied the federal agencies and tried to see how they complied with civil rights requirements.

They used four kinds of grades, to determine the effectiveness of a federal agency or its compliance. One was practically no compliance. Two was extremely poor compliance. Three was barely adequate compliance. And four was satisfactory compliance. In all the studies I have seen, no one has ever scored satisfactory. And the overwhelming majority of the federal agencies fall in the area of either relative noncompliance or minimum compliance.

I say that's a disgrace and our tolerance of that and our willingness to allow that to continue, our willingness to state that we have affirmative action programs in the knowledge that there are no compliance officers who pursue them anyhow, and to take federal funds as federal contractors, either in medical schools or law schools or in community industry, knowing that no one really ever comes around, and knowing that there's never been any real enforcement, our willingness to do this is a form of cynicism that I don't believe the American people will tolerate and that the professions can survive with.

In San Francisco today the doctors are on strike. They're on strike because they don't want to be sued or held

accountable in court for their errors. Now, that's not the kind of denial of medical service that holds much interest to a minority person who's sick, to a person who is stricken with poverty. And needs surgery.

Over and over again in the professions one sees these professional concerns that never touch the real concerns of people without means and people for whom civil rights acts are passed and affirmative action programs are developed. I hope you will improve that situation as a result of these meetings today and the events that follow.

THE CHAIR: Thank you very much, Chancellor Mitchell.

We are most grateful to Mr. Deutsch and Chancellor Mitchell for setting the stage so well for the meeting today. And I might ask now for those committee members who will be questioning the first panel to gather up here at the table and maybe we can get somebody to move this?

In order to provide a frame of reference for the morning's sessions, which will be on access to the medical schools and professions, one of our committee members, Donna Lucero, is going to present a brief overview of the access of women and minorities, statistical data that we have gathered to the medical schools and professions.

Donna?

DONNA LUCERO

A. (By Ms. Lucero) Thank you, Madame Chairperson, and members of the Colorado Advisory Council and our guests. The theme of this meeting is access of the medical and legal professions by minorities and women. This morning we will be exploring issues which concern the medical profession only, motivation in academic preparation opportunities, recruitment, admission and retention of those minorities in medical school and the problems they face in getting established in the profession once they've graduated. National statistics indicate that minorities and women are considerably under represented in the medical profession. Minorities make up 16.8% of our country's population, yet Black physicians make up only 2.2%, and physicians of Spanish origin are 3.2% of the total of physicians employed in the United States.

There are only 60 Native American physicians in the entire nation. As a whole, women across the nation comprise only 9% of the nation's physicians. Even though they make up over 50% of the population and 39% of our work force.

But positive things are taking place, the enrollment in medical schools has increased nationally from 3.6% in 1969, to 9.5% in 1974, you can see it's still really down

there. The proportion of women increased from 8.8% in that same period to 15.4%. Until 1970, our University of Coloardo School of Medicine had graduated only seven Blacks, 14 Mexican-Americans, and no Native Americans in its entire 87-year history. This year, however, the medical school enrolled 26 minority students. And that comprises 21% of the entering class.

The proportion of women in the entering class increased from 8% in 1966 to nearly 30% this year. However, many basic problems persist. The pools of qualified women and minority students who apply for admission to medical school needs to be increased. Less than a third as many women as men apply for admission here in Colorado this past year. National studies done of the elementary and secondary school levels show that many minority students are not provided with the educational opportunities required to get into law -- into medical school.

Incentive counselors, people, others who lack the necessary information, fail to channel minority students into programs that would provide them with the academic background required for the medical school program. Lack of women and minority physicians to serve as their role models once they get there, also hamper recruitment efforts.

Traditional criteria for admitting students to medical school is another problem. It's been called into question

for failing to sufficiently take into account the non-academic qualities required to make a good community physician.

The time-honored medical college aptitude admission test, the AMCAT, is suspect because of possible bias against minorities due to cultural and socioeconomic factors on that test.

The under-representation of minorities and women on medical school faculties is another area that's well documented. One result of this has been poor communication between the faculty and minority students, which in turn is detrimental to the learning process of those students.

Another area is that approximately 60% of women physicians enter into four areas of medicine, pediatrics, internal medicine, psychiatry and general practice. In other areas such as surgery and obstetrics-gynecology, women seem to be nationally under-represented.

The question arises as to whether women are free to enter the specialties of choice or whether there are factors in our institutions or even just in our society which attract them into specific types of practices?

The various panels in our meeting this morning will explore some of these issues from a variety of viewpoints. We hope that what we bring out today will help us to implement some solutions to these problems which confront minorities

and women in gaining access to the medical profession.

THE CHAIR: Thank you very much, Donna.

Would those individuals who are on our first panel like to come up and join us at this table up here?

That's Mr. Sierra, Lopez, Yamamota, Dr. Pollock?

Before we start the questioning, I wonder if each of you would introduce yourself, tell us your name and what you do and then we'll start with our questions.

Would you start, Jim?

MR. LOPEZ: Yes, my name is Jim Lopez, I'm the regional coordinator, National Chicano Health Organization. My office is here in Denver.

MR. YAMAMOTO: My name is Don Yamamoto, I'm support services coordinator for the University of Colorado Medical Center office of Minority Student Affairs.

DR. POLLOCK: I'm Bruce Pollock, I'm the head science adviser for the Boulder Campus on the University of Colorado.

I'm down on your program as chairman of the pre-medical advisory committee, but this is in fact only a trivial part of my role in advising pre-professional students.

Q (By Ms. Lucero) Thank you.

Let's start with you, Mr. Lopez, would you please describe the nature and purpose of the National Chicano Health Organization? Just as it relates to us here in

Colorado, and for the sake of brevity, let's go ahead and call it NCHO?

JAMES LOPEZ

A. (By Mr. Lopez) Okay, thank you.

Yes, NCHO is national organization here in Colorado, we are basically an educational program for Chicano students who are going -- pre-health students going into health so we work at all the undergraduate campuses working with the Chicano students trying to bring to them what information they need to go into the health careers as well as to work in a brokerage capacity to have them being accepted into the different health professions.

That's kind of in capsule form, what we do.

Q. Thank you. How do you assess the needs for Chicanos and other minorities in the medical profession?

A. Well, you know, just looking at -- listening to your statistics that you gave us just a few minutes ago, this is the whole reason that HEW has chosen to found or to fund an organization such as ours, because the need for the Chicano community to have their own members be able to bring to them a health delivery system that they can truly be a part of by having those professionals there, is the

whole reason, we, you know, exist. So I think the validity of an organization, ours goes without question the Chicanos are not a part of the health delivery system and we wish to be, by beginning first of all with our students who will become health professionals, on to where the Chicano community can have a part within the health delivery system itself.

Q. Jim, one thing I had wished I could have brought into that was to show some statistics on Chicanas in the medical profession and there aren't any. Do you have any idea how many there are in that --

A. We don't have a direct statistics of how many Chicanas there are in, versus Chicanos, again this is come from cultural again. We are La Raza, we are people and we're not concerned now with women or men, we're concerned with Chicanos and as a people we're concerned about a total.

But you know, off the cuff, as there are very few Chicanos, that become health professionals, it's even less for our women.

Q. Could you give us some idea of difficulties you had in recruiting Chicanos and Chicanas?

A. Well, I think the difficulty lies not in the motivation of Chicanos or Chicanas, wanting to go into the health areas, the difficulty comes in the fact that Chicanos and Chicanas are being tracked to go into other types of work.

If they're lucky enough to be able to go into colleges, they're definitely not traced into or tracked into the health professions. It's coming from background types of things, such as your parents, your background is not such to see you as a health professional and your people need so much work, why don't you go into social work?

So many of the problems that we encounter is the Chicano student is constantly refused a type of positive reenforcement by counselors and by faculty members, etcetera. Anybody he encounters, he gets very little positive reenforcement. That they could go into a health career that this profession is open to them.

They're constantly being bombarded with the fact that this is an area where you really don't fit.

Q Could you relate to us some of the problems that specifically women might have in this area?

A Well, again I think culturally we have a thing called machisimo within the Chicano community and within our culture and this has also been a part that has played a role in the Chicano not going into the health careers. Traditionally our Chicana women did not go into these types of professions and therefore this is reenforced now, even stronger by a White community that expects our women to stay exactly where they were whereas the Chicano community is asking our women to go into these types of professions.

Q How do you feel that the low number of minority persons in the profession relates to the delivery of health services in the community?

A Well, I think that when we talk about the health delivery itself and the Chicano having not a part of the health delivery system, we're saying that for Chicanos to receive an adequate health care, they want to be able to deal with Chicano doctors, with Chicano nurses, etcetera and when we're saying that we're saying that the health delivery as it is being brought down to us presently is not adequate because Chicanos are not part of that health delivery, they're not delivering the services to their -- to our people and therefore, by Chicanos becoming health professionals, Chicanos would be able to identify with the health care delivery.

We are, as a group of people, Chicanos have constantly been set in the role of emergency health care, we only go to the hospitals, we only go to the clinics when we're in pain, when it hurts. When there's an emergency.

We're saying if -- if Chicanos could become health professionals, have access to the fields, become graduated, be able to be the health deliverers our people would then better understand preventive health, they would understand that health care is more than just, when you're sick

or when there's an emergency. But they would get this because there would be Chicanos there.

People who could relate to them, speak their same language, understand them, both culturally, etcetera.

Q Jim, one last question, could you tell us what you specifically are doing to recruit more minorities into the medical profession?

A Yes. At -- here with NCHO we are working on practically every campus in the State of Colorado, org --

Q At the undergraduate level?

A At the undergraduate level, working with these Chicanos in both fashions. One, we work with Chicanos that have designated a health field as their major at their undergraduate studies and we work with them to make sure they get the right requirements, give them counseling, and a very large part of our time is taken up just giving them the positive reenforcement that they need.

Number 2, we work with the students at the undergraduate level, those Chicanos who have not even thought of going into health and we try to expose them to, to all Chicanos if they have an undisciplined or undeclared major, or they -- or they have declared some other type of major, we try to expose them to another alternative which is health. And try to motivate them to go into that.

Q Thank you very much. We will try to save time at

the end to get back and ask you to discuss some of your points together.

A. Thank you.

Q. (By Mr. Torres) Donald Yamamoto, will you briefly describe the program you are responsible for at the school of medicine, minority student affairs office?

DONALD YAMAMOTO

A. (By Mr. Yamamoto) Okay, the program I am associated with as support services coordinator is primarily directed towards retention. What I deal with is in the area of working with students, developing programs in study skills, reading, anxiety reduction towards test-taking, how to appropriately study, how to get the most out of your textbooks, developing some sort of adequate tutoring system so that students who -- especially minority students get the adequate tutoring that they oftentimes sorely need.

Basically, it's a many-faceted program. It basically operates on a one to one relationship, I usually work with the students one to one on any of the aforementioned programs that I just talked about.

Study skills seems to be one of the most predominant problems that I find, you know, in working with medical

students at this time.

Q Can you tell us the reason why so many minority students have a deficiency in basic learning skills?

A Oh, that's a -- a many-fold question, it could take years to answer. I think basically what I feel is that the problem really lies in the entire education system when that minority student first begins his education.

Oftentimes or since, like the death of Martin Luther King, we've taken a very, very patronizing attitude towards minority students, I feel in education, that we try to impress -- bring up and matriculate as many minority students as possible, and at the same time, not providing them with the real education they need.

I'm saying that in many four-year and community college programs, that were set up in the '60's and early '70's, that they are oftentimes watered down to show a student's success, in an effort to show a student success they were watered down to the point where that course was not oftentimes the equivalent course that a majority, White student may take.

One example I think was very blatant, was Model Cities program at Metropolitan State College. The week end college program.

And that course, many of the courses were watered down heavily to show a positive source of reenforcement,

showing that this student, yes, you can succeed.

But at the same time, this program was not of an equivalent nature so that once that person matriculated through the week end college program, and was allowed to enter a regular, four-year curricula, they oftentimes failed.

A blatant example like I say, would be the -- they recruited 30 women to go into a nursing program at Metropolitican State College, through the week end program. Most of these people failed when they were later absorbed into the regular Metropolitan State College system, because of lack of funds, Model Cities program was later disbanded.

I feel that they were not given the tools to matriculate, that they were misled, often lied to, I feel, that the education they were receiving was good enough to get them through a nursing program, and it was not.

In some cases, emphasis on just basic compensatory skills was downplayed. I feel that a larger need for support services, skills reenforcement-type centers has been sorely lacking here in this state, as where it's growing on the east and west coasts.

Metropolitan State College, unfortunately, also has probably one of the best skills reenforcement centers. And however, their funding and the staffing is quite inadequate for these types of, you know, programs to develop, to help

the student matriculate to the programs.

I think the direction, education should pursue, is not only -- should we water down this course to show that this person can come, I think what they should pursue is a position where a student who has to prepare for med. school, who is taking physics, who's taking biochemistry, who's taking inorganic chemistry, not water it down, not try to provide some alternative but try to provide a supportive program along with that program, so that that student may matriculate through a curricula that is equitable and equal to that of a majority, White student.

In many cases, this is not the case.

Q. Do you have any recommendations to -- for alleviating special problems that minority students have pursuing a career in medicine?

A. I think the one thing, I think we -- improvement on the premed. advising. I think many times in many universities, the premed. advisers are not always readily identifiable, the courses in which they take are not always readily available as far as advertising these programs to the, you know, what should a student take to prepare himself for med. school?

Oftentimes there's quite a question as to whether this may be physics 101 or 102 is going to be the adequate course to prepare themselves for entry into the medical

program.

Oftentimes there's a little bit of discrepancy between these things and oftentimes it's not communicated to the student. I think one of the basic things that a student must have is a well-rounded -- a very good knowledge in the written language, that is English, because when he -- if he doesn't, he's not going to matriculate that well through much of the reading material that is forced upon him, that he must take in order to participate well.

The AMCAT, as was mentioned, was an exam that you must take to get into med. school, it, no matter what, you must know how to read that exam to pass it. If you don't know how to read it you're not going to pass it.

Many of our students, as far as minority students encounter this problem because they oftentimes, although they are in college, have very low reading levels. This is a -- again falls back on their later education, the secondary and elementary schools. I think the one thing that I would say is we need to develop more programs in support of a student once he's into college to help him improve his skills, basic skills in note taking, study skills, reading, oftentimes, like I say, these are many things that many of our students are lacking once they come to medical school.

Q Thank you very much.

Q (By Mr. Sears) Before I start questioning Dr. Pollock, Mr. Yamamoto, I'd like to ask you what would you do about that medical admission test that you were talking about? What's your position on that?

A Well, that's rather -- the problem with that is now it's being changed and I hope for the better. It seems to me that they are taking in factors not ever looked at before in the sense that they are looking at, hopefully, more rounded individual and hopefully they'll be able to draw that out of this test. But still, the one main thing remains to be seen is that the examinations are still of a reading nature, and whether or not the students that are matriculating through college now have that high skill of being able to -- and finesse of being able to read and reason and use inductive or deductive reasoning on these tests, is going to be the major point, you know, thing that we'll have to look at and see.

