



Winter 2004

An Official News Magazine of the National Medical Association

Closing the Gap

□ NMA joins other minority medical organizations in support of legislation to address disparities proposed by Senate Majority Leader Bill Frist.

From Staff Reports

U.S. Senate Majority Leader Bill Frist, MD (R-TN), and Senators Mary Landrieu (D-LA), Thad Cochran (R-Miss) and Mike Dewine (R-OH) introduced comprehensive legislation to reduce and eliminate health disparities for racial and ethnic minorities and other underserved populations.

The "Closing the Health Care Gap Act" was announced at a news conference with prominent health professionals and advocates from minority health organizations, including NMA President Randall W. Maxey, MD, Ph.D., and John Maupin Jr., MD, president of Meharry Medical College.

"This legislation is the most comprehensive national initiative to address disparities in health care access and quality," said Sen. Frist. "A gap does exist in health care today. While we've made great progress in recent years, there are additional steps we can take to improve, expand and enhance quality care for all Americans."

"The promise of this important legislation obligates us to right some of the wrongs from our nation's past," Dr. Maxey added. "Even though there are some who would rather portray America's healthcare glass as half full, we at the NMA are convinced that such a characterization is an overstatement of the facts. Thankfully, Closing the Healthcare Gap Act of 2004 assumes a more realistic posture."

The "Closing the Health Care Gap Act" will address several key areas necessary to close the health disparity gap for racial and ethnic minorities and other underserved populations in America.



NMA President Randall W. Maxey, MD, Ph.D, at podium, speaks to U.S. Sen. Bill Frist, far left, during the announcement of the "Closing the Health Care Gap Act." Also present were, from left, Renee Rodriguez, MD, Louis Sullivan, MD, U.S. Sen. Thad Cochran, Meharry Medical College President John Mauphin, DDS, and Morehouse School of Medicine President James R. Gavin III, MD.

The legislation aims to improve the overall quality of care, expand access to care, enhance research opportunities and foster innovative outreach programs to address health care disparities. It also strengthens leadership at the local and national level and promotes programs to increase the diversity of the nation's health care work force.

Specifically, this legislation requires the establishment of uniform data collection methods and specific collection of that data by race and ethnicity.

See Act, page 4

"The promise of this important legislation obligates us to right some of the wrongs from our nation's past."

**- Randall W. Maxey, MD
NMA President**

NMA Survey: Some Physicians Dissatisfied

By L. Natalie Carroll, MD, and
Sharon Allison-Otley, MD
Special to NMA News

Many physicians indicated they have experienced a general decline in the satisfaction with the daily practice of medicine and a significant number are considering leaving their practice, according to a survey by the Gallup organization on behalf of the NMA.

The highly anticipated survey of African-American physicians, conducted by the Gallup for the NMA, has been completed and the results will be published in the April Issue of the Journal of the National Medical Association.

The survey is rich in insight into the practice of medicine, the perceptions of physician respondents and major issues facing physicians.



Carroll



Allison-Otley

See Survey, page 4

Prostate Cancer Awareness Still Low

□ A survey sponsored by NMA shows African-American men remain unaware of disease's danger despite high incidence and mortality.

By Jessica Carter
Managing Editor

One of the leading causes of death among African-American men is relatively unknown to them, according to results of a recent survey commissioned by the NMA.

Roughly 5,300 African-American men died from prostate cancer and more than 27,000 were diagnosed with the disease in 2003. Yet more than half of African-American men surveyed did not consider themselves at risk for prostate cancer.

"In general, prostate cancer is very curable, if it's caught early enough. Going to your doctor for annual checkups could save your life," said Gerald Hoke, MD, chair of NMA's Urology Section. "Unfortunately, in the African-American community there's not enough of the awareness that tends to lead to early diagnosis. Knowing the risk factors and symptoms, and getting screened is an important start."

African-American men are diagnosed with prostate cancer at least 60 percent more often than white men and are more than twice as likely to die of it. It is estimated that in the United States about 230,000 new cases of prostate cancer will be diagnosed and approximately 30,000 men will die of the disease in 2004.

