The Foundation of the American Academy of Ophthalmology
Museum of Vision & Ophthalmic Heritage

Conversation Between Mildred M.G. Olivier, MD and J. Bronwyn Bateman, MD
Orlando FL, October 22, 2011

Drs. Mildred M.G. Olivier and J. Bronwyn Bateman recorded this conversation on October 22, 2011 during the Annual Meeting of the American Academy of Ophthalmology, in Orlando, FL.

In this excerpt **Dr. Olivier** describes arriving days after the devastating 2010 earthquake in Haiti. **(.mp3 file)**

Here**, Dr. Bateman** discusses her work establishing the Rocky Mountain Lions Eye Institute at the University of Colorado at Aurora and her leadership roles in other organizations. **(.mp3 file)**

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MILDRED M.G. OLIVIER: Mildred Olivier. Today is October 22, 2011. I'm in Orlando, Florida.

JANE BRONWYN BATEMAN: Jane Bronwyn Bateman and we are in Orlando, October 22, 2011.

MILDRED: So, Bronwyn. First of all, even your name is not very easy for some people to say, so perhaps you can tell me how you got your name.

BRONWYN: Well, first, I'd like to say I'm delighted to be here with you, because you are such a wonderful lady and have been a great friend to me and the specialty of ophthalmology. I have enjoyed sharing a room with you at meetings and getting to know you well. In Haiti, you are well-respected and I very much enjoyed meeting your friends and colleagues. You are a fun traveling companion - and I want to thank you.

Well, my father was a Welsh illegal immigrant who was an officer in the U.S. Navy in World War II and Bronwyn is a Welsh name.

MILDRED: So that's how it started.

BRONWYN: That's how it started. And the Batemans used to fight off the English in the mountains of Wales, as I have been told. So, if I get feisty, that's where I got it.

MILDRED: Well, I'm going to ask you about how you decided to go into academic medicine.

BRONWYN: Curious story. My mother was a pediatrician and graduated from medical school in 1941, and she did her residency during World War II, while my dad was busy with the U.S. military in the Pacific theater. I grew up in Long Beach, California and married my first husband, Roderick

Smith, right after medical school at Columbia University. We were the only two Californians in the class. Then, I became a resident at the Jules Stein Eye Institute at UCLA. He developed a mesothelioma, an asbestos-related cancer, in our second year of residency and I was glad to be back in Southern California as my parents helped me take care of him while he was ill. At the time, we thought he got it from asbestos exposure when he was a deckhand on his stepfather's commercial fishing boat. And I cannot thank Brad Straatsma enough for allowing me to stay as a resident at UCLA while he was ill. Both Bob Hepler and Leonard Apt were also wonderful during that period. As happens with mesothelioma, he passed away and the UCLA Orthopedic Library is named after him. After he died, the USC Cancer Center contacted me again to sort out the origin of the tumor and found me as Jane Smith. We found the asbestos exposure in a childhood home in Glendale, California.

MILDRED: Wow.

BRONWYN: And I worked hard to try to deal with it. Brad Straatsma sent me to Honduras for the senior resident rotation right after his death and I worked on improving my Spanish. Dr. Nicholas Odeh, the Tegucigalpa ophthalmologist who was trained in the United States, was our preceptor. He and his family were wonderful hosts and mentors.

So, I went into academic medicine because I wasn't sure what I wanted to do with my life, and it seemed to be a reasonable short-term plan.

MILDRED: You know, as you were talking, I was thinking, what can you say to other people who have challenges like that during their residency? I mean, you obviously had mentors that helped you to do something else, maybe let off some steam that way. Is there any advice you might be able to give somebody that goes through difficult times like that?

BRONWYN: I think my advice is to try your best to be strong and always have faith that you can move ahead and do a good job. And lean on those you trust. My family was very supportive, although they were as devastated as I was. My friends kept me going – I was the third wheel on several of my friends' dates.

MILDRED: So once you then made that choice for academic medicine, what about the specialty training? What was your specialty and why did you choose that?

BRONWYN: Well, again, I have only the most wonderful words and feelings for Brad Straatsma. He called me in and basically said, 'What do you want to do with your life?' And I said, 'I don't know.' And he made a suggestion: 'How about ophthalmic genetics.' And that was the era when syndromes were being described and before DNA was really harnessed to identify the gene defects in hereditary diseases.

MILDRED: So that's what made you go into…

BRONWYN: I didn't know what to do, so I said, 'Okay.'

MILDRED: So, in that era, you were at UCLA in L.A. Tell me a little about what you did there?

BRONWYN: Well, I took a Fellowship initially at UCLA with Art Rosenbaum and Leonard Apt, both talented and creative pediatric ophthalmologists. Then, I took a Fellowship with Irene Maumenee, who initiated and built ophthalmic genetics as a subspecialty in the U.S. Thereafter, I spent time with Marshall Parks, an insightful pediatric ophthalmologist and fabulous surgeon. Lastly, I took the Boards in both Ophthalmology and Medical Genetics (Clinical Genetics section). There are now five of us who have Boards in both Ophthalmology and Clinical Genetics.

While at UCLA, I ran the Medical Student Program and then the Residency Program. I managed to get RO1 grants from NIH to use then-standard techniques to map genes and eye diseases to chromosomes and thereafter identify mutations in regional candidate genes. The DNA methodology at that time was more cumbersome and applying the techniques to eye diseases was new. I joined the American Ophthalmological Society and I have loved the history of the organization and the people. And it was a wonderful chapter in my life at UCLA, an institution where there was respect and thoughtfulness for everyone.

MILDRED: So, I did sort of ask you why you went to that subspecialty, but didn't really ask you why you initially went into ophthalmology.

BRONWYN: The ophthalmologists I knew were happy, nice, and honest people.

MILDRED: Had you known an ophthalmologist then or…?

BRONWYN: I didn't know any ophthalmologists before medical school.

MILDRED: So you just picked that as an area of interest?

BRONWYN: Out of a hat.

MILDRED: So you were in L.A., but then you went on to other things in your life. Why did you leave L.A. and why did you go to the University of Colorado?

BRONWYN: I was offered the position as Chair of the Department. My current husband is a skier and I thought this would be a good match. He was (and is) in practice in Sacramento and there are many nonstop flights to and from Denver. The University of Colorado needed support to build an eye institute. The Lions of Colorado and Wyoming had already made a commitment of $6 million to the University to build an eye institute, but they only had about $100,000 when I arrived. I thought this would be a challenge and that I could meet interesting people and learn about this area of the United States. I took a 6 PM flight from Denver to Sacramento on Fridays and a 6 AM flight from Sacramento to Denver on Monday mornings – my husband called this the 'flight from hell'.