Q So you think there's a built-in cultural bias on that test, is that what you're saying?

A It's not a cultural bias, it's a bias to all people who have had problems before in getting adequate education. And the bias is that, like I said, if you can't read it, you're not going to pass it.

Q Thank you.

Dr. Pollock, I'm interested in your position as

director of the health sciences advisory program at the University of Colorado. What are your responsibilities in that respect?

DR. BRUCE POLLOCK

A (By Dr. Pollock) My responsibilities are to serve as an academic adviser to the health science students, which is premed. and predent., pre-dental hygiene, pre-med. tech., everything, basically, basically everything except physical therapy and nursing, and I collaborate rather closely with the nursing adviser in this.

Also, I serve to help particularly medical and dental students with their applications to professional schools. It might be useful to give you a little, some of the background numbers here that we're dealing with.

We're dealing with roughly 2,000 students in health sciences, no one knows exactly how many. In med. school applicants this year, we had a total of 220, 162 of these were male, 58 were female. These numbers can not be considered real hard numbers because we're still in the acceptance process and our data are not complete.

There are also a lot of multiple acceptances floating around, so I can't give you really hard figures.

But at the moment, we've had 58 males accepted, 19 females, for a total of 77. This was as of yesterday afternoon. About 39 of these have been accepted by the University of Colorado Med. School. Which is -- which means that roughly 50% of the premedical students which we're placing in medical schools are being placed at the University of Colorado. The rest are being placed nationwide in all sorts of schools.

Dental, we've had 27 applicants, 11 of which have been accepted so far, and these also are nationwide.

Minorities, we have had, for both medical and dental, I should say, we've had six identified as Chicano or American -- Mexican-American, all of these have been accepted as of the present time. Blacks we've had three accepted, one who has not been accepted, he's a Michigan resident and we've sort of lost track of him. He did not complete his application at Colorado and so it's probably reasonable to guess that he was accepted elsewhere.

Orientals, we've had two accepted, one who's on the alternate list of the dental school, one who has not been accepted is an individual approximately 15 years older than the normal individual being accepted in a professional school.

We've had four people identify themselves as economically disadvantaged minorities, none of those have been

accepted into a professional school.

Q Now, what's the makeup of this premedical advisory committee, how many minorities are on it, how many women are members?

A Well, the premedical advisory committee, as I said earlier, is a rather trivial part of my job. The students applying to professional schools need letters of recommendation. At the Boulder campus, one of our problems is that the classes these people are in are so large that they do not get to know faculty members well enough to write letters, or many of the students do not. Therefore we have created a premedical advisory committee, which is a committee that the students have gone out to select faculty members that they thought would be good at writing letters for them.

The committee of students was chaired by a young lady who was involved in it last year. This year, and she's volunteered to do it next year also, and they've talked to faculty members, the faculty members have volunteered to write letters.

The committee met with the students who are interested or with many of the students who are interested, established procedures under which the committee would operate, and then the students were interviewed, usually by two committee members of their selection. And the committee members

wrote letters of recommendation.

The students had basically four options, in getting letters of recommendation. One was not to use the facilities of our office at all or of course, then the facilities of the premedical advisory committee.

One was to get from faculty members that they knew well, their letters and transmit them through our office to the medical schools.

One was to get letters from the advisory committee, and one was to get both their own letters and letters from the advisory committee.

And so this is the way this thing is operated. The advisory committee, in other words, is serving voluntarily to help the students in what's a rather necessary component of professional school acceptance.

Q. You mean the advisory committee just furnishes letters of recommendation after they become acquainted with these students, is that their function?

A. That's right, the advisory committee does not evaluate or compare the students as is the case of many other schools. There's several reasons for this. One is we have well over 200 by the time you put the medical and dental and everything else together, we have close to 300 applicants per year. And no advisory committee members do see all of these students, that's one of the problems.

So it becomes a logistical problem of how you get a uniform evaluation of students. Some schools do this, but we feel we have too many students. The faculty members also feel that they do not want to take -- they feel very uncomfortable with the feeling that they are a life or death link in the student's acceptance by a professional school, so they don't want to say this student should be accepted, this student should not.

Q How do premedical minority students know of the existence of this advisory committee that would be able to write letters of recommendation for them?

A They -- the existence of the advisory committee, the advisory committee was set up at a campus-wide advertised meeting of all the students. All of the students, minority and nonminority, participated in establishing the procedures and they have the same access to the committee as anyone else. We don't recognize any -- minorities at that stage.

Q Is there a premedical curriculum requirement --

A No.

Q -- major?

A No, there is no premedical major. The premedical requirements, and this is true also of predental, are the requirements which are established by professional schools nationwide, and these are actually rather few.

Q. Heavy on science?

A. Well, they include a year of general chemistry, a year of organic chemistry, a year of physics and a year of biology. So these are basically just the freshman and the organic chemistry the sophomore level courses in those departments.

Then there's some mathematics usually through college algebra and trig. although some schools require calculus and we suggest that they get calculus. English, literature and composition, these are all of the preprofessional courses.

Q. They get enough English to learn how to write these prescriptions that I can't decipher?

A. We do a lot of kidding about that.

Q. Well, more seriously, are minorities and women students at the university encouraged to consider medicine as a career? What do you do affirmatively in this regard?

A. Well, this is a question which precede the advisory committee. The question of whether they're encouraged or not, and I think this question has to be discussed relative to specific groups, not just women or minorities, because there are different -- different questions involved.

The ethnic minorities as I see it, and I think it's been stressed by the preceding speakers here, our problem seems to lie prior to the university. And for reasons which

I do not fully understand, the ethnic minorities are very reluctant to seek advice from -- either from my office or it turns out frequently from the ethnic minority counselors on campus. There are something like 13 ethnic minority counselors on the Boulder campus serving about 300 students. And I see, I serve about 2,000 students, and many of these students appear to be -- seen rather infrequently by either group of counselors so that, I think to me, is one of the major problems we have in positively attracting the ethnic minorities, and it goes much earlier, goes into the grade schools and the high schools.

I -- once they get into the system, our figures on acceptances would seem to indicate that they move along rather well, the problem is getting them into the system.

The economic minorities, the problem is to identify them realistically and this gets to be quite a problem because some students are really economically disadvantaged, some students simply think they are.

And this is -- I see this very frequently, parents seem to communicate to their children that they're broke and the children take this and run with it. And frequently put themselves at an economic disadvantage but they really don't have to do this and that's a problem there.

With the women, the problem is really one of stereotyped goals and these goals seem to be stereotyped in high

school and my role very frequently seems to be to shake them up and say, well, do you really want to be a nurse or do you really want to be a dental hygienist or would you be better off, would your talents be better served by going into one of the other professions like medicine or dentristry?

And every -- I'd say I average perhaps one or two girls a week in which I get into these questions rather deeply. They are not scripted by society towards professional goals or towards the same professional goals as are the males. I don't think I've ever had to encourage a male to go into a higher level or more demanding level of profession, but I do very commonly with the females.

Q Mr. Lopez, I'd like you first, if you would, and then Mr. Yamamoto, to comment on Dr. Pollock's statement of the reluctance of ethnic minorities to seek counseling in the premedical program, do you agree with that, what can be done about it?

A (By Mr. Lopez) I think one of the things that has to be done when we're taking a look at the Chicano student, say specifically in Boulder, your question on, should, you know, should the Chicanos or are the Chicano students going to the counselors?

I'm saying that, you know, they can go to the counselors but they're in fact, at the counselor level, not

receiving the positive reenforcement what they need. They need -- you know, and positive reenforcement means more than going to a counselor and him saying, make sure that you take a year of biology with a lab, etcetera, he needs the positive reenforcement that I'm talking about in program development, the counselor situation is not where it ends. That's just where it should start.

It should start with tutoring then, what happens when the -- because my reports that the students have given me is many times they've gone to counselors, etcetera, and they say, well, okay, you need some help in biology or in organic or something, but that's all, they know that.

They know they're having problems in the health sciences. What they are talking about is we need tutors. We need these kinds of mechanisms, we need tutors, we need people who can take us through the field and show us and this is what they're not receiving.

This is why they're not being encouraged on to go into the health careers because they know that they're going to have these kinds of problems, and they come up to these problems, there's nowhere to go.

There's nowhere, no mechanism for them to receive these types of services which is, you know, the large one being tutoring. This ability to break into the system needs more than just talking to them and telling them how,

it's also showing them.

So that through, like an organization like ours and NCHO, up in Boulder, the students got together and they brought down people like Dr. Riley, etcetera, who were very helpful in setting up some things called mock interviews of AMCAT test, okay? Or excuse me, of the interview that they would have before being accepted into medical school.

I think these are the kinds of program development things that we're saying are lacking and therefore, in lacking are causing problems to the Chicano students in going into the health careers.

Q Thank you.

Mr. Yamamoto, would you like to comment?

A (By Mr. Yamamoto) Basically, students, I think I find that a lot of the minority students fail to really feel confident in going to advising programs, primarily because of oftentimes they're singled out as being getting, receiving special treatment by the majority students also. And so it's sort of a kind of like a backlash going on on many campuses because of the fact that, quote, EOP or affirmative action type programs are for special students only, minority students.

And oftentimes, there's a backlash and oftentimes you'll get a student saying I won't go in there because I

don't want to be pegged like that. I think some of the programs that advising, preadvising committee should be looking at, I think, are programs in how to prepare for the AMCAT's. I, myself, in doing this as an offshoot as part of my functions at the medical center, is preparing a program for AMCAT's. But that's going to be changed because it's no longer the AMCAT's, it's going to be called the AMCAP's, and I don't know exactly what the student's going to be facing but as Jim said, the need for more supportive type programs, the need for more encouragement.

Minority student with maybe a 3.0 student, you know, in sciences, may not look like the greatest candidate but he has the potential, especially if he's maybe a sophomore or junior, to change that around and if he's given the encouragement he could probably bring that up.

In many cases, you know, that's not often the case. Support services I can speak of like study skill centers at the University of Colorado Boulder campus is not the greatest one in this state, that's why I don't speak too highly of it, mainly because it's only staffed and directed by one person. And she's told to go develop program, supportive programs for the entire university, that's not possible. You need money, you need staff and they aren't getting it.

THE CHAIR: Excuse me, might I ask now, if Joe Sierra

is here?

(No response)

Q. (By Mr. Sears) Yes?

A. (By Mr. Lopez) I wonder if I could also respond to, you know one of the areas that was brought up and this is dealing with the letters of recommendation. As we said, you know, there's these many students, these numbers of students coming into an advisory office saying, we need letters, as Dr. Pollock brought out, the professors don't know them so what use is the letter of recommendation? If all they're doing is putting a stamp of approval on a letter that they can run off a mimeograph machine a hundred times?

Okay, I'm not saying that this is what's done, but I'm saying this is the process and this is what the minority students don't like about the system of going into the medical profession. That you have to play these little games, that medical field wants to play with, that you have to learn this little system that is so in-house and it's in-house because if you get a letter of recommendation from a professor that is nationally known or well-liked, then you've got a chance. But for a minority student you're lucky if you've even gotten to see this professor once and

therefore you're not going to get a letter, so do you follow on what I'm saying?

It's such an in-house thing with just letters of recommendation, they're, you know, we're told nationally that we don't pay attention to the letter of recommendation, it's not used that heavily to weigh a candidate. But the same time, let a candidate come in with a nationally known letter of recommendation of a highly respected M.D. doctor then it's weighed upon and this is where, again, one of those subtle areas that keeps the minority student from being accepted into medical schools.

You know, it's closed, and I think this is what we've tried to -- trying to find access to taking a look at this.

We've said that the AMCAT test is being changed, it's being changed because they're proven that it is biased against cultural people that are different from the majority society, that's why it's getting changed, that's why we're taking a look at a need for us to, you know, get to the core of the problem.

The core of the problem is dealing with a student who's got to go for an interview to be accepted into medicine and into the medical center, he has to have an interview. That interview is so subjective that if I don't like the way you part your hair, I can give you a bad recommendation, there's

nothing subjective. It's so subjective that a student is -- can be approached from so many different angles and therefore, you know, these are the subtle things that hurt the, that keep people out.

When a Chicano has to go to an interview and be asked questions like what are you, are you a part of the Chicano movement? What do you think about the crusade for justice? These are not questions that should be asked of a student that wants to be a doctor. What does having to be a member of the crusade for justice have to do with becoming a medical doctor?

So I think, you know, that's where we have a problem. So you have people like Don and myself who take these students in, who are going to a conference and we have to take it, we have to tell them be expecting this kind of question because these are the kinds of things that are asked and I'm saying if you could get to the core of the problem, which are too subjective a selection, too close of an in-house to accept minorities into that structure.

Q (By Ms. Lucero) Jim, many of the points that you are bringing up would have been covered by Joe Sierra, who is a student and we regret that he couldn't be here today.

We had -- he had planned to discuss some of his successes and problems at the high school level, and his -- with counselors, with his teachers, what his role was once

he got in college with his other classmates, his financial needs, and some of the problems in being admitted to medical school and it would have been very nice if he could have covered those.

While we have Mr. Yamamoto here, would you, could you assess for us the effectiveness of the programs that you do have at the minority student affairs office for meeting the deficiencies of the minority students so that they can succeed in medical school?

A. (By Mr. Yamamoto) Primarily mine are more of like bandaid sort of procedure. When a student is admitted to the med. school he's -- when a student is admitted to med. school he's pretty much supposedly should have the tools necessary to be sure for four years. In some cases basically what I see as the biggest problem, like I say, for many of our students is not the inate ability to know what biochemistry is, what is histology, basically it's how they organize and what behaviors they carried with them from the, you know, from the previous college they attended.

In many cases it's developing sort of stopgap measure while they were an undergraduate to make it through four years. And oftentimes I find myself not just telling them well, this is, teaching them study skills but it's trying to change their entire behavior, where they study, how they study, under what conditions do they study

and many times it's -- it can be quite astounding. And the problems that a medical student goes through in order to find a nice, quiet place to study. Especially when, you know, like our center is away from the main campus at Boulder, therefore students have to find their own housing.

And oftentimes this housing can be pretty poor and not conducive to really adequate studying. The programs I think that I -- I feel have worked well, is, number 1, is the tutoring program where at least now I've been able to, instead of -- it's been in the past up to the various departments to provide the tutorials, and provide the tutors necessary for tutoring.

Now what, in many cases what happened was it was kind of like shopping, our list of people we got, go out and see them.

Oftentimes the people are so heavily involved in research or doing clinical work or on rotation that they were not available to do the tutoring. So in support of whatever programs the departments could develop, I set up the tutoring program in which a student could walk in and get, let's say he has a problem with physics, or I mean biochemistry, and he can come to me and say I'm having this difficulty in biochemistry, could you help me? I then can just look to my file, and all my tutors are active, on active file and they are always available because I

specify times that they should be available. And I can get them that tutor that is always there. They work under a contract system with each other so that they are committed to each other when they work, they agree upon the times they're going to meet, they agree on how many times they -- you know, at what hours they will meet, and so there's a commitment there.

