PRESIDENT'S COLUMN

PREVENTING DISEASE AND PROMOTING HEALTH IN THE MINORITY COMMUNITY

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Despite the progress made in health care in the last several decades in America, there continues to be a significant disparity in morbidity and mortality between blacks and whites. Furthermore, there is a direct correlation between poverty and increased morbidity and early mortality. The complications of poor nutrition, inadequate housing, lack of employment, stress-laden environments, and other "satellites" of poverty cause increases in the use of health services and the cost for that care.

With the inception of Medicare in 1965, emphasis was placed on access and availability of health care. The focus of health care has most recently been on cost containment. Out of this emphasis there have been changes in the health care delivery system. Many competitive health care organizations, emphasizing care for the least amount of dollars for the largest number of people, have been initiated (HMOs, PPOs, etc). These are usually prepaid, contracted health services with some kind of volume guarantees or exclusivity agreements in exchange for reduced rates.

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Competitive health organizations have greater success with economically advantaged young people, who are less likely to be high consumers of health services. Poor elderly and minorities with

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increased demands for services are less likely to be included in these plans. In addition, providers of potentially high-risk users—poor, minority, elderly, and disadvantaged—are frequently excluded from these plans. The program of reimbursement for hospital patients, Diagnostic Related Groups (DRGs), is especially designed for the least sick and for the patients who can be maintained in home environments while recovering from acute illnesses. Providers who render services to a significant number of poor patients find themselves inadequately reimbursed because minority members tend to seek care later than more advantaged groups, with the result that illnesses are more severe, with multiple complications. Some hospitals limit the number of "excessive service users" by admissions quotas, and some limit these patients by excluding physicians from their staffs who are potential "high-risk" patient providers. This limits access to health care by poor minorities and by physicians who are predominantly providers of health care to poor patients.

Many of the newly initiated health organizations' participants must relinquish their freedom of choosing providers, and thereby, may be giving up quality and quantity of services. For the participant in a health crisis, this access to limited services may come too late to make any other choice.

There continues to be a lack of emphasis on prevention of illnesses, especially in minority communities where attention is directed, by necessity, on day-to-day survival and where little emphasis is placed on programs for "staying" healthy. Despite the availability of preventable measures (eg, vaccines, immunizations, etc), there continues to be large numbers of unprotected children, especially children of minority groups, in the United States. The high infant and maternal mortality rates in blacks could be decreased with adherence to preventable measures, including protection with immunizations, prenatal health care, and avoidance of lifestyles that are adverse to good health. With the shift of responsibility of health care maintenance from the provider to the consumer, much education as well as providing other programs in the minority communities are necessary. Competitive health care organizations that reduce cost and limit choice are not the answer for disease prevention or health promotion in the minority community.

I propose that education of the public—outreach programs to provide immunizations, and coalitions with groups, agencies, organizations, and churches—is needed to improve the health of minority communities.

The National Medical Association with the National Council for Negro Women launched an immunization program a few years ago. That program was successful but needs to be continued and expanded. With a program coordinated by the National Medical Association National Office, the constituent and component societies of National Medical Association could rededicate their efforts to have every child appropriately immunized. With this program of providing care to minorities, emphasis should be placed on prenatal health care also.

I announced in July 1985 in Las Vegas a program for the National Medical Association called "War on Lifestyles Adverse to Good Health." This program is snowballing with the help of the news media, sororities, and other organizations. It is hoped that the benefits of this as well as other programs will bring about positive change in minority communities. This program to insure protection to all for the preventable diseases and the avoidance of lifestyles that are adverse to good health would significantly improve the disparity of morbidity and mortality between blacks and whites in America. Blacks live 5 to 7 fewer years than whites. Infant mortality is also significantly higher in blacks than in whites.

The rate of cancer continues to increase in blacks in direct relation to participation in lifestyles that include smoking and lack of proper diet adherence. Hypertension continues to increase the morbidity and early mortality of blacks. Diet adherence could improve the treatment of high blood pressure, and could conceivably prevent future increases in hypertension.

The concern of escalating health care costs is really the concern for who is going to pay for the care of the indigent and how much they are willing to pay. The cost of health care could be reduced

with the prevention of illness and complications of illnesses. More innovative programs are necessary to have health care accessible to the minority community.

In considering mechanisms for providing services for minority communities, often the availability of providers is overlooked. With the "oversupply of physicians" in America, fewer than 3 percent are black. It is a documented fact that black physicians tend to place their offices in areas where there are minorities, the poor, the elderly, and the disadvantaged. With lack of black physicians to locate their offices for easy accessibility to these disadvantaged patients, care for them becomes diminished. More efforts must be directed to improve the applicant pool of minority medical students, and more aggressive efforts must be made to have those admitted graduate as physicians, properly trained in various selected specialities to render a range of services.

The whole system of health care delivery is evolving. To have an effective health system in America, all persons involved must be included in the planning. When educated and informed, the consumer can make choices to most effectively use the dollars spent for health care. When the consumer has freedom of choice, providers are challenged to give quality health care for the least cost, third party payers and the government are stimulated to provide education and preventive measures, including immunization programs and programs to change lifestyles adverse to good health. All of us and others of the same consciousness must provide the leadership to see that prevention of diseases and promotion of good health in the minority community become a reality. The improved advances in technology, the acquired knowledge in health care must not be limited to a select few, but rather accessible to all. Poor health for some is a threat to the security of all.

Providers of health care to the minority communities must continue to advocate freedom of choice for the consumer and must continue to advocate access of quality health care at an affordable cost. Providers must plan programs that will help prevent disease—immunization, proper nutrition, adequate housing—and eliminate lifestyles adverse to good health such as smoking and drug abuse.

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Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category* C: There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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