MILDRED: Wow. Well, I was thinking of the social challenges that affect professional women in terms of relationships and you were a widow but yet, you were able to meet a second individual and get remarried. I wondered how these issues impacted you as you were transitioning from one place to the other. Being a single woman out here, it's not always easy to find the right mate while pursuing your profession.

BRONWYN: I was taking one day and one year at a time. Being a single woman is not easy and one learns to fix toilets, cars, etc. But friends and colleagues become very important. I would add that husbands are rewarding but a lot of work. And, as you know, you just try to do your best in life and make the right decisions. One always makes a few wrong decisions, but you just hope that you don't make too many – and you try to not get married to the wrong person!

I want to compliment you— being a single woman, you started out taking responsibility for yourself early and it's a good way to go through life.

MILDRED: Well, I do have the challenges of having an elder parent, so it's always exciting.

You know, we really haven't had that many women and minorities in high positions of academic medicine. I know you're very passionate about the role of both women and minorities moving up the ladder and trying to break that glass ceiling. You were Chair at University of Colorado. Perhaps you can talk a little bit about what it was like being a chair, the challenges that occur, differences, and what kind of an impact a woman chair might be able to make, different than perhaps a male counterpart?

BRONWYN: That's an excellent question. The challenges are formidable. I think that women and minorities have a tougher time than men, and they become a little bit tough. But women and minorities offer so many different perspectives to medicine and ophthalmology and I hope that a hundred years from now there will be many women and minorities in positions of leadership and that they will say there are no subconscious biases. Our society and taxpayers expect to see successful women and minorities in leadership positions. Everyone wants to be a high earner and women spend it just like men do. More importantly, women and minorities pay taxes and dues— unless they are well-represented at the highest levels, the federal/state/county/city tax structure or organizational dues should be lowered. I hope that the advantages women and minorities bring to medicine and ophthalmology will be increasingly appreciated as time passes.

MILDRED: But why do you think we don't have a lot of women chairs,

and how do you see future changes for women and minorities in the field? We have a lot more women in medical school these days, so the future could change. But it seems that the positions of power are filled with men. Why aren't there more women and minority chairs— is it a mystery? Do you think it's on the women's side or the men's side, or a combination of both?

BRONWYN: I will do my best. Power and income are linked and both influence the subconscious mind. I think the subconscious is very powerful, and both women and minorities are not treated fairly because of what is below the surface. Women are not as financially driven as men and tend to be less willing to compromise values. Because they are not as aggressive surgically, institutions, whether they be universities, hospitals or practice groups, do not value their leadership. Money talks when businessmen make decisions. Minorities are handicapped by deep-seated historical prejudice and women are at the mercy of cultural biases. Fortunately, women and minorities bring fairness and sensitivity to the table. They humanize the medicine and have the Avis philosophy of working harder. Complicating the situation, women have more responsibility for raising children and taking care of the elderly than men, probably because of genetic instincts and cultural values. So, fundamentally, I think that if women and minorities pay taxes and dues, the rewards need to come their way and, hopefully, in such a dramatic fashion that past injustices can be mitigated. I hope such dramatic changes are on the horizon. There have been advances over the past 30 years, but women and minorities have a very long way to go.

MILDRED: So as a woman chair, why did you leave that position?

BRONWYN: Well, I feel that I accomplished many things at the University of Colorado. When I arrived in 1995 I had a very small, closet-type office. The Lions of Colorado and Wyoming had decided that the university was to be perceived as an enemy because they did not honor a 1991 contract with them and to build the Rocky Mountain Lions Eye Institute. So, I became a bag lady and went to Lions Club meetings in homes, hotels and bars in Colorado and Wyoming. Doing this, I met some of the most wonderful, hardworking people in the world. They were committed to building this eye institute. And, ultimately, with them and other donors, I brought in $11 million. We accomplished our goal and built an eye institute for the University of Colorado and the people of both Colorado and Wyoming.

I re-organized the residency with specific goals and duties at each hospital and for each subspecialty rotation. And it was wonderful knowing the residents and helping them become full-fledged ophthalmologists with a sound knowledge base and good values. We created three fellowships during my tenure, pediatric ophthalmology at The Children's Hospital, and retina and cornea at the University of Colorado Hospital.

I became president of the PAAO and I was able to practice my Spanish. During this period my goals included bringing the smaller, emerging countries into the organization at the same high levels as the larger, more populous and economically powerful countries that were already in the leadership positions. We had meetings in Nicaragua, Haiti, Honduras, and I met talented and energetic ophthalmologists of all ages during that period. I was the first woman president of the American Association of University Professors (AUPO), the organization for chairs of ophthalmology in the U.S. and Canada. In that capacity, we worked on standards for fellowships.

Maintaining my research laboratory and my NIH grant was a challenge during this period. I left the University of Colorado under very unpleasant circumstances and it was a difficult time for me. The process was financially-based and cloaked in secrecy. As a pediatric ophthalmologist or geneticist you don't bring in as much money as some of the more lucrative specialties.

So, now I am the Honorary Counsel of Nicaragua to Colorado and I have thoroughly enjoyed that responsibility. And I'm looking at options to fit my skill set with a new challenge. Hopefully, no new husbands, but you never know.

MILDRED: Well, actually, that sort of segues into my next question. It has to do with the fact that you were a department Chair and I know you said you were a bag lady— I happen to know you have two places you go back and forth between as well as having children. I just wondered about how you managed those challenges.

BRONWYN: It was very difficult. Many couples have commuting jobs. I got on a plane at 6 p.m. on a Friday and came back on a 6 a.m. plane on a Monday morning. My husband and children came to Denver from

Sacramento many weekends. But having had a father who fought in World War II, I learned that whining isn't productive nor does it change reality. I don't know how my mother managed to work full-time as a pediatrician and raise five children – in retrospect, I hope I helped.

There are many challenges for women and minorities in ophthalmology. But, I think the important thing for women and minorities is to remember the American dream for ophthalmology. From my perspective, a meritocracy and valuing women and minorities in leadership positions are the two key concepts. Hopefully, the federal government will regulate universities, hospitals and medical groups through accreditation and licensure requirements that will call attention if participation numbers do not reflect sufficient representation. From my perspective, self-regulation and peer-review in medicine has had an adequate opportunity, and women and minorities have not fared well.

MILDRED: Well, I certainly know that the passion for you happens to be about the status of women and minorities in medicine and ophthalmology and in trying to reach out and increase leadership. I think those are great points.