Also there's a fairly good monetary commitment as far as the tutors, I feel are paid well enough so that they have this kind of motivation to want to tutor.

Q They're paid by the university, not by the student?

A Yes, they are, the university provides for all students, not just minority students, free tutoring.

THE CHAIR: We have just a very few minutes left, obviously there isn't enough time to begin to do more than scratch the surface, getting what we could from you gentlemen. I wonder if any of our staff members or the other committee members up here have specific questions that might be answered very briefly?

Q (By Mr. Muldrow) Dr. Pollock, although you say this premed. advisory committee is only a small part of your total job description, it seems to me that it is a very important one.

Specifically how many women and minorities are represented on this committee? I mean do they really have

access to the members of their own groups on this committee?

A. (By Dr. Pollock) There is one minority member, there are no women, the women on campus who have been asked -- on the premed. committee. The women on campus who've been asked have turned it down because of other commitments. We, also, this year had a committee for some of the dental hygiene students and I was fortunate enough to get one women who would be one of the interviewers for all the dental hygiene students who went through, that was only six or eight, but we don't have the numbers of people on the campus who are willing to provide the time on the committees. We had one woman on the premed. committee last year and she simply said she wouldn't do it again this year.

Q. So this is, there is a lack of representation from these groups, minorities and women really on this committee, who could counsel with or get to know minority students and women. How, then, do these minority students get their letters of recommendation? What do they have to do?

A. Well, basically, most of the -- most of the Chicano minority committee -- minority students are actually getting letters from Chicano minority -- professors on the campus. Some are not, some have actually been sponsored and really, I think of one Chicana in particular, who --

who's been accepted to two med. schools this year, primarily because she came to the attention of a particular biology professor who sort of provided her the support that she needed to go on, and he provided letters and so forth, too.

But many of the Oriental and Black students, I would -- I don't have the figures but I would say that their letters would probably distribute just about the same as the minority. A few through advisory committee, mostly from knowledge of individual profs.

Q. Thank you, Dr. Pollock. One question for Mr. Lopez.

It's been brought out a couple of times here already that minorities do have trouble getting proper counseling down in the lower educational levels. And that often, as a result of this, they are tracked into other professionals -- or occupations, sometimes nonacademic sorts of things, or they're not permitted to enter science courses which would prepare them for medical school.

What is the reason for this lack of proper counseling? Can you identify very briefly any specific causes for this?

A. (By Mr. Lopez) Once again it's a matter of those counselors not knowing how to counsel a minority student and when we have, you know, taken from a different perspective when we see a knowledgeable Chicano or minority counselor, counseling, we don't have that problem.

Dr. Pollock, I think, brought out a very good issue, the Chicano girl who had got accepted by the two schools was counselled by a Chicano biologist. See. So it's a matter of not understanding the culture or being able to relate to that person.

To be able to give them that encouragement, to be able to make them, give them, show them that there's an alternative here.

THE CHAIR: Excuse me, Jim, Dr. Pollock is shaking his head, was there a misunderstanding here?

A. Did I misunderstand?

A. (By Dr. Pollock) Yes, the faculty member who stimulated that student to go on to med. school was not Chicano. No, he was not.

A. (By Mr. Lopez) Oh, I'm sorry.

A. (By Dr. Pollock) No, I don't want to name names but he -- and she has talked with me on this on a number of occasions, and -- well, after she got into it, then she was helped by a Chicano faculty member, but her stimulation came from another biology professor.

THE CHAIR: Thank you very much. We very much appreciate your giving us your time and your help and if you think of things later that we have missed because of lack of time, we'd appreciate very much our committee members and our staff would appreciate hearing from you, so

that you can share further information with us.

Thank you.

One of our staff members just asked me to mention to you that there apparently are a good many more people in the room than have signed the register just outside the door here. If you would like a copy of the report, if you would sign that, we'll -- then you'll get one, sign that with your address.

As you can see our format is that various members of the committee will kind of come and go so that we can keep some fresh people up here all the time.

Two of the members whom you've not yet met are Maggie Aro, to my immediate left, and Gary Jackson, next to her. You've already met Cas Garcia.

Our second panel, Joe Aragon, Ray Lucero, are they here?

Before we start with the questioning, would you each introduce yourself, please, tell us who you are and what you're doing right now?

MR. ARAGON: Okay, I'm Joe Aragon and I'm a third-year medical student at the University of Colorado Medical Center.

MR. LUCERO: My name is Ray Lucero, I work for the University of Colorado Medical Center for about, oh, a year and a half as their recruiter, and I worked for the

National Chicano Health Organization in Los Angeles for about a year and eight months.

Q (By Ms. Aro) Good morning.

Mr. Aragon, I wonder, first of all, if you could briefly describe the procedures that you were required to follow in applying for admission to medical school, were they different in any way than anybody else's?

JOE ARAGON

A (By Mr. Aragon) I don't know if you can say that it was different or not. I don't know what other people go through to get to medical school, but I had been out of undergraduate school for three years before I even, or two years at least, before I even considered medical school, and I was working as a medical technologist, and if it hadn't been for a close friend of mine having gotten into medical school in the University of California at San Francisco, and come to me and saying, there's a chance to get in, I would have, you know, I'd still be a med. tech.

Q Did you have trouble getting letters of recommendation? We've already heard about letters of recommendation, was this a problem?

A Yes. Well, I went -- my undergraduate work was at

New Mexico State in Las Cruces, New Mexico, and as was already brought up, it's very difficult to get to know your professors even in a small institution like that. So I did have difficulty, the people who did write them for me, I understand, wrote very poor letters for me.

Q. Now, if you have encountered any academic difficulties, was help available?

A. At what level?

Q. In medical school? Once you are in medical school you are a third-year student, have there been academic problems and have you found help for them?

A. Yes, there have been academic problems and it depends on how you define help, you know. There are people available at the university who say they want to tutor, but I've found out from my own experience that people who I have gone to have hurt me more than they've helped me. Okay?

Q. By omission or commission?

A. Well, I don't know. I -- I went to the tutorial sessions and it seemed like I got a worse grade the next time.

Q. Were these always available when you needed them? And soon enough? And often enough?

A. Well, I'd say they were available, yes, and at the right time.

Q But you had to work to take advantage of them? Was it a chore?

A It's not a real chore, it's just, to me it was detracting from my regular study time. Okay, they say come and see me at such and such an hour, so I'd go and spend an hour or an hour and a half with them, and again I wasn't getting that much out of it, so that, you know, I guess I was wasting my time.

Q Now, financial problems as far as minority students have been brought up. Is the financial assistance that you're getting from the university adequate for your needs, you're a third-year student, where do you stand as far as money is concerned?

A I went into the -- the first two years I was using the university for my financial aid and I got tired of being treated like a begger to tell you the truth, so I went to HEW's physicians shortage scholarship and I'm receiving aid from them now and none from the university.

Q Now, how much do you owe in loans from the university?

A Ten thousand.

Q Would you have to pay that back if you were not able to complete your medical school?

A I don't know, to tell you the truth.

VOICE: Yes.

Q (By Ms. Aro) We're getting a yes answer, all right.

Now, what kind of contact have you had with academic advisers? Has the relationship with them been helpful to you, the ones that you were assigned? Were they assigned to you when you went into med. school?

A (By Mr. Aragon) Yes. We -- when you go into med. school they assign you to two advisers, one's the first two-year level and one is at the second two-year level.

The one at the first two-year level was, I'd say adequate, to a point, and then once it came where we were taking the course that he was teaching, the adequacy sort of filtered away. I don't know if it was a personal thing that he didn't want to be giving advice on his own course.

Q Was there an opportunity for you to change such an adviser or --

A No, I didn't really need it at that time.

Q Okay. What kind of recommendations would you make concerning the school of medicine's admission procedures with regard to minority students, and also the supportive programs that are provided for them?

A Okay. As far as admissions go, I think that there's a definite need for Chicanos on the regular admissions committee. Not only at the subcommittee level but at the regular committee level. Which we do not have due to the technicalities that members of that committee must be members of the faculty or M.D's of the faculty or M.D's out

in the community, I guess. And there aren't no faculty members, so how can we get people on that committee? We do have -- it has been changed over the last year that students can participate in that regular admissions committee. And we're lucky enough to get a Chicano in there for the following --

Q. For next year?

A. Right. And depending on the pressures and stuff, if he goes on to do it or not, you know. But what we really need is a faculty member sitting on that committee that is -- that will support us.

Q. Thank you very much, and we'll get back to more questions in just a moment.

Q. (By Mr. Garcia) Hi, Ray.

RAY LUCERO

A. (By Mr. Lucero) Hi. I guess it's my turn.

Q. Yes, it is.

We had -- once had a discussion in Durango when you were working as a Chicano recruiter for the school of medicine.

Could you tell us a little bit about what you did as a Chicano recruiter for the school of medicine?

A Okay. My purpose was to visit the various undergraduate classes and universities in the State of Colorado and also some outside of the State of Colorado.

My purpose was to talk to prospective Chicano applicants about the prerequisits and the procedures which a student must follow in terms of trying to get admitted to the health science professional schools, not only medical schools but all the health science professional schools.

My job was to, essentially let them know the procedure to follow and the politics that is inherent in getting into a medical school. And all other health science professional schools.

I'd like to emphasize this point, people have alluded to it but they have not really talked about it openly. It is very political in terms of deciding who gets into a medical school and who doesn't. It's very political. And you talk about it in terms of, you know, letters of recommendation, you talk about it -- anything you want to talk about, grade point averages, anything you want to talk about, I'd like to say that, you know, the fact is for the last several years we have consistently had an adequate number of Chicanos, and I mean well-qualified Chicano applicants to the medical school. And they were rejected left and right.

The fact is you know we -- we have only, I mean not we, the officials at the University of Colorado -- the University of Colorado, we've only admitted a few each year and the fact is the number of well-qualified people, the people who could have succeeded academically and socially, was really kept to a minimum. And I have some points I'd like to talk about. As I go through here.

First of all, I really think there is no support system. Anywhere there's not an adequate support system in terms of trying to encourage and trying to get Chicano and other minorities into the medical school.

Since we're talking about medical school specifically. You know, the fact is it's the same old story, we don't have Chicanos at the -- Chicano faculty and administrators in sensitive areas at the undergraduate level and I can assure you we don't have any in the medical school.

Essentially what I am saying again to bring out the political reality is if you don't have Chicano faculty at the undergraduate level and if you don't have Chicano faculty in the medical school, you don't have anybody to protect and promote your interest, to get you into that school and then, also to make sure that you get out with a degree. That is the point I'm making. We don't have administrators in sensitive or significant areas at the undergraduate level or again the medical school.

You look at their number of administrators and you count them on one hand, and you know, I can assure you it's very insignificant. And so these are very real points, they have to be dealt with.

I -- I don't know what the answer is, of course we have to get admitted into the Ph.D. programs and all that glad and they ain't letting us in there, either, so what do you say, you know?

The problem is such a comprehensive one, you know, it beats the imagination. Okay, now, since we don't have very many Chicano faculty at the undergraduate campuses in the state, you know, and we don't have any in the medical school, what's the answer?

You know, I guess the answer is of course, obviously, trying to get faculty into these positions where they could help us. But you know, the immediate answer I guess is to sensitize non-Chicano faculty.

I'd like to comment, I mean I'd like to respond to Dr. Pollock's statements, you know, about encouraging Chicanos to, you know, apply for medical school and then push forward aggressively trying to get in.

The fact is from my experience, the vast majority of Chicano applicants simply do not trust you or your committees or other comparable committees at other undergraduate institutions. And very simple, very clear right to

the point. And the reason is very simple. You know you're using middle class Anglo criteria against Chicanos, and you know, of course, if you go according to hard data, objective data, all that kind of jazz, you know the fact is Chicanos normally have lesser grade point averages, we normally score lower on the graduate record exams, the medical college admissions test, you know, all these objective tests anyway.

So, you know, we have Chicanos who have gone to your committee and other committees in the state and because of the fact that they have a 2.7 or a 3.0 average, you know, these advisers are telling them forget it. You aren't getting into a medical school.

I know -- I know several Chicanos who are currently in medical school who have been absolutely turned off, and the fact is there's an entire history, year after year after year after years, these guys, these women telling our students forget it, you aren't getting in. You know, I can't blame them for not trusting the institutionalized mechanism of getting in.

And then again it comes to the same thing, we don't have Chicano representation on these policy making committees. Either at the undergraduate level or in the medical school. So you know we don't -- essentially I'm saying we don't have anybody to protect and promote our

interest.

Okay. Another thing is simply this: You know the fact is we're going to have an adequate number of Chicano applicants from now on, that's all there is to it. But the recruitment process must continue. Because the fact is the Chicano applicants aren't getting the right information and they're not getting encouraged, they're not getting any support from some of the people who are there now, so we have to have recruiters who will go out and tell them the way it really is.

Okay. Now, since we'll have an adequate number of Chicano applicants trying to get into the medical school, what we have to deal with is the number of interns and residents. Damned, you know, they have very few interns who have come here to Colorado and I don't think there's been one resident yet.

There might -- oh, yes, there has been, I'm sorry. But the fact is, you know, they keep bringing interns and residents every year. It's only been in the last couple years that they even had one Chicano intern, you know, and they've had a sprinkling in the past, very few, but they've had their toekn sprinkling. You know.

Okay, the fact is if we're going to have residential programs, recruitment programs, you have to deal with, you know, faculty out there who are going to be sensitive to

the Chicano needs, they're going to admit them into the intern programs and the resident programs and offer positive support. Instead of cutting them down all the time.

I know several examples and I could name names of students who wanted Colorado for an internship, they were turned off absolutely. You know, all the faculty could tell them was your weaknesses, your weaknesses, your weaknesses, your weaknesses, they enumerate all of them but they won't say you know -- we know you're kind of deficient or we know you're weak in this area, but we'll help you, we'll work very positively with you, and try to help you get through here.

I know several students who have said, hell with Colorado, I'm going to another medical school, they want to help me. I know I'm deficient in this area but there's no -- there isn't that kind of support at the medical school.

Q. Does the National Chicano Health Organization have any form of a data bank on Chicano, say physicians, scientists, people who would be able to render this positive support that is required to enable people to graduate from medical school?

A. That is one problem. There is one compilation, there is one directory of Chicano scientists, not M.D's, we have a small -- we don't have a comprehensive census, let's call

it that way, but there is one directory, it's called SACNAS, the Society for the Advancement of Chicano and Native American Scientists.

Q. Does the medical school make any use of these resources that you've indicated to us?

A. No, they don't. They definitely don't. You know, I -- I know of several examples where Chicano faculty definitely wanted a position here at the medical school, absolutely no question about it. Dr. Antonio Aguilar, one of the, you know, one of the outstanding neurosurgeons in the country, wanted a position here, turned down absolutely, you know.