I also know that you were able to go with me to Haiti, and that's another passion of yours. And having been the president of PAAO, maybe you could also take a few minutes and talk about reaching out to do those types of mission work.

BRONWYN: Well, I have sort of a slightly different viewpoint. I know your passion has been in Haiti and I commend you. Having traveled to Haiti with you, I know that the Haitian ophthalmologists and those in other emerging countries have tremendous capabilities, but are living in an economic and medical environment that is difficult. From my perspective, education is extremely important, but is insufficient without an infrastructure to incentivize the ophthalmologists to provide eye care to their own people. Outside ophthalmologists come in and out. They don't understand the language, the culture, the history and take away business from the local ophthalmologists. So, I've always wanted to support programs where the local ophthalmologists have educational opportunities and ultimately work in a setting that permits them to care for their people from all walks of life

and make a good living. So, I have enormous respect for your dedication to the Haitian ophthalmologists, people and the system of eye-care in the country. And, I have a dedication to Nicaragua and Honduras, where I lived for a period of time. The ophthalmologists in the Latin American emerging countries are very bright and talented but the infrastructure is not well-organized. I hope for whatever programs can support medical infrastructure for the local ophthalmologists and enable them to become the most important eye care professionals in their country.

MILDRED: And do you think the challenges for a woman ophthalmologist in Haiti, Honduras or these other countries are different or similar to the challenges that we women and minorities are experiencing in the United States in terms of leadership skills or trying to break the glass ceiling?

BRONWYN: I think it's tougher in the United States because of complexities of the health care delivery systems, the financial incentives and, again, cultural values. Money reigns, so there is a premium for retina and ophthalmic plastics in leadership positions. Historically, these are two ophthalmology specialties in which women have been under-represented. However, American women are trusted, so I think when we do things in emerging countries, there is a higher level of credibility. As an example, I'm going to turn the table. You have enormous credibility with the ophthalmologists in Haiti. They know you are a knowledgeable ophthalmologist, a superb surgeon and an honest person. Equally important, your cultural understanding and language skills enable you to understand issues. The Haitian ophthalmologists and the people trust you to organize and bring American know-how to the country. So, I think you don't walk on water yet, but you're close.

MILDRED: As I'm sure you are in Honduras and Nicaragua when you go there. People can see your passion and how you feel about skills transfer, sort of teaching them how to fish, as opposed to giving them the fish. And you certainly fight for things. When you give your word, everybody knows that what you say is what's going to happen, no matter how long it takes you to get the task done. So, I think I can say just as wonderful words about you. As a younger person, it's great to have advice and see what people have gone through, and the struggle and experiences and how that helps us, so I've learned a lot from you.

BRONWYN: Well, you're a great roommate and traveling together, we got to know each other.

MILDRED: So is there anything that you'd like to add, as we're coming to the end of our conversation?

BRONWYN: I hope that the women and minorities who are coming up in the ranks will seize the opportunity and will make a difference for ophthalmology, for America, and for the rest of the world. I think they have many more opportunities than you and I had, and we just need to do a good job and help them to become as strong, as effective, and as successful as possible. And, I hope Americans will promote medical infrastructure in emerging countries to enable ophthalmologists to treat their citizens.

MILDRED: As we speak we're at the 2011 AAO meeting here in Orlando, Florida. And as we make our closing remarks, we should record for posterity that the incoming president of the AAO is an accomplished lady. I remember hearing those stories of women at AAO meetings of the past, putting these little notes in the bathroom so women could meet to discuss women's issues in ophthalmology. Ironically, I think now that there are so many women involved they don't really know or understand that history. Perhaps you can just say something about what it was like when you were there and there weren't as many women. And why now we're seeing so many women at the Academy meeting, ophthalmology is more exciting!

BRONWYN: Well, I think the AAO is making headway. But there was a time when women ophthalmologists had to be intelligent, ladylike and politically savvy. For instance, there were hazards to creating and bringing Women in Ophthalmology to the forefront. Many men did not see the advantages of the organization. I had forgotten, but the Council of the AAO *twice* voted down giving Women in Ophthalmology (WIO) a vote at the annual AAO Council meeting. The third year, they asked me to participate in a debate to articulate the pro-vote position for WIO; they had an articulate gentleman present the opposing position. That year the AAO Council voted to give WIO a vote at the annual meeting. And, I would love to say it was because I was so persuasive, but in reality, I think they got tired of the WIO asking for an organizational vote. I suspect they thought, 'Well, you know

what? Let's just give them the vote, get rid of the issue and address more pressing topics.' It was an interesting experience trying to put the best face forward for the WIO. And, I think I've repressed the name of the gentleman who was on the other side of the debate, but he was persuasive. Nevertheless, Women in Ophthalmology now has the vote, and therefore, more influence on AAO policies.

MILDRED: Well, certainly, we've had a woman president. We've had Dr. Susan Day and now Dr. Ruth Williams is the incoming woman president. So I think those are strides that certainly the Academy has made. I think it's up to us to try to continue to push them to put more women and minorities into leadership positions and I think that the organization has come a long way from when women were putting Post-It Notes in bathrooms and minorities met at the AAO meeting through the Roman Barnes Society. That society was founded because African American ophthalmologists were excluded from social events for decades.[1]

BRONWYN: Yes, we thank 3M. There have been major strides, but we have to keep going.

MILDRED: We have to keep pushing. Well, I've really enjoyed a lot of the comments that you've made and I certainly hope that people who listen to this will get some insight as to the challenges and some of the opportunities that are there for them on many different levels, whether they want to go into academic medicine, do subspecialties and/or help abroad. I really want to thank you for this great conversation, Bronwyn.

BRONWYN: Well, I'm going to give advice to the ladies a hundred years from now: find good friends and nice roommates.

MILDRED: And good wine.
[END PART I]

BRONWYN: Jane Bronwyn Bateman, October 22, 2011, Orlando, Florida.

[1] The Roman-Barnes Society of Ophthalmology, founded in 1968, is a professional membership-based organization of African American physicians specializing in diseases of the eye. Many members of the Roman-Barnes Society are also members of the National Medical Association and are recognized for their outstanding achievements and contributions to ophthalmology.

MILDRED: Mildred MG Olivier, Orlando, Florida, October 22, 2011.

BRONWYN: Well, Mildred, it is a pleasure to be able to interview you, not only about you as a human being, but about your career as an ophthalmologist, as a glaucoma specialist, and as a lady who has done so much for women and minorities, and to learn about your personal heritage .

So, I want to start out by saying every time I have worked with you, you walk on water. You're wonderful and you're a great roommate.

MILDRED: Oh, thank you.

BRONWYN: I'm going to start out by asking you about your heritage, your background, your family, and how you came to become an ophthalmologist.

MILDRED: Both my parents are from Haiti. My dad is from Les Cayes and my mother is from Jérémie. My dad worked for the World Health Organization and his job was to go around the country to the different departments of Haiti and assess infectious disease. At the time, they were looking at syphilis and how effectively penicillin was working. So he would go around and draw blood and that sort of thing. He had never been to the town that my mother was from, Jérémie, and he was supposed to go.

My father loves explaining the story. His colleagues went on ahead to Jérémie beforehand and they met my mother by chance. And so they said to my father, 'We have a woman for you. She is smart, beautiful and nice! We saw her. This is your future wife.' So, of course my dad arrived with excitement since he had never been to Jérémie and he met her. At the time, my mom was an ambitious young nursing student. Unfortunately, she had lost her parents at a very young age and was working hard to be successful. She had the ambition and foresight to get an education. She wanted to be a nurse and was putting herself through school. She was living at a convent and, I think, probably trying to decide whether she wanted to become a nun. Once my father found her, he kept knocking on the convent door. Well, obviously, you can't knock too late at night and I suspect the nuns were wondering about his intentions. Fortunately, he kept running into her on the street as the town was small. Eventually, they got married. Well, actually,

they didn't quite get married that way. My father thought, 'Wouldn't it be great for my future bride to specialize in infectious disease?' At the time, there were a few places in the U.S. with specialty training for nurses. Cook County Hospital in Chicago was one of them. So, she listened to him and considered Chicago while she was doing a rotation at a program in Maine.

My mother had left Haiti to do her rotation in Maine and now was going to do infectious disease subspecialty at Cook County Hospital in Chicago. Knowing that he was going to get married, my father started building a house in Haiti for his future family. Then, the political situation in Haiti under Duvalier (Papa Doc) changed dramatically. So, my father called my mother and said, 'Don't come back. I'll meet you in Chicago.' The day the house was done, he got the keys and moved to Chicago; we've never lived in that house. In fact I went to see the house after the 2010 earthquake in Haiti and it was destroyed. But like so many Haitian people, it's always a dream that they will go back to the homeland. So, my parents went to Chicago in 1958 and got married in the presence of a small number of Haitian colleagues. My dad was not a physician at that time.

Many years later, my dad decided to go to medical school, a dream for him. I was in college and we were both studying science. Being in the United States in the 1960s was not easy as he was older, a black immigrant and had a family to support. He came over with an accent, knowing English, but not really having a command of the language. So, being an immigrant, he came to the United States with all of the hopes and dreams in the land of opportunity. He eventually finished medical school and became a physician. He used the background that he had in the World Health Organization as a lab technician to obtain jobs in the lab and Blood Bank. Eventually these two sets of skills and the fact that he was a physician landed him a job at a small psychiatric hospital in Chicago where he was able to practice all of these skills. He was one individual able to do the job of many. Today, the CEO of that hospital now runs the hospital where my office resides. He reminds me of how my dad did the job of many others, how efficient and charming he was during his tenure at the hospital. And, that's how I was able to work with my father, which was fabulous when I lived in Chicago. I had worked as a lab technician in medical school and got hired working with my dad during summers and holidays at that hospital. Ironic that today almost more than 20 years later the same father and daughter team exists.

Although I had told him at one point during my younger days, 'I will never be able to work with you', the table turned after he became a physician. He reminded me of that many years later. In fact, even today, my dad, at 88 years of age, helps me in the office. Many people at the AAO have met him because I have taken him with me to so many events. He reminds me of my comment to him many years ago. But, it's been great being able to work with him. Even now, he helps with my private practice. Every morning he goes to a P.O. Box, picks up the checks, deposits them in the bank, comes back to my office and leaves the receipts and EOB's on the table for me.

So, that was my parents' background. I have two brothers, Ernst (a financial consultant) who lives in California; Oswald Jr. (who works for a commercial air corporation) who lives with his wife, Linda (a registered nurse) and my niece (Solanges) and nephew (Antony) in Minnesota.

For many years we lived in Chicago. Because of my parents' background, they wanted us to learn to speak French fluently. I started school only knowing French and learned English in private schools. Then, we moved to Canada, where we lived for about a year because my aunt was there. During this time, my parents had a commuter marriage as my father was in Chicago. My father often drove through the night on the weekends to see us and spend time with us. My paternal aunt and cousins had all left Haiti under Duvalier (Papa Doc), except for one uncle. Some left under disguise to get to the airport and out of the country. After about a year, my younger brother had medical problems and we moved back to Chicago. We lived in the suburbs in a predominantly White neighborhood, and I attended Catholic schools, as Haiti is a country with a strong Catholic heritage, so, I learned another culture.

It wasn't until I went to my residency in New York that I encountered a large Haitian group. Haiti has three languages and many people in Haiti speak four languages—French, English, Creole and Spanish. I had always heard my parents speaking Creole between themselves. They never really wanted us to learn Creole. Creole has only recently been recognized as one of the national languages by the Haitian government but has been spoken for centuries. Many Haitians speak Creole among themselves and with the less educated household help. Private communication between my parents was almost always in Creole.

I got to New York, thinking, 'Wow, a Haitian population!' I was saying, 'Bonjour! Comment allez-vous?' I'm speaking my nice, little French, they were looking at me like, 'What is she saying?' So I realized, 'Oh, my God, I'm going to use those words my parents used.' So, I started speaking Creole, literally like that. And the Haitian students started understanding and speaking back to me. So, I was now becoming much more fluent in Creole, and my parents were wondering, 'Where did you learn that?' I said, 'Oh, I've been listening to you guys for years. Didn't you understand?' That's really my background, my family background.

BRONWYN: It's a wonderful American story. My father is 94, and I am so glad that you're telling your father's stories, because fathers are very important for their daughters. That's a great history. I can attest to your fluency in Creole and French. Being trilingual and probably knowing some Spanish, you are a very talented lady! And your father and mother must have worked so hard to bring you up to be such a good human being, and so talented and smart, all those things.

MILDRED: The Haitian culture is an asset, I think when you're an immigrant. It's really about taking whatever opportunities there are in your new country. My parents were trying to make a better life for us. I know the sacrifices that they made, but you don't really realize some of those things until you get older. Education in Haiti is very important. In fact, a lot of wealthy Haitian people send their children to Europe to get their education and most return.