I know other faculty who, other people with Ph.D's who wanted jobs here on faculty. They didn't get any serious consideration. They were wined and dined and treated very beautifully, you know, big deal, you don't give them a job, you know.

And this is the problem. We have to have Chicano faculty here. You know, people have been interested, people have applied, but the fact is they have not been hired. And that's -- and you know names are available, that's no problem.

THE CHAIR: Excuse me, we're running into a time problem, we're going to hit this all morning, I'm very much afraid, and I suspect you --

A. Let me make a couple statements --

THE CHAIR: You've made some very provocative statements already, I think, that we've got some burning questions to ask you if you could --

A. Well, okay. I could talk for two weeks about the problems in the medical school, you know, it's -- just overwhelming, but okay, ask some questions.

THE CHAIR: That's the problem, we've got excellent resources here today, obviously, and it's the shame of it that we don't have really adequate time to get all we really could from you.

I'd like to -- may I see if any of our committee members or staff people have specific questions that they'd like to ask any of you?

Q. (By Mr. Muldrow) I'd like to ask Mr. Aragon one question, you indicated that tutorial and supportive programs are available when you need them, paid for by the university, yet you did indicate that you felt they were inadequate. Could you be a little more specific? How do you feel that these are inadequate, speaking from your own experience or from the viewpoint of minority group persons?

A. (By Mr. Aragon) That's a very difficult question to answer. I mean the only thing that I can say is it was inadequate for me, you know. I didn't gain anything by going to the tutorial.

Q. Can you give a specific example of how it might be inadequate or -- in what way do you feel it was inadequate?

A. Well, I'll just give you an example of what a tutorial that I went to was like. I mean I was doing poorly in one class and I got a note from my adviser saying he wanted to talk to me so I went and talked to him. And got a note from the advisory office which at that time was run by Dr. Moski (Phonetic) and I went to talk to him, and I got a note from Dr. Beck's office and I went to talk to the dean.

And then, after all this, I went to talk to the department, and so we set up a tutorial with -- with a faculty member, and we'd go to the -- we'd go to the tutorial and we'd sit there and we'd go over areas of the lecture which we felt we didn't understand. Okay?

And we'd spend about an hour to an hour and a half going over specific areas which we felt we didn't understand what the guy was talking about. And that would meet weekly or every -- twice a week or something like that.

The fact is it didn't help me. That's the whole point, that it might have been adequate for other people but it wasn't adequate for me. And I don't know what the answer is to making it adequate for me.

Q. Just briefly, do you have any recommendations about the supportive program for minority students, what kinds of

things might be added or needed?

A. You mean the program that --

Q. I'm thinking of in terms of once a student gets into medical school, a minority student, what kind of supportive program might be helpful to them, which are not now provided?

A. I think that -- as I was sitting out there I was getting this feeling inside, you know, that told me that we're having this meeting three years too late. You know. Our Chicanos now are not going to have problems. The Chicanos coming into school are up there with or better than the rest of the people that are being admitted. And this problem isn't going to be one of supportive but positive reenforcement, identification with faculty members, identification with interns and residents. That's where the problems going to be now and in the future.

I mean the days of academic difficulties are over. I mean we've done our homework through NCHO.

Q. (By Mr. Jackson) I have a question.

Joe, if I may ask a question, you've indicated that you feel that the problem in the future is now going to be at the intern and residency stage. Is there anything that Chicano doctors can do, Black doctors can do, that are in the profession right now to support students that are in this intern stage or in this residency stage or to get them

into these stages?

A. Well, I think, you know, I don't know if you've misunderstood my point but we have to get more interns and residents into the program so that people who are in the first, second, third and fourth years of medical school have somebody to identify with. Okay. People on the outside in the community, I think it's very difficult for these doctors out in the community to apply any sort of pressure towards the university, because of its closed system, you know. You have to become a faculty member to have any type of sayso into the proceedings of who's going to become an intern, you know, who are we going to take?

Q. I think Ray made a comment in terms of sensitizing non-Chicano faculty members. Do you have an idea of how this sensitivity program could be conducted? Are you saying that it would be the type of program like they do at certain big corporations where they attempt to sensitize management, sensitize executives in these upper echelon positions?

A. (By Mr. Lucero) In the first place, I'd like to say, there's a million mechanisms you could use to sensitize current faculty members, but the most important one that I could think of is, damn it, hire Chicano faculty.

The only way -- you know the fact, you have to look at the M.D. community, in the first place, M.D's even look

down at, on Ph.D's as being inferior to M.D., they've the idea, you know, that they're the elite, the gods of the world and all that.

Now, the fact is the only way you're going to get faculty sensitized is get Chicano faculty in there. And it will be the faculty who will be responsible for educating or enlightening the other faculty. You know the fact is the medical faculty are not going to listen to outsiders.

I know they're thinking I'm an idiot now and I know they think everyone else is unless you have an M.D. credential, you know, and this is the way they think. Very closed-minded. So, you know, it has to be Ph.D's or M.D's who get into that staff to sensitize other faculty.

And the fact is, look at the politics, who gets promoted? Look at the curriculum and promotions committees, look at the admissions committees, you know, you ain't going to have a say if Chicanos get in unless you have a Chicano on the admissions committee, you ain't going to have a say in terms of promotions.

A lot of our students are retained, you know, we don't have -- I don't think we have one that's flunked out yet, but the fact is some of our students are repeating an entire year. You know, if we had Chicanos who were there on that curriculum and promotions committee they would say hey, wait a minute, they can do their politiking to make sure

that that student isn't retained an extra, you know, made to repeat an extra year, or made to take courses over, because the fact is it is political.

And -- you can couch it in whatever terms you want, you know, educational, awareness, quality education, anything you want to talk about, but the fact is you don't have somebody to promote you in there and to protect you, especially in that medical school, you know, if you don't have somebody there, you know, you're going to run into a lots of problems, so you need Chicano faculty, plain and clear.

THE CHAIR: Thank you very much, Mr. Aragon, Mr. Lucero, we really very much appreciate your comments and if you have any further data or anything in written form that you would like to submit, I have a feeling you've got a lot more you would like to say, please submit that to us within the next month so that we can include whatever else you'd like to have included as a part of the formal hearing.

Thank you.

Could we ask Dr. Chavez and Mr. Clinkscales, members of our next panel to join us, please?

Would you introduce yourselves, please?

DR. CHAVEZ: I'm Dr. Demetrio A. Chavez, I'm a surgeon practicing in Denver.

MR. CLINKSCALES: I'm Douglas Clinkscales, Director of Minority Student Affairs, University of Colorado Medical Center.

Q (By Mr. Jackson) Dr. Chavez, if I may ask you a few questions, my name's Garry Jackson.

Would you explain to me or indicate to me where you attended medical school?

DEMETRIO CHAVEZ, M.D.

A (By Dr. Chavez) I went to school at the University of Colorado and graduated in 1949. I should have mentioned when I introduced myself, I am an advocate in your advocacy program at the schools now, concerned with the minority students.

Q Okay. Now, when you attended medical school, at that time in your class how many Blacks and Spanish surnamed were there in your class?

A In my class there were no Blacks and there was one Spanish surnamed individual, myself.

Q And that was yourself?

A Yes.

Q And what was the size of your class?

A I believe it was somewheres around 65 to 70, perhaps.

Q. Could you explain to this group the nature and the purpose of the student advocacy program that you are a member of?

A. Well, it's an effort on the part of the faculty, I think to provide some -- somebody that minority students can identify with. How effective it is, I don't know. I have reservations about it. I think it's better than nothing.

But I don't -- I don't think it's a good substitute for having faculty, regular faculty or regular administrative positions for Chicanos.

Q. When was this student advocacy program created?

A. I believe about 1971 or so, wasn't it? '72? '72.

Q. And how many participants are there in the student advocacy program, I'm not talking about students but enrolled such as yourself?

A. There were three Spanish surnamed doctors and three Negro doctors, and of course I might add that at least seemingly to me there's very little to choose from as far as Spanish surnamed doctors, there's nobody, you know, you can't -- they're hard to find, see?

Negroes, I think, I'm glad for them, I think are in a very fortunate position, they have two medical schools in the country and there's many more Negro doctors so it's easier for them to rotate every year.

Q. Now, if you could, could you define your specific

role in this program, exactly what you do with the students and how many students that you counsel?

A. Well, I am assigned approximately a group of ten Spanish surnamed students, and -- but I must say that I don't really have that much contact with them. I think it -- maybe I -- oh, I would say probably I meet with an individual Chicano student maybe a total of maybe twice, two or three times a month at most. And this is on an individual basis. They are supposed to see me on an appointment basis through the student advisory office, but most of them don't bother.

Q. Now, when you meet these students, what do you discuss, their academic problems or their --

A. Well, the role of an advocate actually is to represent their interest and protect their interest. In reality, this is rather hard to do because as an advocate you really don't have a position of any influence. For that reason I say that to me, what a Spanish surnamed student needs or a Chicano student needs is a Chicano faculty or administrative positions.

Q. Now, in this advocacy program you've indicated that there are approximately five people in it. Are any of these persons women? Minority women?

A. No.

Q. How about just women, rather than minority women?

A. No, no members of the opposite sex. As far as I know.

Q. Do you feel that this program as it is constructed right now is effective in any way?

A. I think it's effective in a minority sort of way, I told minority students myself, at times, that I can, to me it would be some consolation to have a Spanish surnamed doctor sitting in on one of these promotions committee meetings, but in reality, it's only a consolation because the -- the position of power is not there. I mean if you were a regular faculty member you would, to me it would seem you'd have much more influence on, you know, general policies.

Q. Do you feel that as a result of the student advocacy program that the students themselves are stigmatized in any way?

A. I don't know. I think you'd have to ask students this. But I -- I do think that there are certain mechanism set up in handling the minority students that do stigmatize them.

For instance, and this is perhaps meant in a very humanitarian sort of way and maybe it's very well-intentioned, but they have a policy, I believe it's in effect starting this next year, that the incoming class will be, it will be made a requirement of the minority students that they

take a review course or refresher course to help them academically. Now, this seemingly, on the surface, would seem to be a very good thing, yet I can envision myself for instance, in coming in, I would feel like I was being singled out for, you know, I'm an inferior student, we're doing you a favor, we're taking you in, we're going to help you.

What the Spanish surnamed individual, as far as I'm concerned, needs, is, they need more selfconfidence and this is something that goes way back to the kindergarten.

We need better teachers, we don't have good teachers throughout our entire system, either for the Chicano or Anglo or Swedish or Scandinavian or whathaveyou, we're lacking in teachers that have good imagination and the ability to motivate students.

Q. Now, of the students that you counsel, are there any women that you counsel?

A. Yes.

Q. What is the major difficulty that the women express to you in going through medical school?

A. I think the major problem that the women that do have problems seem to have is, to me it seems to be academic, but there is a large factor played by this role of being singled out and perhaps maybe an inferiority complex. You know, you do poorly in one test and it snowballs and you

do poorly in the next test and that makes a student feel, well, you know, he looks at all these brains here, see, they have grade average of 3.6, I have a grade point average of 3.0, and so maybe there is something to this.

In reality that really isn't so, I don't believe. I mean I think that you get out of a subject what you put into it, and if you concentrate on studying, anybody, I don't give a darn whether it's an Indian or whatever ethnicity a person may have, I think you -- at their level of medical school you should be able to do all right.

Q Doctor, we are running out of time, I'd like to ask you one general question.

What would be your recommendation in regards to the effort of the medical school to recruit minority medical students and what would be your recommendations in terms of efforts that the medical school could make in terms of retaining them once they have entered?

A My recommendation is this: I think that the medical school should make a definite effort, no if, ands or buts, to set up a committee equally representative -- representative of medical school faculty and the Chicano community itself. have a committee that the people in medical school are responsible to or at least required to report to periodically, so they'd know what efforts are really being made to recruit faculty, to recruit students,

what's being done to resolve problems. If you have something like this, in my estimation, I think at least you have a beginning.

Other than that, the solution I think lies, a lot of the problem lies outside of the realm of medical school. I think it lies in grade school, I think it -- this racism as you perhaps are well aware of, is nothing that you can prove that somebody's a racist in a court of law, it's something that you'd know, you feel, you sense it, it's an emotional sort of thing and most people that have been subjected to racism know what it is.

I'd know damned well when somebody is racist, I may not come out and say that they're racist, but you know I -- I have a pretty good idea and I keep it to myself. I know I try to -- my own reasoning is say I protect myself from anybody I think is a snake. Period.

Q. Thank you, Doctor.

Q. (By Mr. Garcia) Mr. Clinkscales, would you briefly describe the nature and function of your office at the medical center, and what you do?

DOUGLAS CLINKSCALES

A. (By Mr. Clinkscales) The function of the office is to

basically, to help the medical school and I'll speak in terms of the medical school, since the focus is basically on the medical school, but we tried to provide the same services for all the programs.

Our mission statement is to create a pool of applicants that the various schools and programs can select candidates from, pool of minority applicants, to help the institution understand the variables that are important and that are not standard in considering the various applicants for selection. And to help the students through the application process, to provide a point of reference for them as a resource so that they can get through the medical school and graduate and go into the internship programs.

Q. What efforts does your office make to recruit minority students?

A. Well, Mr. Lucero was up here, basically he worked in our office and you know, it would be sort of redundant to go right over the same things that he has just said as far as the recruitment mission. They visit the campuses --

Q. I understand Mr. Lucero has not been there for some time and we're also interested in recent developments from your office.

A. Well, basically we're still doing the recruitment, we have a high school program that we've ran since 1969 to bring, we started out with Manual High School and then

expanded it to north and west and it brings in 25 to 30 students a semester and they get 180, it's a 90-hour course, they get ten hours of credit towards high school graduation, and it exposes them to basic science and clinical preparation. The things that a medical students go through, get lectures from various faculty members, this type of thing.

We go up to campuses, talk to students about getting into medical school. We help them through the application process. Try to coach them on what should be and shouldn't be said in interviews, stuff like that.

Q. I see.

Do you, in your recruitment efforts of minorities, make any efforts to recruit minority women? Any special effort in that particular area?

A. We define -- have defined basically minority as not being just males, we recruit men and women. Yes.

Q. So, basically, you just make the general effort to recruit without any special emphasis on --

A. The effort is on color, not on sex.

Q. Okay. Assuming that there is all of this, when you do get minority women into the -- your pool, is there any special effort to help them?

A. We provide the same services, hopefully to all students, irregardless of whether they are Black or Native

American or Chicano or Asian or male or female. You know. We don't say, well, we're going to give this female more services than we'll give this male, just because -- there's not much rationale behind that.

Q You indicated that you also provide this applicant pool of minorities, do you do any of the initial screening of the minority applicants? And if so, what criteria do you use?