So, education was always something that my parents stressed. I was heading towards medicine because my dad worked in the medical field and my mother was a nurse and I was the oldest child. From as long as I can remember, I wanted to be a doctor. As the first child in a Haitian family, there is a lot of pressure to be successful and take opportunities because those opportunities don't always exist. So when I see immigrants coming to the United States and excelling here, that for me is just the minimum that they have to do. And when I also see people who are here in the United States who don't take advantage of opportunities, I think, 'Wow, what a waste,' because there is such opportunity here. We have a President who is a Black person, who was able to reach the presidency here in the United

States. That is an amazing feat and that is the American dream. When you have a president in Haiti, like Aristide, who came from poverty and was elected president, it's not something that generally people want to see since there is a hierarchy in Haiti. People from poor families are not expected to assume leadership positions. People are known by their family name, their relationships and by the schools they go to and where there were educated. It's a different concept. So, it's great to see that when you reach for something here, you're really commended for it.

BRONWYN: Well, yours is a wonderful example of an immigrant family that has done incredibly well and I think it's so nice you have your dad helping you at 88. I am sure that you make him feel like he's got to keep going and help you be even more successful.

MILDRED: My mother died from hepatitis C. When she had me, she had had a blood transfusion and so for many years after it was attacking her liver, and eventually her liver failed. She was scheduled for a liver transplant, but it was just too late. She had gone into a hepatic coma. I remember…I was going off to the ARVO meeting, and she was just going to the hospital to wait for a liver transplant since she had already had interferon for many years. Luckily, she obtained a liver from an organ donor over the Memorial Day Holiday. I thought, 'Oh, the transplant will go fine. I'll be back soon.' But unfortunately, when I came back, she was still in a coma, because she had a second assault to her brain from lack of oxygen by a technician who had accidently dislodged her oxygen so I never really got to say goodbye to her. She died almost 6 months later in the hospital from another complication during a time when I was chairing the 25th anniversary of the Association of Haitian Physician's Abroad (AMHE) meeting in Chicago with other health care professionals. I had been involved with AMHE since medical school.

But my mom…you've said so much about my humanitarian side, which I really think that I get from my mother. For as long as I could remember, my mother was always the person who was trying to fundraise to build something in Haiti. She adopted three little children, triplets, in Haiti. My father has tried to continue helping them. Now they are teenagers. I have never been to my mother's home town, but hope to be able to put an eye clinic there one day and meet the triplets. I can't tell you the number of

people for whom she got U.S. visas so that they could have a better life. Even on Halloween, it was always UNICEF for me, it was never about going out and getting candies or cookies. It was just about how I could help other people. But I really get that quality from my mother.

BRONWYN: My mother was a pediatrician and she was also very philanthropic and… moms are important role models.

How did you decide on ophthalmology and glaucoma? How did you take that path?

MILDRED: I had always wanted to go into medicine and when I was in medical school there were already more women by that the time. In fact, probably half our class consisted of women. But, there were few minority members of the class. In fact, I was the only Black in my medical school class.

I thought I wanted to do OB as there weren't many women OBs at the time and the practices were starting to look for that. But fortunately, I had to give the very last talk for my third-year rotation in internal medicine on diabetes. The father of one of my colleagues was an ophthalmologist and he wanted to be an ophthalmologist too. Steve said, 'You know, I have these slides on diabetic retinopathy. Would you like to use them for your talk?' And I said, 'Sure, give them to me. Let me see what it's like.' I was just amazed that people were going blind from a chronic disease. I was intrigued and thought, 'Well, let me find out more about ophthalmology,' as I had become the class expert on diabetic retinopathy.

I went ahead and did an ophthalmology rotation at the University of Illinois and found that I loved it. While I was on the rotation, another person who's going to be doing one of these oral histories, Dr. Eve J. Higginbotham, was there. She tapped me on my shoulder in the library and said, 'What are you doing here?' I said, 'Oh, I may want to be an ophthalmologist and I was doing some research.' She said, 'You know, you need to do some serious research,' and she sent me to work with Dr. Mathea Allensmith at Harvard. I did an intensive research project with her and we had several publications. I also visited the Boston ophthalmology programs while I was there. I matched in ophthalmology at Harlem Hospital Medical Center / Columbia

Medical Center. The Boston area at that time had a program that would subsidize minority medical students to come to the area to do a rotation learning more about the area and the program. That led to great opportunities and contacts many years later. Boston is another area that has a large Haitian population.

During my training in New York, Eve called me up and said, 'What are you going to do?' I told her that I planned to do cornea. And she said, 'I don't think so. I think glaucoma needs you.' I said, 'Glaucoma?' and then remembered, 'Oh! You know, I was always intrigued from the beginning about the diabetes and blindness, and here was another chronic disease that did the same thing.' So, I did a Fellowship with Dong Shin, MD, PhD at Kresge Eye Institute in Detroit, Michigan. I found I really loved the fact that I could go from babies to elderly people and that I could do both the medicine and surgery. It's been a great ride. I just love it. And, I owe it all to Eve.

That's the importance of having friends and mentors throughout life, just sort of reaching out. There was no reason for her to reach out to me on that day, but she tapped me on my shoulder and things changed forever.

BRONWYN: Well, I have a compliment for Dr. Higginbotham as well. She also has been one of my roommates. And you know I always have fun when I share a room with someone and hear their history and see them in action. I thoroughly enjoyed going to Haiti with you and look forward to another trip. And I'll be honest, it's the lady ophthalmologists in Haiti that really pack the punch and they are wonderful people and they believe in you and trust you.

I'm going to turn a little bit to your mother's passion, and that is your humanitarian efforts. I would like you to comment on how you have gone about being such an important person on the international scene, aside from being trilingual and a talented glaucoma specialist?

MILDRED: You know it has been a wonderful experience because I want to help the Haitian people, and agencies in the U.S. have appreciated my efforts as a liaison. Over the past several years I've received several awards including the AMA's Nathan Davis Humanitarian Award, the Benjamin F. Boyd Humanitarian Award from the PAAO, and the American Glaucoma

Society Humanitarian Award in 2012. I find that to be incredibly humbling. On the other hand I think, 'But this is what I do. Why am I being awarded for these things that I think that everybody should just do as part of just being a human being?' I mean, I'm a Black physician and glaucoma specialist in Chicago– sadly, the only Black glaucoma specialist in Chicago.

Of course, there's the Haitian community in Chicago, so I'm there for them. I cover a lot of that area. I teach at Cook County because I want students and children of my patients, many of whom are Black or Hispanic, to understand you can be a minority physician and that they can aspire to be an ophthalmologist. I just feel like it's my duty to do that. I also think that the public wants to see that women and minorities are in high positions in our society. Chicago is a big city and being the only Black glaucoma specialist, I have a responsibility to the community, to elected officials and to educational institutions.

BRONWYN: I could not agree more. It is your responsibility and you know that you are doing a great job. I suspect there are so many little kids who come in and say, 'I want to be like her when I grow up.'

MILDRED: When I was doing my residency, Dr. John Mitchell, our neuro-ophthalmologist, was going to Haiti frequently. I thought it was an ideal time in my life to become involved and I returned to Haiti. Initially, I went as a glaucoma specialist doing glaucoma surgery and then it just started… something started to ache; I was doing surgery and then leaving the country. When I did surgery in Chicago, I was following the patients all the time, intensively. Here, if their vision drops and you have to do this or that, the patients get specialized treatment, but not in Haiti. It wasn't right. I just didn't feel right about it. Then I started to think that I needed to do something else. That something else evolved into skills transfer; going there and saying, 'I know this is a hard case. I'm happy to have you look at me do a case, but I'm going to teach you how to do the rest of these cases' and then bringing other people with me and doing different procedures.

Haiti was in the international spotlight after the earthquake. It was, obviously, a horrible experience for the Haitian people, but it gave a highlight on the country and an opportunity for medicine in Haiti to move forward, to get basic skills and continuing medical education for everybody

and to establish infrastructure for the long-term. Even after the earthquake, I found myself having to do administrative work in Haiti. It was not about going and trying to help the people there. I was the go-between for all these people coming in to Haiti. They were speaking different languages, writing in the charts differently. Were they really MDs? Was he or she really a nurse? The Haitian administrator didn't have the grasp of the English language to orchestrate.

It was a difficult situation and I, as well as everyone around me, was in a state of emotional trauma. We were frightened about the prospect of further earthquakes. Then, having the Americans and others coming into the room and saying, "Here we are, move over!" was difficult to confront. I asked, "Do you really want them to move over? Is that what you meant?" "Oh, no, no, no." So bridging that cultural divide was the opportunity to realize where I could be the most effective during the crisis after the earthquake. I think I brought a level of respect for the Haitian physicians, administrators and people.

BRONWYN: You are such an asset to Haiti and to the physicians there. Could you tell us about that first trip you made to Haiti after the horrific earthquake?

MILDRED: Well, about 4 o'clock in the afternoon, one of the Haitian ophthalmologists, Dr. Reginald Taverne, called me and said, "I need some Mitomycin. When are you coming to Haiti next?" I said, "You know, I'm really busy with patients right now. Let me see what I can do. Let's talk again later this evening." And, about an hour later, the earthquake hit. I knew that I had to go. I had already been planning to go to Cap Haitian, second largest city in Haiti. I hadn't gone to Port-au-Prince for a while. But, I knew I had to go to Haiti soon, and getting there was going to be a nightmare. But, for whatever reason, things happen in life… United Airlines doesn't fly to Haiti and hadn't flown there for a long time. They did have a humanitarian plane that was going there, they called me, and said, "You know, we have one ticket. Do you want a ticket? It goes directly from Chicago to Haiti." Through the various connections of Jack McHale with ORBIS they got my name but said, "How about two tickets?" They said, "We'll get back to you." And, they did and they brought my nurse, Astrid Januszkiewicz, and eventually a third ticket for a Haitian neurologist, Dr.

Serge Pierre-Louis, as well. Because I had already been planning to go to Haiti, to Cap Haitian, my office transformed into a central command station with all of the well wishes, prayers and financial offerings. Meanwhile I almost overslept the next morning trying to catch the 4:00 AM flight trying to make arrangements. We started to bring just two or three people as part of what I thought would be an eye team, bound for Port-au-Prince instead.

One of my Haitian colleagues in Chicago said, "Why are you going? You know how it is. You get there. You get in people's way." And I just said, "Are you kidding? I mean, the fact that I know the language is going to help so many more people. I know the languages! We can help people – patients and the folks coming to rebuild Haiti!" I don't think he regretted going at all.

Going there… Our plane landed in Port-au-Prince but we were stranded at the airport for four hours. I had bargained with United Airlines to give all of the aid organizations with representatives on the plane six bottles of water because it was liquid and none of us could bring it in our bags. They had extra, and divided the bottles among the people on the plane. People were looking at the water like it was gold, and we had to decide how to use it. We didn't know where we were going to be, where we were going to stay, how long we were going to be there, how we were going to eat and when we would leave. We had just arrived and I had to be selfish; it really hurt to do that, because we had to keep the water hidden in my bag. After several hours, I was able to contact a friend to pick us up at the airport. Marie Carmelle Jean Baptiste said, "This is the first day that I have had gasoline in my car and I don't know how long it'll last - but I want you to look at the devastation." As we drove down the streets of Port-au-Prince, I was so sad—kids on the street, people just everywhere. You know, they had nothing. It broke my heart.

BRONWYN: How many days after the earthquake hit?

MILDRED: That was about 12 days. It took me about a week to arrange transportation - it was hard. We got to the Haitian Community Hospital where my friend, Dr. Brigitte Hudicourt's family had a hospital for the poor and middle class. She is an ophthalmologist and comes from a long line of physicians in Haiti. Her parents trained in Chicago at Cook County Hospital

and had built this hospital as a way of giving back to the community. Lots of people were outside and lots inside. We went into surgery and my ophthalmic nurse went in. We knew there was trauma, but nothing could prepare her for doing an enucleation of the eye, taking off an arm… orthopedics was taking off an arm and amputating a leg at the same time, just huge cases. When I got there, I do remember Dr. Brigitte Hudicourt just saying, "Oh, my God, there's relief here." Because they had been there for the first 24- 48- 72- hours… they had been up all night, so many nights. They were just psychologically and physically exhausted. And so, they were very happy when we arrived. Then they--- many of those Haitian doctors--- needed to go home to see whether or not they had a home, whether or not they had lost somebody.

I spoke this morning here at the AAO about Dr. Emmanuela Laguerre, a Haitian ophthalmologist who died alongside her husband and one of her sons. Fortunately, another son survived. You just had these stories of people telling you they were walking a few steps ahead of somebody else who died. A few feet made the difference between life and death. A guy behind him died, and they were able to go on.