A We work in conjunction with a subcommittee of the regular admissions committee, which I guess four out of the five people that function in the interviewing process and selection process function full time, in a full time capacity, with the regular committee. We work with them on scheduling students for interviews, get them there, to provide support for them financially, housing, to show them the campus, to explain any questions that they might have to try to help them define what their financial aid need will be, that is the relationship with the--

Q Okay. Now, one additional question, do you consider the advisory program.....for minority students in medical school adequate?

A What program are you talking about?

Q The advisory program, this program that we've been talking about?

A My program? My --

Q. Yes.

A. It's adequate in some respects, of course nothing is perfect. We -- there's a lot of things that need to be developed and there's a lot of things need to be expanded, but basically I think we have a good start considering the state of the art across the nation in other medical schools and where we had to come from.

Q. You indicated that there might be some areas that you might desire to improve, what would some of these areas be?

A. I think we need a better -- more sophisticated program as far as support for students when they have academic problems. I think we need to be able to tie a closer linkage between our office and the various departments, as students go through in the basic science years.

We need to get more involved in the internship and residency programs for students, because everyone has been talking about faculty, but the fact of the matter is, you know, there's been a little focus -- seemingly a lot of focus on getting Chicano faculty at the medical center but there is no Native Americans there, there are very few Asians that really relate from a third-year..... perspective to students, there are very few Blacks there.

We need to focus in and try to encourage the internship and residency programs to select more minorities into

that pool because that's where, you know, that's where the faculty comes from. It's not here to other schools.

Q. (By Mr. Jackson) I have a question, if I might.

I believe it was Mr. Lucero that indicated that he thought that the academic problem with minority students was becoming less and less. Would you agree with that statement, and that the major problem now with minority students would be the fact that they need some type of support that they could get through having a minority faculty member?

A. Well, in 1969 and 1970, briefly, students were selected with lower GPA's and AMCAT scores than are getting into medical schools all across the country now. That's the factor of the pool being a little bit more competitive, students are still coming in, though, basically one to two standard deviations away from the -- from the total class as far as the means, that is one to two standard deviations away from the mean AMCAT and grade point averages, so there is still a discrepancy.

Students still have problems. They're not as significant, you know, the impact isn't as great, most students can handle it by doing, having some type of support services. But I won't say there are no academic problems, at least we're still having them at Colorado. I don't know what's happening at other schools.

Q. Well, what do you consider the major problem then?

A. Support for the students, a better relationship as far as support services for things like national boards, which no one has really talked about that I've heard, things like how do you get ready for your finals, how do you get through that type of situation? Helping a student prepare and sort of a programmed approach, some of the things that Don Yamamoto was talking about.

MR. JACKSON: Thank you.

THE CHAIR: Any other questions from the panel? Bill?

Q. (By Mr. Muldrow) Dr. Clinkscales, the summer program sponsored by the medical school was mentioned. Would you just briefly state what you feel to be the effectiveness of this program? Does it meet the needs of minority students? Is it required for all minority students to enter this program or who does participate in it?

A. (By Mr. Clinkscales) It's not required for all minority students. What the institution has tried to do is tried to take a look, a historical look, at the minority students that have gone through medical school over the last four or five years, and tried to select which -- what are the critical variables that determine whether a student will or will not have problems in three or more courses in the first two years, the basic science years for the major impact of student varying for minorities comes about, and

to apply this to the entering class after they have been selected. Totally. And pick out what students will have a problem, then try to design a course to help meet those needs or try to help improve the probabilities that a student is going to have a successful experience in medical school.

That's the way the program is set up. Now, whether -- now my opinion on it, in spite of the fact that it's not required for all students, I don't feel that any student should be required to attend that, and the medical school knows that, because there's really nothing that I know of that we can show that happens to a student in that course that will determine whether that student will succeed or won't succeed. It's sort of like, it's a project now, it's in the -- in the study stage, it will probably be three or four years, if they continue that process before they can have hard data that say X number of students came into the program and they did this, they went through the summer program and they succeeded, X number with similar criteria came in and didn't succeed and they failed, because they're not at this point now, yet. So I feel it's a mistake to require a student to participate in it.

THE CHAIR: Thank you very much, Dr. Chavez and Mr. Clinkscales, we very much appreciate your participation.

We're already about 15 minutes behind time so we will take a five-minute break rather than a ten-minute break, we'll reconvene in just five minutes.

(Short recess)

THE CHAIR: Can we get started again, please?

LaRae Washington, Dr. Aronson, Dr. Thulin here?

I'd like to remind you to please use the microphone, it's difficult for the people in the back to hear unless you're kind of close to the mic. Would you introduce yourselves, please?

MS. WASHINGTON: I'm LaRae Washington, a senior medical student.

DR. ARONSON: I'm Dr. Karen Aronson, I'm a graduate of the University of Colorado, was a resident in psychiatry for a year and a half, and will be a resident in general practice at Mercy Hospital in June.

DR. THULIN: I'm Barbara Thulin, I'm interested in exactly what my other colleagues are interested in, women in medicine, we haven't heard a lot about it yet but we will.

Q (By Ms. Lucero) Thank you all for coming.

Now we get to hear from the women.

Mrs. Washington, you're unique and a minority in several aspects, as a woman, as a Black and I understand

you're the mother of four children. Could you tell us how these factors, what impact they had on your admissions procedure?

LARAE WASHINGTON

A. (By Ms. Washington) That's almost ancient history but it did have an impact at that time. And may I preface my statements that I will make that things have changed quite a bit in the admissions procedures, and in the attitude of the university, there's still problems, but it has changed quite a bit.

When I applied four years ago, it was, I ran into a number of difficulties. I did have a high grade point average and graduated from the University of Colorado in Boulder with a -- with honors. And at the time I applied, most of the questions were directed to my husband and how I was going to clean my house and cook my food and nothing was really asked of me as a -- how I would be as a doctor and as a student.

Q. Did you experience any academic difficulties?

A. None whatsoever.

Q. How have you felt about your time in medical school as being a Black and a woman?

A. I've alternately enjoyed and hated medical school as I think all medical school students do. At times at 3:00 o'clock in the morning after having a patient with a lot of problems, you wonder what in the hell are you doing here, you know? But in general, it's been a very rewarding experience and I would not have done anything else.

The faculty and how they have reacted toward me, if anything it's been oversolicitous. And this, I think, is, I don't know exactly what their reason is, but it has been oversolicitous in some ways.

At first, whenever you go in a service or meet people, they seem to think that you are either a novelty or they ignore you, it's one thing or the other. And seems that you have to almost prove yourself, you're almost put with that burden instead of just being yourself and having them react to you. But I think, in all, things have gone rather well.

Q. I understand you've been accepted into the obstetrics-gynecology residency program, congratulations. Are you the first?

A. First woman accepted in that program?

Q. Yes.

A. No, I'm the sixth, but I understand that I'm the first woman in about 15 or 20 years. I don't know the exact time period, it's been a long time.

Q How do you account for so few women being in this field?

A There are probably a number of reasons, but I think years ago the obstetrician and gynecologist was on call seven days a week, 24 hours a day, and this isn't so conducive to any other type of activity. And I think women just were not going to tolerate that. But in the last few years the doctors' practices in general have changed, they are not on call 24 hours a day, they refuse to be, they're usually in group practices in which they're on call every fourth night or something of this sort.

And so now more women are interested in obstetrics and gynecology, OB-GYN, and they are getting more applicants.

Also, there has been an attitude in the department of, well, women can not take this, it's too hard a residency program, and on and on and on, and this has been brought up to me enumerous times, you know.

Q So, as one of the possible residency programs you might have a choice of, you feel that women have specifically been excluded from this residency program because of its demanding schedule and not for any other reason?

A I think primarily because of the demanding schedule but I'm sure there's other factors in there too.

But I have not been demonstrated this to me, you know, personally, and I've not talked to other women, but

I've just heard by, you know, word of mouth, so I can't give a real accurate history of it. But the fact that they have not had very many women in the last 20 years, I think, is really an indication in itself there are other problems.

Q Was this your first choice of a residency program?

A Yes, it was. I might add that I probably will not stay in the field just because the residency program is a very demanding one, which I realize, but I'm a single parent now and being on call every third night and in a department that probably they can not adjust their schedule because of the lack of residents they have, that I would probably -- will change fields.

Q What recommendations would you have for alleviating this problem so that you or another woman could stay in this field and still have a family and other concerns?

A Not only for a woman, I think a lot of the males now that are graduating are not willing to spend the time that was spent in the past, there is a lot of information, a lot of things to know but we are also interested in patients, along with the academics of medicine, and to adequately be able to deal with patients you have to be awake and after 36 hours on call you're not very kind to some patients that are wanting an extra five minutes of your time. You're not willing to give that as much.

So they should have, I believe in programs, especially

in the residency and internship years, that will give the type of person who wants more time to spend on outside activities, like I think over 90 hours a week in a hospital is really ridiculous.

I mean you lose sight of being an individual and being a part of a family and being part of the community. And actually dealing with people and patients that are as people.

Q. Thank you. You've said so many things and you answered a lot of extra questions that I'm glad you brought out. We'll get back to you.

Q (By Mr. Torres) You know, I feel kind of flattered sitting over here with three women and interviewing three other women. Not only flattered but honored.

Dr. Aronson, would you give us your status at the C.U. Medical Center?

KAREN ARONSON, M.D.

A (By Dr. Aronson) Right now I am not employed or working at C.U. Medical Center but I was until January 7th of this year when I decided that I wanted to pursue other medical training besides psychiatry.

THE CHAIR: Dr. Aronson, would you speak into the

microphone?

Q (By Mr. Torres) Did you have any problems being admitted to the school of medicine?

A No, I did not. I came from an eastern school with good grade point averages and MED-CAT scores and those credentials did not have trouble gaining admittance to the medical school or to the psychiatric residency program. Myself.

Q Do you know of any questions put to you before your admission that were asked different of male students or applicants?

A I'm not sure, before I had my interviews, I read this book called Women in Medicine and it said that admissions committees did ask certain questions of women about family life and boyfriends and things like this, and I was prepared for them and I didn't think that they were overly emphasized at the time, and I don't think they've precluded my gaining admission.

Q Could you outline any problems that you encountered during medical school, that you feel were unique?

A Well, I think that one of the major problems, both in medical school and postgraduate, is the lack of adequate role models for women in the entire field of medicine and in certain specialties. During the first two years, basic science of medical school, there were four women that

gave lectures during two years, during which we had hundreds of lectures by men. And we only had maybe four to eight lectures by these four women. So we had very little contact with role models during the first two years.

During the second two years, this was slightly better, though there were very few women, both at the intern-resident level and on the faculties of many of the departments within the university. I must say, though, over the years, that things have improved somewhat. I now understand from my friends in medical school that there are more women giving lectures in the preclinical years.

However, I'm not sure that they are faculty, tenured faculty, but rather instructors in the clinical years that come in during the first two years and lecture on the clinical correlations with basic science.

As far as the intern and residency positions, there were no women medical interns or residents during my first three years of medical school and the last year there was one woman accepted in the department of medicine.

As Ms. Washington has stated, there were no women in the department of OB-GYN, no women residents, interns or faculty except -- I disagree with her to some extent, about the reason for this in some departments. Studies that were done by the American Medical Womens Association

showed that as of around 1969-70, OB-GYN was one of the five most popular specialties for women to enter. And in fact, women were entering this field in other parts of the country. But they were not entering it at the University of Colorado for reasons which perhaps are more difficult to explain, but relating to the selection process of applicants to the residency level.

This has improved and now they are accepting at least one women. Two women, okay. I think this also makes problems even in the community because then there are very few or -- OB-GYN women practicing even in the State of Colorado where other states of comparable populations have more women, because I think the doctors do stay in the areas where they graduate or at least that's been traditional. Some departments have been represented well, mainly pediatrics and there have always been a few residents in psychiatry. And anesthesia and maybe one or two in surgery.

These departments, many of them still have trouble with the numbers of women faculty. In psychiatry we had, and have very few women faculty, very small numbers in my career as a psyc. resident, there have been a number of men hired for positions while the -- there have -- they have not been filled by women, they've been filled by men.

This, it seems to get into a vicious cycle, because

many times the people that are hired on the faculty are graduates of the residency program, and if there are very few women graduating in the program, then there's not much to choose from, not much chance of getting a position if there are very few or no women graduating in the programs.

Other schools have remedied this to some extent, by advertising nationally in magazines for, you know, women or minorities to apply. I have not, in my readings, which though limited, have seen such efforts taken here.

As I said, these things are improving and now there are women interns and residents in medicine and surgery and in psychiatry, though this has taken many years to accomplish and hopefully with some added impetus to hire faculty and to at least search out for qualified women to take on faculty positions, that this will help the role models problem that I think all minorities and women face.

Q. What other recommendations could you give us besides the ones you have given us to alleviate any disparity in treatment, if there is any disparity of treatment, between the sexes?

A. Well, when I went through medical school there were many problems in this area, we had to put up with scandalous deleterious remarks about women and slides shown from Playboy and in the teaching of medical curriculums and various other

sundry unpleasant experiences. I think this has changed either because the number of women has increased so dramatically that these things can no longer go on, or perhaps the administration has made, you know, some statements that these kinds of things will not be tolerated any more. I'm not sure which. Either of those two things are helpful, I think the faculty, we try to approach, when we were students, to stop this kind of practices but were not very successful.

Perhaps just time and getting more women in the field has helped.

The other thing is I think that women ought to be recruited at all levels for medical school, intern, residencies and faculty. And this just has not been done enough.

In the past years, in 19 -- early 1970's, while women made up less than 10% of the graduating classes, they were graduating in the top 10% of their classes, in a higher proportion, let's say 20% were graduating in the top 10% of their class, even though they made up less than 10%. What has happened to these women I don't know, but they're not on the faculties of the university, they were graduated high, their standards were certainly as high if not higher than the bulk of the graduating class, and they did not wind up in intern and residency programs, at least at

the University of Colorado, and perhaps this has affected their tenure as well.

I -- I do not see lowering the standards in recruitment as helpful, I think there are adequate numbers of qualified women around, they just need to be sought out for these different positions.

Q (By Ms. Aro) Thank you very much.

Dr. Thulin, I think we're on.

How are you this morning?

BARBARA THULIN, M.D.

A (By Dr. Thulin) Fine.

Q We're delighted you've joined us.

A Thank you.

Q Could you tell us what working relationship you've had with the University of Colorado School of Medicine?

A I graduated from the university, took my residency in -- at the university, took my internship in the city, and was on the faculty part time in my early years in practice.

Q Could you outline the problems and needs that you see which concern the recruiting of women in the medical profession?

A. Well, I would just like for the university to tell us their policy on women. I don't know what it is. There doesn't seem to be an articulation of the policy on women. Where -- what do they mean when they say they have a minority student affairs person, does that include women? Are they recruiting women? Are women being recruited actively?

I know of one statement two and a half years ago which said, from an administrative person, that we have so many women applying to the university for the school of medicine, we don't need to recruit women.