It was hard, but as I said, I… I needed to help in the most strategic ways. I decided the administrative route would be the most effective. In the Haitian Community Hospital, I was able to do that. Sometimes, we would have to go around to non-governmental organizations (NGOs) or other government's representatives. We went to Project Medi-Share/Bascom Palmer Hospital an NGO, and negotiated with Dr. Bob Greene for some cots or anything the people could sleep on. In addition we found ourselves negotiating for oxygen tanks for people who were going to die soon if we didn't help, people who had a few hours left. It was hard to find everything and anything. It was heart wrenching, but my prior relationships and current relationships with the Association of Haitian Physicians Abroad, Dr. Jack LaFontant (a Haitian gastroenterologist) Mike Brennan (Chair of AAO Haitian Task Force) and his connections aided in bridging the communication to get supplies and open doors from the military presence that was there on the ocean with state of the art equipment and personnel, but their space was limited given the impact of the disaster

BRONWYN: I hope you're going to write a book about your experience there. I traveled with you one time to Haiti and the lady ophthalmologists took us to various hospitals and it was profound then. It must have been heartbreaking after that earthquake. And I'm sure people knew you were an American - you have American body language and clothes. So, you must have been mobbed.

MILDRED: Well, there were a lot of foreign people. There were so many different groups—Swedish, Korean, Chinese, German and Americans. I learned a lot about international crisis situations. As an example, people came with walkie-talkies so they could communicate with each other. I used one person's equipment to make calls to their support people for equipment we needed. If I had to find the guy who had the key to the bathroom, I had to physically go and get the key to the bathroom.

I remember one touching story. What was so heart-wrenching was that life and death was everywhere. I went to the OB section to organize our plans. There were a couple of OB Jamaican doctors there and one guy comes to me, knowing I was an American. He could tell I would speak Creole and he couldn't. So, he said, "You know, my wife is supposed to have a baby, and she's having contractions.' And I said, "How far apart are they?" Finally, I said, "Call me when they're 30 seconds …" because I had to find a room for this woman and all the spaces were occupied.… Then, I had to trace the man who had the key to an empty exam room. I went back to administration, "Do you have any rooms anywhere? This woman is going to be delivering…" So, they found a room, I got the guy with the key and I opened it up. Then, I moved on to the OB. "All right, I have your room," and I put the woman in there. Here you had life, as you were having death. So life goes on.

BRONWYN: It must have been an incredible experience.

And what do you think you're going to do in the future? How are you going to make the difference for Haitians with eye diseases and for the Haitian ophthalmologists? What are your plans?

MILDRED: Well, I really see myself as a facilitator. I never see myself as taking something on and leading it that way. I'm always trying to put people

who are interested in going to put Haiti together. Yesterday, at this meeting, the Academy, we did that. You certainly put together proposals as to what you'd like to see in Haiti. It's a matter of taking all of those people, putting them in a room, sitting down, trying to divide what needs to be done.

So, I have always seen myself as a facilitator. I don't see myself as taking on that whole plan of eye care in Haiti. I do think that one has to look at the whole picture because it's been in so many dysfunctional pieces. The huge problem, I think, is organization, planning and communication. We saw so much of that on TV during the Haiti crisis. There's food right here in a warehouse and yet, 60 people are starving, and nobody knows that the food is in the warehouse. That lack of coordination happens the same way in ophthalmology. Knowing that we have industry-donated lenses there, that we have this scholastic program, that we have this lamp, that we have a microscope… Knowing that this person wants to work in Les Cayes or Cap Haitian, that "missionary" people that are coming through, and determining if they work with the Haitian ophthalmologists, then, we become able to raise the quality of care for everybody. Most importantly, knowing the culture and the language is the key element.

I'm looking also at medical school reformation. There are five medical schools, most of which are private, that should be standardized with one entrance test. The underserved, less educated people have not in the past had the right to go to school, so the public schools give some a chance. When I take on these roles, it is important that I represent not only my ophthalmology side, but also a past executive member of the Association of Haitian Physician's Abroad. (AMHE)

How do we get people interested in ophthalmology? Raise the awareness. If you think of all the problems a Haitian person has, it is formidable. He's just trying to have a house, have electricity, basic water… but there's not that basic security we have in the developed world. So, sometimes eye care falls low on priorities for the government and for the people. But, we have the obligation to say how important that is, because people can't work if they can't see, or somebody has to lead them somewhere being blind.

I have never envisioned myself as a person trying to take on a major cause. I'm just trying to put the people who have the money and the willingness together in projects that look like they can go together.

BRONWYN: You're doing an unbelievable job. You really understand and care about the Haitian people and the Haitian ophthalmologists, and you can make such an incredible difference in that country. And I hope 50 years from now we have the opportunity to do this again, so you can talk about…

MILDRED: Both you and I will…

BRONWYN: We're going to be really old ladies, so I hope you're going to do this for the old ladies in the future.

As such an experienced person, what do you think that organized ophthalmology, such as the American Academy of Ophthalmology, could do to be the most effective organization in future disasters?

MILDRED: First of all, I have to say Dr. Michael Brennan was amazing. Once the earthquake happened, the AAO quickly put together the taskforce along with the PAAO. Obviously, Mike has had a lot of international experience, so that was his first thought because of his experience. Nelson Marques of the PAAO was wonderful. We worked with the Haitian Society of Ophthalmology.

It is important to communicate directly with the country's ophthalmology society to support those on the ground. The situation is different for each society and it will work differently in each country, but I think making "the ask" is important. One has to put a list of assistance and supplies needed. However, the language barriers and culture may not reflect the actual needs on the ground or the request of an individual or the society.

The other important component is basic things. We knew that we needed mobile units very quickly so that the Haitian Society of Ophthalmology would be able to go out to the people. Refractive error or lost glasses are very important in the few hours and days after the earthquake. We wanted to assemble preparedness packages because initially there are certain things you need, depending on the disaster. So, very quickly, we needed basic

supplies. In Haiti, we needed a lot of oculoplastics equipment as specialists came in early. As quickly as possible, they needed to be mobilized and coordinated with the Haitian Society of Ophthalmology (HSO). Then, and perhaps most importantly, we needed better communications, particularly in remote areas. With the Internet these days, there are probably ways of doing this with pictures or telemedicine if there's a complex situation. We could have moved faster.

Fortunately, we were able to communicate with the US Navy ships also through relationships with Michael Brennan. There were certain trauma cases that had to go the ship for surgery or high-level care, but that took a lot of time. Because of Dr. Brennan's background and knowing key individuals from IMC and the U.S. Navy, some of that happened quickly. But if it wasn't for Dr. Brennan and Mr. Marques, as well as the Haitian Task Force, we would not have been as effective. Stephanie Marioneaux's contacts with Gregory Mevs through the fact that her father was once an Ambassador to Haiti helped enormously. Relationships matter! So, perhaps some of those things can be put into place for immediate implementation and communicated to future teams.

As you know, the Academy's role has always been about education when you're talking about international people. Disasters are very different, so perhaps it would take a taskforce to organize plans.

Japan's disaster was easier for the AAO. It happened. They called. I think they needed a van, and Bascom Palmer, University of Miami, and Project Medi-Share were able to get an eye van to the Japanese region. Richard Lee, M.D. of Bascom Palmer, was instrumental in going back and forth and coordinating the supplies and equipment to Haiti as well as Dr. Stephanie Marioneaux.

Traveling to remote places, especially in countries such as Haiti, can be difficult. Because there wasn't access to fuel for cars, we could not easily access the rural regions. So, other ways may work better, maybe mopeds or something else. For each country, it will be different. Like everything, you can have some basic things that you need right away, and maybe those are mobile satellite ophthalmic lanes. Key elements might be a portable slit lamp, a way to take pressure and a way to take pictures. Even if the situation

is complicated or requires surgery, taking a picture and sending it to somebody here in the U.S. or a central location who could say, "Oh, okay, we can do that."

BRONWYN: What kind of problems did you encounter that first visit after the earthquake?

MILDRED: Well, really, most of them had to do with trauma. Buildings collapsed on top of people and they had fractured orbital floors and they had ruptured globes. Now, homes and facilities are being built with earthquake proof and solar power to decrease another disaster and the first earthquake June 3, 1771.

And, I have to tell you, the other thing is glasses. I mean, if you wore readers, if you had readers, and suddenly they were in the collapsed house, you may not be able to go back to your job. Or, if you are a myope and you don't have glasses, you can't see to get on the right bus or you can't find your relatives. So the basic of everything, even getting glasses, becomes a massive effort. Supplying glasses doesn't take a lot of money but it takes organization and preparation.

BRONWYN: Well, when we were working on our grant application, reading glasses were an important component because people didn't realize that they could go back to work if they could get a pair of reading glasses and…

MILDRED: Absolutely. After the earthquake, that's what really kept some people sane. If they had a job, they could go back to work. A lot of the nurses stayed at the hospital because there was not much at home, so they were helping. There are many artists in Haiti; reading glasses are critical to the livelihood of many creative people.

BRONWYN: What about the future for African Americans in ophthalmology? What kind of advice would you give now? And to the young women who might be thinking, "Well, what am I going to be doing 10 years from now, 50 years from now?" You and I will be in wheelchairs, but…

MILDRED: Well, I would say African Americans and minorities have had a tough time in ophthalmology. When I was going to medical school, a lot of people said that minorities and women should go into primary care. "You're Black; you should go into primary care." And the reality is that we need subspecialist minorities, whether they're Hispanic or Black. Frankly, there are not enough ophthalmology programs taking in the African American and Hispanic applicants, for whatever reasons – I am sure that one can substantiate why they feel they aren't accepting minorities into their programs. I've reviewed the statistics. You know Dr. Edyie Miller-Ellis and I have the Rabb-Venable Excellence in Research Program, which has a R13 grant from the National Eye Institute at the National Institute of Health through the National Medical Association. It was challenging when I was on the NEI Council there, because they kept saying, "We can't find qualified minorities." But this past year, we had 40 medical students, residents, and fellows present at the National Medical Association. The NMA was created over 100 years ago when the American Medical Association (AMA) did not allow Blacks to be members. What it proves is that African Americans and other minorities are there. They're out there, but one has to look in the right places, and it must be a constant vigil. They might not have the opportunities if a program uses Board scores as a justification for not ranking them highly. Is it really Board scores that make a physician an excellent doctor or one who has compassion and cultural understanding? I think we have to look into that. I challenge the ophthalmology residencies to try to find those applicants and to use public's tax dollars in an equitable way. The National Medical Association is happy to help, because we need more minority applicants. We have fewer than a hundred Blacks across the country in ophthalmology today – a sorry state of affairs in 2011. And that's why, it's sad to say, that in Chicago, a huge city, I'm the only Black glaucoma specialist. Now, that doesn't mean that somebody who's Black has to come to me, but they should have the choice of being able to go to a physician who has increased cultural understanding and represents them. I can say the same for the Haitian population in Chicago. We should have trained enough so that Blacks and minorities have choices. Although it shouldn't matter what your race is, it does. You know, if you see Dr. Olivier, she is just as well trained as 'X' over there, you have a choice. If your personality doesn't go with that guy, you can go with this other guy. I think we really have to challenge that.

I would say for African American women, it's probably easier than it is for African American males. The Black male in medicine is not there; we can't find him. Unfortunately, too many American Black males are in jail. And, that's true. But the professional Black male, sometimes he goes to business. He doesn't come to medicine. Why is that? Maybe there's a fear on the other side, because sometimes when people see a Black male, they're afraid. Maybe the women don't frighten them as much. So maybe they're more apt to take a woman applicant Black than they are a Black male applicant.

BRONWYN: I would like to echo your comment about scores and… I think to increase minorities, Hispanics, Spanish-speaking individuals is essential.

MILDRED: And, American Indians.

BRONWYN: Creole-speaking ophthalmologists. We need to do the right thing for American society, and that is definitely the right direction. We have so many Haitians in the U.S. and they need to be able to find Creole-speaking doctors.

MILDRED: There's so much in culture as well. We were talking about the earthquake, but one of the cultural problems was with the amputees. The NGOs were bringing prostheses to Haiti, and the amputees wouldn't wear them. Somebody finally figured out and it was because they were white legs. They said, 'We don't want to do that.' So, somebody got brown paint. They painted them and then the amputees started wearing them. Here, the foreigners were thinking, "Wow, we're helping you guys. Here we are. Why aren't you wearing the prostheses?" But they weren't wearing them because they couldn't relate culturally to them. So, Hispanic patients also have cultural preferences. Many want a Hispanic doctor see them, because they understand so much about their culture.

BRONWYN: I agree 100%. A Hispanic patient may want to see a Hispanic doctor to pay respect to him or her, and because the level of trust may be higher. These cultural issues are the essence of America. It's our asset, but we need to do the right thing and officially recognize that people who are well-trained, who understand the culture, understand the language of others are essential to our profession and our country. And if you are an African

American who is completely fluent in English, French and Creole, you have a broad range of cultures you can service.

MILDRED: Wow, thank you. I do wish I could speak Spanish, since in America the Spanish-speaking population is growing. In medicine, communication is essential in obtaining trust. Better understanding of an individual's culture helps us to treat people better and broadens our horizons. Many years from now when someone reads this document, I hope that we will have eliminated many disparities in health care and inequalities of life.