I don't know what their policy is, I wish they would articulate that policy. And how is it decided upon? Is this a decision of the executive committee? Is this a decision of the full faculty? Where is that policy articulated and decided?

I don't know. As you see, we don't have, there is not a woman person from womens' affairs, there is not a woman representative on the Boulder committee of advisory personnel, and yet I feel as if 50% of us are women, and there has to be some sort of policy.

Now, I would like to speak again to a different problem within the structure of the faculty. We seem to have been invisible, and in the last several years, there have been great movements made in terms of tracking women in professions and seeing that women got the opportunities,

at least available through the Civil Rights Laws, for educational opportunities, but what has actually happened in terms of enforcement of those Civil Rights Laws?

At the university I'm aware that the civil rights persons from the department of HEW have an affirmative action plan with certain goals, with certain timetables, but I'm not aware of any results. Women still maintain a position within the faculty which is 15% of the full time faculty, that hasn't changed.

Women still maintain an academic position of 94% below the rank of assistant professor. That means that they are not even in the -- in the great throng that are rushing up to the tenured faculty. Only ten women are on the tenured faculty at the medical center, and these women hold those positions in two types of tenure, one continuous, or one continuous and one indeterminate tenure. I think all of these problems of tenure as they regard women are really obstacles held by the gatekeepers.

Q. Dr. Thulin, could we ask you to say or state, if you feel a substantial number of women in medicine and related science fields are qualified to teach in a medical school faculty?

We have a goodly number to select from that are qualified?

A. I think that the statistics, if you look at the sta-

tistics at the University of Colorado, you will see that there is little discrepancy in the percentage of women selected from the percentage of women who apply. I don't think we're getting any favored treatment.

Q Now, I meant to faculty, I meant it continued the same?

A We are meeting a definite criteria, we have no special treatment.

Q Could you outline maybe the special problems that you feel women face in being hired to a faculty? A medical school faculty?

A I think it's hiring, I think has to do with the makeup of the general department, for which that person applies, the chairman, and I'm using the word as I see it because it is not a chairperson at the university, it is a chairman, 100%, these decisions are made by chairmen.

The persons applying are frequently selected from a search group, a woman has never been a member of a search group at the university to hire a department chairman. The search groups are made of of colleagues from the different departments and they make recommendations to the dean, who selects from among those recommendations, those persons recommended.

I know of only two women who have ever been considered seriously for a chair of any department. They were

not selected but at least they were considered.

I would like to see women appointed to search committees, I would -- we only have ten tenured faculty women, so they're going to be busy, but I would like to see women appointed to the faculty search committees so that chairmanships will begin to be coming up and being filled by women in the future. This is where the power is.

The chairmen remain for life. And I think that unless you get an input into the chairperson -- chairs of these departments, the departments will remain perpetuating themselves which have been White, male, Anglo Saxons.

Q Dr. Thulin, statistics show that a large proportion of women physicians have entered certain specialty areas, we've talked to that point. I wonder if you'd like to comment on your feelings as to why? Certain areas been selected by women or women are channeled into the certain areas?

A Well, there have been barriers, strong barriers in the past for women going into the surgical fields, they have not been accepted in surgical residencies, this has been not just a practice of this university, it's been nationwide.

The surgical specialties are more highly salaried, they are competitive for this reason, the earning power of the surgical specialists in -- throughout the country, is

far above the earning power of the pediatrician, for instance in fields in which women have large numbers.

Q. Do you have some recommendations, some specifics that you think would help women, qualified women, become faculty members of note in medical schools across the country and particularly ours?

A. Well, I would like to see the dean take this -- this matter under advisement, and make some real efforts in terms of seeing that the policy making decisions include representative women from the faculty. I think this can be done. I think that when you realize that the policy making decisions are made in committee, in executive committee, which is composed of, on a chance of 100% men, that women are not going to gain entrance to that select boardroom.

Q. Okay. Thank you, Dr. Thulin.

THE CHAIR: Any questions from other members of the committee?

Q. (By Ms. Lucero) Dr. Thulin, do you know if any Chicana women have been graduated from the University of Colorado School of Medicine?

A. Yes, I believe so. There's one, one in the present class.

Q. One that's graduated or she's --

A. (By Ms. Washington) No, you can ask Jeanie Sanchez

if in the past there has been, but I know myself and another woman will be the first Black women that ever graduated from the University of Colorado Medical School.

A (By Dr. Thulin) Those are two firsts.

Q Thank you.

Q (By Mr. Muldrow) Just one question for Mrs. Washington.

Dr. Aronson has stated that things have improved considerably since she was an undergraduate medical student. Have you had any difficulties, have you been excluded from any learning situation or been unable to take full advantage of any learning situations because of your sex or because of your minority status?

A (By Ms. Washington) Because of my sex, yes. Quite a bit. I can stay here all afternoon and tell you the incidents that have happened in the last four years but I can just tell you one, on one service was a surgical subspecialty, we were rotating through different sub-specialties for a week, and for four days they refused to believe or accept that I was a medical student, and I was supposed to be a nurse and after repeated telling them who I was, it was still ignored. I did work up a patient thoroughly and was supposed to assist on a surgery, but was denied this opportunity and a male student that had no prior knowledge of this patient was able to assist. And

I was shoved off into a corner. And so these type incidents still happen.

Q. How did you handle this particular incident, and are you able to cope with these things?

A. Yes, I have a very big mouth. They knew --

(Laughter)

A. -- they knew before I walked out of that surgery room what had happened, and exactly what they did, and I did get apologies but apologies do not help at all.

I mean I was denied a very valuable teaching experience on a female patient that had a urological problem.

A. (By Dr. Thulin) LaRae had a very big mouth in the admissions process as well. And what I might add is that when a nontraditional woman comes in for that interview, in which she's going to be thought of and approached by the biases of the men who are considering her as a nontraditional woman, it's very difficult for those men that are making decisions to see her in roles other than an aggressive, very uncharitable, unbenign kind of role. And if you do this in an admission procedure, if you're a woman, you don't get accepted. So that most women who have interviews come on not like Buck Rogers, but they come on, if they're going to get in, in the traditional way

of the nurturing mother earth kind of person, and I think this is too bad.

A. (By Dr. Aronson) I'd like to say something about, in relation to what Mrs. Washington has said. There are certain problems that women run into in the learning of medicine, specifically since there are so few role models and so few women physicians on the faculty, when we are learning things like physical diagnosis and how to examine patients, we oftentimes have to have male instructors which makes things more uncomfortable when we're learning certain areas of the body.

And this is a very new and unfamiliar thing, and also because of cultural and social things within the society, it's always been acceptable for men to examine women, but women do run up against problems in examining men in certain areas, that if they had other women to talk with or help them overcome these problems it would be much easier.

It does happen sometimes that a man refused to have a woman examine them, but you are the physician and you must overcome these problems and it would be helpful to have other women to go to to see how to handle these kinds of situations.

Also, I do support some of the things that Mrs. Washington said about the difficulties with some of the

specialties, when you are on call every other night or every third night, it is much more difficult, especially if you are married or have children or both. And there could be improvements made if these schedules were somewhat more realistic both for men and women.

Or perhaps these things -- these things can be overcome if the woman does have financial resources too, to obtain child care and household help and things like this, but when you come out of medical school with several thousand dollars worth of debt and the -- you're not making that great a salary, it still is very difficult to overcome those things.

I don't know, it used to be that housing for interns and residents was wanted, I don't know, residents and interns don't want it anymore. I think something, though, along that line, of day care or maybe even housing facilities near the hospitals and things would be useful.

But --

A. (By Dr. Thulin) Could I say something about the flexibility of the programs in residency and internship?

I -- you know, the administrative heads and the department heads say, well, we don't want to disturb our scheduling. Because it throws a monkeywrench in everybody's time schedule. And it is true that setting up special hours or dividing residencies among two women or a man and

a woman takes a little more trouble in devising that schedule, but it can be done.

I can cite to you the presence of a person now who is in the clinical years, who was admitted to the school of medicine with a, what I would consider a serious drawback on his credentials, but again this was a -- this was a male committee, analyzing and conceiving other males coming into this program, a member of the Bronco football team was admitted to the school of medicine. His schedule was carefully arranged, is to this day carefully monitored, very specifically, he gets exceptions and no one says a word.

THE CHAIR: Thank you very much for your participation and your help. We appreciate it.

Dr. Riley, Dr. Beck, Dr. Prugh and Dr. Ward, please join us?

Good morning. For those of you who weren't here earlier in the morning, I'd like you to know the fellow committee members who'll be asking you questions,

Bob Frey on my immediate left, Don Sears next to him and Cas Garcia on the end.

Would you introduce yourselves, please?

DR. RILEY: I am Conrad Riley, and I am Associate Dean for Admissions. At the medical school.

DR. BECK: I'm Paul Beck, the Associate Dean for Student Affairs at the same institution.

DR. PRUGH: I'm James Prugh, the Director of the Affirmative Action Program at the aforementioned institution.

DR. WARD: Dr. Harry Ward, and I'm a dean at the medical school and the Acting Vice President.

Q. (By Mr. Frye) Dr. Riley, I think you and I are going to start off here, if we may. Would you state again, please, your position at the university? I'm sorry, I --

CONRAD RILEY, M.D.

A. (By Dr. Riley) I'm the Associate Dean for Admissions.

Q. All right, sir.

Would you outline for us the criteria for admitting candidates to the school of medicine?

A. They -- an applicant for medical school has certain prerequisite courses they must have taken, and as Dr. Pollock said earlier, they're very limited in number but they have to have had two years of chemistry, one of physics, one of biology, and enough literature and English, hopefully for them to be able to communicate well and math up through trigonometry.

Then, assuming they have these criteria -- these prerequisites, they -- the only requirement is that they have reasonably good grade point averages, reasonably good

MCAT scores, the medical college admission test scores, and how good we don't have any specified level, On either of these objective criteria.

Then we also use recommendations that are supplied by undergraduate faculty, by outside people as they may obtain them, and then we interview all candidates and every candidate is interviewed by at least two members of the committee.

And then we look at the applicants and try to compare them with each other, and try to choose the best 125 we can.

At the present time we are in what I call a real crunch because in the past five or six years the number of individuals wanting to become medical students has become tremendous. We have sort of a way of combining the objective data of grade point score -- averages and the MCAT scores into a single figure. And if you look at what I consider an adequate figure that would be -- insure little or no risk for the incoming student from the academic point of view only, We have some 707 of our applicant pool this year that would have fit that -- those criteria, so trying to winnow it down from 700-odd students to a class of 125 is a very difficult process.

Among the nonminority students, the grade point average that we've been accepting over the last few years

has become ridiculously high, it's so high that I think it's meaningless. And we try not to look at that as the only criterion by a long shot.

Among the minority applicants, we do have a special subgroup as Mr. Clinkscales mentioned earlier, that involves itself primarily with the minority students but the entire committee also participates in the process and does some of the interviewing, and no minority candidate is accepted on the recommendation of the minority subgroup by itself, they are discussed quite fully in the entire committee, and they are chosen on the basis of things other than their objective criteria because, as I -- some of the previous speakers have pointed out, the objective criteria do tend to be lower than among the nonminority candidates.

And when I use the word minority here, I mean ethnic minority.

Dr. Thulin was asking what kind of policy we have about women, I've never heard a policy expressed in the 15 years I've been here and on the admissions comittee and I have seen no need for a policy expressed because it seems to me that we've had some excellent women that have come along, have been accepted and then, very often, in about the same proportion in which they apply in the last few years I notice that they've been outrunning their male counterparts in proportions. We took, last year we took, I think,

about 30% women over a pool, the applicant pool was about 19 or 20%. So this was not done intentionally, it wasn't done with any regret either. We've just been taking women as they look good to us, and they look good.

Q. All right.

I've got a lot of questions all at once here.

You mentioned the subcommittee of the admissions committee, I didn't hear Mr. Clinkscales, I'm sorry, could you tell us what the makeup of that subcommittee is?

A. This year it's been a subcommittee of three of the members of the regular committee, one of them himself a minority, and two other individuals who have expressed particular interest and concern about minorities, and then we've had a regular interviewing member who couldn't be a member of the full committee because of time commitment, from the practicing community who is a representative of the minority group also.

And those four have done most of the interviewing, there have been, occasionally, other -- other people from outside who've joined in the interviewing and as well as other members of the full committee who also interview the minorities too.

Q. All right, and then the full committee, how is that determined?

A. The full committee is appointed by the dean, and it

consists now of 15 individuals, three of those are from the basic science faculty, Ph.D's, the rest are M.D's, two of the members are from the practicing community and one of the members, at the present time, is from Denver General Hospital who's on the full time faculty, but not at the medical center proper. Three of the -- well, we, in the past year have incorporated student members of the committee, one from each of the upper three classes, two of the student members this past year have been women, one of the M.D's on the committee is a minority on the full committee, and two of the faculty members of the committee are women also. So that we have four women on our committee in total.

Q. Four out of the 15, then, are women?

A. Correct.

Q. And one minority you say?

A. One minority.

Q. Male or female?

A. He's a male.

Q. All right. When you interview women and minority candidates do you always include one of their sex and one of their ethnic group, if possible, or what's -- how do you determine who interviews the candidates for admission?

A. The interviewers are really assigned by my secretary and I don't think she pays much attention to -- this is in

the nonminority procedure, the minority procedure is separate. So let me talk about, and as I say, we have not considered women minorities. So that whether a woman gets interviewed by another woman or not is more or less chance. We try to be sure that no one is interviewed by two Ph.D's, and we try to be sure that no one is interviewed by two students, so that a person may be interviewed by an M.D. and a Ph.D. or a student and a Ph.D, or -- it's -- hopefully we try to randomize it as much as we can, and we do not interview in sort of continuous teams, so that person A and person B always work together, we keep trying to rotate that.

So that it's fortuitous by whom one gets interviewed.

Q. I saw some background statistics, Doctor, that indicated less than all of the candidates for admission were interviewed and you stated a moment ago, I think, that they were all interviewed. Did I misunderstand?

A. I probably said it wrong. Not all the candidates are interviewed. Out of the, what we have, I think something like 900 completed applications the past year, we were able to interview about half of those candidates just by virtue of time. We began to interview in August and continued right up through March when the final selection date was done. And we were able to interview about 500 total. Now, the way we screen who will be interviewed is by

looking at what objective data we have available, by the recommendations available, and we also, we don't look very seriously at non-Colorado applicants, people from out of state, we accept, from the WYMALI states, those are the four states in the western area that don't have their own medical schools, Wyoming, Montana, Idaho and Alaska.

And so we do go through a preliminary screening, trying to decide which ones we will invite for interview. And we, as I say, did actually interview about half of the applicants that completed applications last year.

Q All right. Now, do the members of the admissions committee have any particular training in interviewing techniques or evaluating the individual candidates? Do you run them through any kind of an in-house or otherwise training session?

A Usually, when we have a new person come onto the admissions committee we do ask that they sit with one of the older members, just to see, or actually they sit with several different people who have been doing the job for a while, and they get a feel of the different techniques that they use. Now, we don't have any formal type of training.

Q All right.

Let me go back, if I may, to the factors that you mentioned, the GPA's, the MCAT recommendations and the

interview, if I understood what your -- what your total critera were. Who determines how these factors are weighed in any individual case?

A. This is determined really by discussion in the committee as a whole. In other words, each person who has criteria that make them look as if they might be highly acceptable is brought up for discussion, and the people who have done the interviewing and the people who know something about it and the recommendations are looked at by the committee as a whole, and a determination then is made as to whether a given individual should be accepted or not.

It's very hard to say in any kind of a precise way what weight is attached to each of these. The interviewer, when he does his own rating, usually has available the objective data of the MCAT score and the grade point average, and he has also available as a general rule, the recommendations from the premedical faculty, and so that his rating then is based on his knowledge of all these factors, and so that how these things weigh is, I don't think I could state in a mathematical form, and they are -- they all come up before the committee as a whole.

Q. It's a somewhat subjective process then, I gather?

A. It certainly is when you have so many people that objectively look entirely acceptable and the final selection is subjective.

Q. Let me ask you a question, have you formed an opinion about the validity of the MCAT as an indicator of success?

A. Yes, I think that if somebody does up to, let's say above the 40th percentile in the MCAT, broadly the chances are he'll do well, he or she will do well in the didactic first two years.

And I think this is a reasonably good correlation. Below that level we don't have an awful lot of experience because we have used it as a criterion of selection and we haven't selected down very far in it.

Q. I see, and you say the first two years that would exclude the clinical?

A. Yes, I think many people who have looked academically not very strong in undergraduate years, and I now refer back to the days when we had the luxury of accepting people without such high grade point averages, I'm now referring to nonminorities, our experience was that if they managed to survive the first two years, there was no predicting what they might do in the clinical years.

Some of them turned out to be excellent and others just, once they're exposed to the patient problem, didn't turn out to be very effective.

Q. I'm running a little short on time, I'm sorry, here, let me just ask a couple of quick more questions.

Do you actively recruit women for the medical school?

You said you have no policy as such.

A. No, Dr. Thulin, we do not actively recruit women. We have a very great and noble supply of women and we're happy with them.

Q. I see Dean Ward.

HARRY WARD, M.D.

A. (By Dr. Ward) I might just say a comment on that. I -- I'm sure that the committee has a court case that was -- that was heard in Colorado in 1972, in which the entire question of whether a medical school should consider women applicants in the affirmative action program was raised. It was the feeling of that court that there was no evidence that women were educationally deprived in science, and our policy has been in fact not to specifically recruit women. They are evaluated on the same criteria as all candidates, I think that it's important that we remember that this last year's entering class had 37 women.

If you take the number of women that are going into medicine or accepted into medical school, and -- they correlate very well with the number of applicants from women. And as, I think was emphasized by several of the speakers,

I think as the pool has grown, the number of admissions have increased, and I am -- I suspect that within five years, the American medical schools, certainly the University of Colorado, will probably have 50% women in the entering class.

It's been quite a dramatic growth.

Q. Let me ask the obverse, then, do you require higher MCAT's or higher GPA's for women than you do for men?

A. (By Dr. Riley) No. I would say we go through the entire same process for the women and the men and don't make that kind of distinction.

Q. Do you have a goal for women or a goal for minority students? In terms of --

A. We have no goal for women, that is in numbers. We have a goal for them, to become good doctors. But we do have goals, more or less, for minority students, that we have been striving to reach, and at this point we have not quite gotten to the goal of roughly a quarter of the class being minority students. This has been gradually rising, at the moment we're up to within two for this oncoming class, if they all remain in the class that we've offered places to for this coming year.

MR. FRYE: Thank you.

THE CHAIR: Dr. Beck, as I understand it, as Dean of Student Affairs, you are concerned with the academic problems

of students. Are the tutorial -- the summer program, the tutorial program or special counseling, are they directly within your area of responsibility as dean of student affairs?

PAUL BECK, M.D.

A. (By Dr. Beck) I would say as a generalization of that question, yes, although not totally in any one of those areas.

Q. (By the Chair) Could you just very briefly outline those programs and comment on your view as you see the students that are coming with academic problems as to whether these programs are adequate and are -- or are they being utilized?

A. With regard to students accepted to medical school, I'll limit it to that, I don't think you should ignore, I might add parenthetically, the high school preprofessional course.

This may be one of the major factors that may improve the total performance that we will see later on in students. Also, I think adding parenthetically, this kind of process as has been alluded to earlier today is really something that goes over a generation, not just two, three,

four or five years. But forgetting the preprofessional program, we would start in this educational sequence with the summer program. This has been produced in our institution for the last three years and it is a plan to put on another course this summer.

Each year the goals of the program have changed somewhat, and this has been dependent upon the feedback that we've obtained from the students and the instructors who have participated in the program and to a certain extent, from the faculty as a whole, as they've seen the results of the product of the program. It would be fair to say that the summer program has not been used fully, there are certainly, as has been alluded to earlier, there's certainly some suspicions on the part of minority students that they might be singled out for such a program and indeed one summer when we did virtually require every minority student to attend, the backlash of attitude from the students was so severe that we have backed off from that.

So there is the attitude, there is a problem of suspicion on the part of some of the students as to whether this is something for their benefit or something to earmark them to keep an eye on them further down the road.

I -- as has been alluded to earlier, there is really no objective data at the moment as to whether these programs in the summer have been effective or not. This really

requires the look at about four years of experience in terms of total numbers of students to be able to find out whether they have really shown a difference in performance, particularly in the first two years of medical school.

The numbers of students that have taken these programs over the summer have varied from two minority students in one summer to as many as about 14 or 15, I think the first summer. Obviously these numbers are too small to make any broad generalization since a lot of individual factors relating to individual students may have a strong bearing on how the course may affect them.

I would dare say, however, that in interviewing the students who have taken the course during the last two summers, that is those who were not required but who voluntarily took the course after it was offered to them, the majority of these students according to the surveys that we have taken of the individual students, have indicated that they thought it was helpful to them.

Now, the help seems to be more in the area of giving them some idea of what to expect in terms of the difficulties of the medical school courses, the time requirements and so on. There's been lessfavored comment about whether the things that they've learned have actually helped them that much in medical school. I suspect that the reason that this is the case is that the summer program has been limited

to about six weeks each time, one of the reasons for limiting it to that amount of time is to not burn the students out in the summer course before they got started in the regular school year.

I don't think that 12 weeks would be enough, either, I really think the problem goes way back beyond that and it seems to me that the things such as the preprofessional course for the high school students which would stimulate their interest in this type of activity, would point out the things that they need to learn, the skills that they need to obtain is going to be the kind of thing that's going to help prepare minority students in particular for medical school in a long run.

Now, I've only answered part of your question there.

Q. I think I asked too big a question. I'm sorry about that.

It was alluded to in an earlier panel that perhaps faculty and staff should be sensitized to the special needs of minority students and economically disadvantaged students. Is there any formal orientation or training which does this at this time?

A. First, there's no formal orientation of faculty for this purpose at the medical school, but I really question, in a long run, whether there's any program that can effectively sensitize people, even -- it's been alluded to that

industry has these kinds of programs. Certainly the program is put on. The people may be brought there, they may be compelled to be brought there, but attitudes don't change just because you're told to change an attitude.

I was thinking about this particular review session this morning as I came here, I review my 37 years of experience in this area. I'm a product of Denver public schools, I'm a graduate of Manual High School, the class of 1951, where I was class president. I've lived with minorities a good part of my life. I point out at that time that high school had a composition of about 40% Black, about 25% Chicano and obviously there was no majority in that school at that point in time.

My experiences through the growing up period indicated to me that the kinds of things that sensitize people were day to day interactions with each other, because it's that kind of thing that helps to bring out the kinds of problems that individuals have. One can point to the problems that groups of students or groups of people may have but they may vary quite a great deal from one individual to another.

It is my opinion, I'm not sure that it's shared by the rest of the members of the faculty or the panel, but it's my opinion that as more minorities come into medical school and more faculty are exposed to these students,

they become sensitized by the very fact that they have to begin to work with them and become aware of their -- that they are individuals who have individual problems, and I think this process has been reflected within our own faculty.

Three years ago it was certainly not the case that we could get tutorial assistance from the members of the individual faculties of the individual departments. This year I can assure you that there are some kinds of programs, some maybe better than others, some maybe not as good as Mr. Aragon has alluded to, that he would like them to be, but nevertheless there are people in each department now who are willing to provide help, I think as they become more aware of what the students are facing, they, in turn, may change their techniques in terms of helping the students.

Q. In the current year only about 12, or I guess it's about 2% of the total of 593 residents and interns at the university are Black, Spanish surnamed or Native American. In your opinion, why is that so low?

A. Well, first of all, let me point out, in the subsequent year, beginning in July of '75 there will be at least 13 new additions who are minority to the house staff program, of whom about half will be Chicano. I think one of the major reasons is simply the fact that more of these people are becoming graduated from medical school and

as the pool of available people increases so too will the number of applicants increase.

But I think it's no -- it's no secret that the faculty are becoming more sensitized to this issue and indeed one of the standing committees of the faculty, the minority affairs committee, has taken an active role through one of its subcommittees, this year, to encourage the various program directors at our institution to accept graduates from our program in their own training programs.

And I think our success rate has been 65% of our total minority graduates this year will be taking their house staff training in our programs.

Q In your opinion, are women at a disadvantage in getting into certain specialties that have been mentioned before, such as surgery and OB-GYN? Do you feel they are at a disadvantage?

A Yes and no. I think Mrs. Washington really pointed out one of the major hazards. There are certain aspects of certain of the training programs which do emphasize a certain amount of increased commitment of time and less flexibility of time than others do. For our surgery program at the University of Colorado School of Medicine it's still a mandatory thing, as I understand it, for the residents to be on call every other night.

That is far more demanding than is true nationally,

even in surgery programs, but that very fact, I think, would tend to -- tends to discourage most of our students from going into surgery, period. Only about 67% of our graduating class wants to go into surgery, so I think that is reflected in the total student body.

I think for a woman who has some children or -- and a husband to take care of, I'm certain that many of the husbands feel a need for dependency gratification at times, this poses a problem. And that's going to discourage them.

The other side of it is whether or not the faculty members and the program directors themselves, per se, are saying no, we don't want you because you're a woman. I think that this is not an overt type of activity, although at times the fact that the demands of duty are so great, this may cause the program director to make these kinds of insistances. I can't -- these are all conscious-type things and these are all performance-type things. And I'm sure that's what you're really driving at. I don't propose to speak to the underlying subconscious attitudes.

THE CHAIR: Thank you, I've run out of time.

We'll let the rest of the committee members get back into it later.

Q (By Mr. Garcia) Dr. Prugh, I believe we're on and cast our sail.

DR. DANE PRUGH

A. (By Dr. Prugh) Yes, Mr. Garcia.

Q. I understand you're the affirmative action director at the C.U. Medical Center. Could you tell me what representation do minorities and women have on the full time faculty of the school of medicine?

A. Yes. The percentage of women as mentioned by Dr. Thulin, there -- I won't, there might be minor shifts in those statistics.

Q. A rough approximation would be fine.

A. Well, the women are about 15% of the faculty, but most of those are at lower levels, very few, approximately ten are at the tenured level, the senior faculty level.

Among minorities, there are six Black full time faculty, let's talk about the full time faculty first, there are six Black full time faculty currently, there's seven Asian-Americans who are American Citizens. There are no Chicano full time faculty members.

There are three, as has been mentioned, part time Black and three part time Spanish surnamed faculty members who are the student advocates to which Dr. Chavez referred.

Q. I see.

What affirmative action is being taken to remedy this situation somewhat?

A. Well, in 1971, the Office of Civil Rights of HEW did an investigation of the medical school and medical center, and in 1972, the medical school was asked to set up goals and timetables for the recruitment of women and minorities. Those goals and timetables were set up at that time on a five-year basis.

I have to say we've gone from two Black faculty to six Black faculty on a full time basis, we've added several Asian-Americans, but we have not gotten very far in recruiting in that area.

The main problem is that the national pools are so small in the various specialties within medicine, a factor of anywhere from two or three Chicano biochemists, say in the United States, at the time the goals were set, to the largest group of minority physicians is -- was then 250 Black psychiatrists. The problem is with all schools in the United States trying to recruit, there are 105 of these, and therefore the chances of getting even one of the 250 Black psychiatrists would be very small.

Partly because a number of those are in private practice. So really, the recruitment from potentialities for minorities lie in the internal pools to which Mr. Clinkscales and Dr. Beck and others have referred, and these are increasing and just this -- in the residency group which has been selected for next year, as Dr. Beck mentioned,

we're beginning to see the graduates of our program stay on as residents or house staff and hopefully in three to four years by the time they've finished their residency programs, a significant number of these will stay on as junior faculty.

The problem with recruitment of women is not difficult as has been mentioned, at the medical student level presently. It is still difficult at the faculty level because there have been fewer women graduates.

The goals and timetables have not been met but we have two more years to try to meet these.

Q. Could you tell us how your internal hiring process operates, for instance, how does the -- what role does the department chairman play, for instance?

A. In the hiring of a faculty member?

Q. In the hiring of a faculty?

A. Well, this depends on the level of seniority of the position which is being recruited for. If it's a senior position then a search committee would be formed, and as has been mentioned, many of those search committees have not had representatives of women or minorities on them.

In part because we have so few faculty members in this -- in these two categories, but I think we could do more to make sure that minority or women representatives are on those search committees. The search committee, then, would

carry out a national search by writing to various individuals in the field that's being looked for.

As of January 1st of this year, Dr. Ward and Dr. Singleton, the associate dean for faculty affairs, and I, have worked out a set of faculty guidelines which operate through the office of affirmative action, when a faculty position, whether a search committee is formed or not, comes open and a search is to be made, the affirmative action office is notified and the -- I give a recruitment packet to the faculty member or the chairman of the search committee with lists of organizations which are interested in the recruitment of minority and women to whom they can write, to give a job description of the position.

That includes NCHO, which Mr. Lopez is active in, and other organizations.

We ask the faculty member or the chairman, if he is involved, the chairman is always involved in the final appointment but he may not be the chairman of the search committee or he may not be the faculty member who actually undertakes the search.

I ask him to advertise in a women's journal, the Journal of the American Women's Medical Association, in at least one minority journal, the Journal of the National Medical Association and in the Affirmative Action Register, which reaches a large number of individuals, both minorities

and women. They write to a number of other organizations, they contact individuals in minority and women's fields who might know of persons and this is the process they go through.

Q A little earlier you mentioned that you might be able to do a little better in putting women and minorities on the search committees, for instance?

A Well, for instance, one major committee on which I sit as -- incidentally, Dr. Ward, last fall, asked me to be a member, ex officio, of each search committee, and I got permission from him for Mrs. Thawly (Phonetic), my co-director and now Mr. Les Trujillo, who has joined our staff as codirector of the office of affirmative action, to represent me on search committees, but in one instance I am a member of the search committee, ex officio, but I'm also representing the department of psychiatry, which is my basic discipline. I was a pediatrician many years ago.

And on that committee there are no women. Or minorities.

Q How do you assure, for instance, that the school, that each department within the school of medicine, implements the affirmative action plan that you have?

A Well, this is one of the major tasks of the office of affirmative action, to monitor the action, which hopefully will result in the righting the wrongs of the past and in

developing affirmative action. We do this in various ways. We have a yearly statistical collection of data, which indicates what change may have been made in the composition of departments at the student level, at the faculty level, and at the staff level. Which is out -- which may involve nonacademic employees of the medical school.

We then help the chairmen of departments in the medical school to try to find ways to recruit more minorities and women, but we can only give them a certain amount of help but our main job is to monitor what's happened.

Q. I see. Is there any method, shall we say, of assisting a department that has been somewhat remiss in their duties?

A. The method that I've mentioned, just being the faculty guidelines which now have been in effect only for -- since January 1st, I think is one very important method, of assisting what external recruitment can go on. But the question of sensitization of individuals or departments has been raised.

My codirectors and I have met at times with certain departments, we haven't been able to meet with them all at the present time, to try to discuss the nature and goals and -- of the affirmative action approach.

We have, with Dr. Ward's help, now identified liaison officers in each of the schools and the administrative units

of the medical center and we hope these liaison officers will be able to help us in such an educational approach.

Q Since we're running short of time on our portion, may I ask you one final question, what recommendations would you make to deal with the mis -- underrepresentation of minorities and women on the school of medicine's faculty?

A Well, I would subscribe to a number of recommendations that have already been made. I think the major step that I would feel is important, and I had talked this over with Dr. Ward and members of the faculty, would be to set goals and timetables for recruitment of women and minorities in all student groups within the medical school and throughout the medical center.

The Office of Civil Rights of HEW made a recent audit of our situation and I believe they are going to recommend this kind of approach. I have the intention of asking the chairmen within the medical school, and the deans of other schools, to set such goals and timetables and I won't say I disagree with some things that have been said, but I think that women still do need to be recruited.

Or -- excuse me, they are applying in sufficient numbers, but I think we need a policy and a goal and a timetable set in the acceptance of women.

MR. GARCIA: Thank you.

A My fellow faculty members here may not agree on that.

MR. GARCIA: Thank you very much.

Q (By Mr. Sears) Dr. Ward, we've had pieces about the minority programs at the medical center but I think an overview might be helpful at the outset. Just what kinds of minority programs does the medical center have? Would you comment on that?

A (By Dr. Ward) I think we have had a lot of little bits and pieces and let's, if we could just go through it, maybe in the sequence of a medical student. I think it's important also to start off with the fact that this is a program that has about, now, a six to seven years of history, that I think we're just now starting to see the -- some of the results.

Number 1, as was stated, we have a high school -- high school course which we've taken Manual students and now Manual West and North. I think it's been a good program, Mr. Ward at Manual High School certainly is very pleased with it and we plan to continue that.

We will start seeing this next year, in the applicant pool, the first students from this group of high school applicants.

Second area that we started was the specific efforts for minority recruitment. This is the office that Mr. Doug Clinkscales currently is the supervisor of. We then get the students admitted, we then have a summer

program, you've heard some pluses and minuses of the summer program, I'm not convinced that it's all that successful. But we continue to change it, working with the students in that.

The next program are the various retention programs that you've heard about, we have a -- we've just employed Mr. Yamamoto with a specific emphasis for educational skills for minority students. I started in 1972, this student advocate program with three Black physicians and three Chicano physicians from the community in order to serve as models and student advocates.

We've heard that that might be a plus or minus. We have expanded our own counseling program throughout the school, we currently are recruiting for a specific Chicano counselor. After the student graduates we've already had some discussion of the house staff, I think in fact our house staff program has been a small program for minorities, this year 15 of 106 interns selected are minorities, which is larger than our total pool at this point in time.

The end result of all of this is I think to go back to some of the opening statements this morning, I think the statement was made that up to 1970, we had only graduated 14 Chicanos and seven Blacks in the entire history of the University of Colorado School of Medicine. Absolutely

awful number. 14 plus seven is 21.

I think we currently have, in school right now, approximately 75 minority students. I don't have the numbers of the graduates of women from the school of medicine up to 1970, but we currently have more than 100 women in the school of medicine. So I think that we're, as I say, that we're now starting to see some of the product.

The last program, and I think that I would like to mention, is the faculty recruitment. We've had almost no results in faculty recruitment. I think it's very clear. A lot of reasons. We've set up goals and timetables, we've worked with the departments, but we still have had almost no results.

Now, we've talked about the smallness of the pool size, no question about it. The other real problem that we've had is new state FTE's positions. Since I've been dean in 1972, I think we've only had something like nine new faculty positions over the past three years to even recruit to. Unfortunately, at this point in time, the school of medicine historically had reached a fairly level plateau, had recruited its faculty, and we have a very low turnover, and are not growing in faculty size, so that's been a problem.

But regardless of all the problems we haven't re-

cruited any minority faculty, of significance, and for that reason, we have instituted a very significant review in which we will -- our office will not -- will not approve any faculty appointment until we have concrete factual evidence of every effort being made for recruitment of women and minorities.

Now, the efforts that are going in, I think were reviewed by Dr. Prugh, we're contacting all national organizations, we're contacting various societies, we're placing advertisements, and we have -- we now have sort of a checkout sheet that has to be signed that this has to have been done.

I'm optimistic that we're going to change some of the faculty employment numbers over the next year or so, but I, you know, I -- we obviously are going to need a year to see.

Q. We've had some statements about at present, less than 10% of the women faculty members hold positions at the rank of associate professor or above, compared with nearly 50% of the male faculty hold such positions. What are the reasons, what do you believe the reason to be for this disparity?

A. I think that many of the -- many of the faculty appointments for women, and I would have to get all of the numbers that really go into this 15% of the faculty being

women, but many of those positions, I believe, are positions that are not in the normal academic ladder, or thus they are individuals who are in the allied health programs, who are physical therapists, occupational therapists.

Now, these people are given faculty rank as defined by an associate title or what is the title that we use?

A. (By Dr. Riley) Senior instructor.

A. (By Dr. Ward) Yes, senior instructor, and then the highest next appointment is senior instructor.

They are not in a normal academic, and the majority, I'm sure, but I don't have those numbers and would be pleased to provide this to the committee, but the majority of the women faculty that I think you're talking about are individuals from physical therapy, occupational therapy, med. techs. that are not in the normal academic ladder.

As far as faculty leadership in women, again we have some absolutely excellent -- excellent individuals but number-wise, it's too small.

Of interest, as I'm sure most of the room knows, and the committee, Dr. Hope Lowry, who's an associate professor of medicine, was in fact the head of the admissions committee for many years before Dr. Riley accepted the position. We have several full professors that are women, Dr. Lupshinghope (Phonetic), in the department of pediatrics, who's a national -- nationally-known leader,

Dr. McKinzie, who's in biochemistry, but number-wise, I would certainly agree, we need to have more women.

Q. One more question, how is eligibility for promotion and tenure determined?

A. The -- there are certain guidelines, we work under the guidelines of the American Association of Universities, I guess, and that is that there is a maximum of seven years in which one can serve as an assistant professor, so it's the seven-year up or out kind of rule in which the department and the chairman make a recommendation that an individual should be promoted into an associate professor level, which is that level that starts tenure.

The faculty officers, plus the dean, then forms a special committee, a separate committee for each faculty suggestion, and this ad hoc committee evaluates the individual's credentials.

They're evaluated on the basis of research, of student teaching, of service, of administration, there's no specific numbers given to any of those areas.

At the end of that time, the ad hoc committee makes its report, and if it has recommended promotion, this goes into the executive committee which is formed of all the department chairmen that have the final decision making ability. They make that decision and then recommend it to the dean and I submit it in to the president, and to the

board of regents.

THE CHAIR: Yes, I'd like to ask a question, I'm not sure whether Dr. Ward, you or Dr. Riley is the appropriate one to ask this of, I'll let you decide that. But who makes the decision as to whether or not there will be recruiting, for instance of women? Who decides, whose decision is that that there is no policy or that there is no recruiting of women? And if someone thought that that should be changed, who would they talk to?

A. The guidelines for admission are under the rules of the regents, or the decision of the faculty of the school, so if a specific guideline regarding an affirmative action for women for admission to medical school was to be proposed, it would be proposed via the entire executive faculty, that it's called.

The -- and the executive faculty is to establish the guidelines for admission.

Q. (By the Chair) Thank you. And another question. Is the -- this is something that just occurred to me and I don't know if there is an answer to it.

Are we adequately meeting the needs to deliver health services by the number of doctors that are being trained? It all seems to get down to this numbers crunch that is so desperate in the final analysis. Is there -- are we training enough doctors?

A. I don't think it is a numbers crunch, I think it's a distribution crunch. All the -- you know, this is a very hard question to answer, the -- I think that the majority of opinion today would be that we're probably training enough numbers of doctors, but they're not moving into the areas in which they should be.

They're not moving into the ghetto areas of the city, and they're not moving into the rural community. Now, to attack health distribution problems, there are many ways to attack that. Certainly one is at the front door, the kind of students that you're admitting. This is one of the reasons that we have in the past few years tried to make significant efforts to increase numbers of students from the rural communities, to place more and more emphasis on the interview, a more subjective thing, take less emphasis on the MCAT.

Thinking that we can perhaps broaden the base of students. We have reduced admission requirements. We used to have a string of admission requirements that would almost choke you, and we still do have a fantastic string, but they're about 25% less than they used to be.

To try to get a broader based student, hoping it will be the kind of student that will be interested in that.

THE CHAIR: Thank you.

Are there questions from the committee members?

Bill?

Q. (By Mr. Muldrow) Dr. Ward, my question relates to the participation of minorities and women in the decision making processes of the school of medicine. You've indicated that great changes are taking place and statistics do show increases. I'm wondering, it seems -- my question really is, how much of the decisions which have gone into the changes are participated in by minorities and women?

For example, you mentioned the executive committee of the school of medicine, which has the final decision regarding tenure and promotion. In the last five years, how many minorities and women have been a part of this committee which would seem to be a very vital decision making body?

A. Well, Mr. Muldrow, you know that answer. If the executive committee is formed of the department chairmen and there are no women or minorities that are department chairmen, then obviously the executive committee has no specific representation.

Now, the only hooker on that is that several years ago we included in the executive committee the faculty officers. And we have three faculty officers, and this year one of the faculty officers is a woman. And so she is on the executive committee.

In addition, in the executive committee as ex officio

members, are my staff, and the -- and these members take very active roles at the executive committee, and Dr. Hope Lowry, who has been an associate dean for the past, very close to a decade, has always served on the executive committee in that capacity.

Q Just to follow up on that, the executive committee is composed mainly of the faculty chairmen who are all men. Would you advocate a change which would enable more participation at this level by women?

A I would like to see a -- I think if I understand your question, I would like to see us appoint as a departmental chairman, a woman or a minority, and/or both. Now, if you're asking -- if what you're asking, would I like to see one of the chairmen be a woman and/or minority, my answer would be yes.

If you're asking would I like to see the executive committee change so that it is not formed of totally department chairmen, is that what you're asking?

Q That's the question, yes.

A As an administrator, I sometimes have the feeling that I'd like to abolish my entire executive committee. This is a -- this is an important committee, obviously, but it -- and I don't think it's probably really very appropriate for me to remark one way or the other whether I would like to significantly change it. There is a

mechanism that this can be done, but it represents a bylaw change, it's very difficult to achieve.

A. (By Dr. Prugh) Could I add a footnote to that?

There's another way in which minorities and women might be eventually admitted to the executive committee and that would be to shorten the tenure of the chairmen of departments, this is a trend that's going on all over the country and about five years ago I was a member of a committee, a governance committee, which did recommend shortening the tenure to 15 years instead of lifetime appointments as present arrangement stands.

That recommendation was not accepted by the executive faculty but there are ways which are being carried out in, I believe more than half of the medical schools in the country to at least have some turnover on the executive committee.

A. (By Dr. Beck) The executive committee does a lot of work and sets a lot of policies but there are a lot of other committees in the school which have tremendous bearing on how faculty and students fare.

My particular -- three committees that I've sat on in the last three years which I think fit this category, two of these are the curriculum and promotions committees and a third one is the minority affairs committee.

I think it's fair to say that women and minorities

have had increased input to the deliberations and actions in those committees, and while there may not be as many votes held by women and minorities on these committees as these groups might like, I think it's fair to say that by attending these meetings, presenting issues that pertain to the specific problems of women and minority students, the male chairmen who sit on these various committees, on the curriculum and promotions committees, in particular, have been quite a bit sensitized tomany of the problems that the women and minority students face.

And I do believe that this has resulted in changes in their performance, as far as their dealings with students.

An example of one that's a practical issue to women is where do you sleep when you're on night call in the hospital? In the junior and senior year of medical school. I think four or five years ago it would have been tough to get a department chairman to worry too much about that, he would have said go down the nurses' quarters and sleep there. This past year I've had an example where, by changing of room arrangements in one of the hospitals, the sleeping quarters for women on a surgical service has been wiped out. I found that there was great willingness and enthusiasm on the part of the surgical chief at that particular hospital to solve that problem. As I understood

it was solved within about 24 hours. So I think these kind of changes are evolving and it's because faculty are becoming sensitized and I think it's because women and minorities are getting their voices heard in some of these other committees.

THE CHAIR: Thank you.

I have another question I'd like to ask. Who makes the decision on whether tenure of department chairmenships would be changed or not? Whose decision is that?

A. (By Dr. Ward) That again is the decision of the entire faculty, that's a part of the faculty bylaws. Dr. Prugh is a little bit incorrect, a departmental chairman serves at the pleasure of the dean in the school of medicine, he is not given a lifetime appointment.

We are, in fact, having now a significant kind of turnover for department chairmen. We have just appointed a new department chairman for the preventive medicine department, psychiatry department plus the pediatric department.

Of interest we -- well, and then in addition, we are looking for a new departmental chairman in otolaryngology, and in the department of medicine.

We, as I've mentioned, are making every effort to recruit minorities or women for these positions, we have been unable to identify a single woman or single minority

for otolaryngology. We have -- I believe -- some excellent candidates for medicine. And they're just now starting to come to interview.

For the department of pediatrics, we had some excellent women candidates, and ended up making a decision for a male candidate. But we had some excellent women candidates.

THE CHAIR: Thank you.

Any other questions?

Bill?

Thank you very much, Dr. Riley, Dr. Beck, Dr. Prugh, Dr. Ward, very much for your help and your participation.

We will adjourn for lunch now and thank you to all of the participants for taking part so freely and openly this morning.

We very much appreciate your help, we'll reconvene at 1:30 to consider access of minorities and women to the legal profession.

(Recess for lunch)