The nationwide survey, which was supported by an

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National
Medical
Association **News**
An Official News Magazine of the National Medical Association
1012 Tenth St. NW Washington, D.C. 20001

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INSIDE THE NMA

SNMA Looking for Alumni Leaders

By Kara Odom
Special to NMA News

Think back: When you were a medical student, where you a member of the Student National Medical Association? Did you hold an office on the SNMA Board of Directors?

In April, the SNMA will celebrate its 40th anniversary – and its long and unique history – at the SNMA annual convention, to be held April 8-11 at the Sheraton hotel in New Orleans.

Entitled “Unmasking the Faces of Health and Longevity: 40 Years of Advocacy,” the program will celebrate SNMA’s achievements in fulfilling its mission to recruit more African-American students into the medical profession, recognize the growth and enrichment of SNMA’s community services initia-

The SNMA’s 40th anniversary celebration will be held April 8-11 in New Orleans. For information, e-mail annettesnma@msn.com or see www.NMAnet.org.

tives, and examine the changing face of healthcare and associate needs of underserved and minority populations in the coming decades.

The medical student organization was conceived and inaugurated by the NMA in 1964 and steered along through the care and oversight of then-NMA President W. Montague Cobb, MD.

In its 40-year history, SNMA has had among its membership more than 32,000 medical students of color who have joined the medical profession, many of whom are now NMA members.

SNMA’s current leadership would like to identify and recognize the organization’s past leaders and is eager to have NMA members who are also SNMA past officers participate in this unprecedented gathering of medical students and physicians of color.

- ◆ Share your experiences with medical students who now make up the 10th generation of medical students emerging from the SNMA to join the ranks of esteemed leaders and practitioners in the NMA.

- ◆ Sit in on your SNMA region’s meeting. Find out where help is needed. Help students to network with other physicians in the area.

- ◆ Join in the celebration. SNMA will be recognizing and honoring past SNMA Board officers and distinguished past members and devoted partners.

A “Parade of SNMA Leaders” also will highlight past leadership from SNMA’s 40-year history.

Anyone interested in attending this historic event should e-mail SNMA Executive Director Annette McLane at annettesnma@msn.com and ask to receive registration material for the 40th Anniversary Medical Education Conference. It will include the conference schedule, as well as instructions for obtaining discounted air travel and hotel accommodations. A reply form also is available at www.nmanet.org.

Kara Odom is SNMA National President, 2003-2004 and NMA Student Trustee.

National Medical Association *News*

An Official News Magazine of the National Medical Association

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Postgraduates on a Recruitment Mission

By J. Nadine Gracia, MD
Special to NMA News

The NMA Postgraduate Physician Section represents the interests of residents, fellows, medical students and physicians in the first five years of practice. The 2003-2004 section officers are Chair J. Nadine Gracia, MD (PA); Vice Chair Nicole C. Hasbrouck, MD (IL); and Secretary Rachel M. Skeete, MD (NY).

The 2003-2004 agenda of the Postgraduate Physician Section focuses on several areas:

- ◆ increasing the membership and involvement of postgraduate physicians and students in the section and the organization at large

- ◆ developing the infrastructure of the section

- ◆ enhancing the visibility of the section both within the NMA and externally

- ◆ strengthening its involvement with the Student National Medical Association.

Membership recruitment and retention remain among the top priorities of the section. We are at a critical time during which the survival of the NMA depends on the recruitment of physicians in training and medical students.

Our section is working with the NMA



“We are at a critical time during which the survival of the NMA depends on the recruitment of physicians in training and medical students.”

**- J. Nadine Gracia, MD
chair, Postgraduate Physician Section**

Membership Division to spearhead an aggressive membership recruitment campaign targeted at residency and fellowship programs, medical schools and the SNMA.

To improve the infrastructure of our section, we have established the positions of Postgraduate Physician Liaison to the Scientific Sections and Postgraduate Physician Regional Representatives. These positions will serve to improve communication and involvement of postgraduates in the scientific sections and regions.

Our publicity campaign includes creating

a Postgraduate Physician Section Web site, increasing our article submissions to the NMA News and devising methods to involve our section members in HOD councils, committees and task forces.

Finally, our section has dedicated itself to supporting the SNMA, the most important lifeline of the NMA. Our section’s officers are proud SNMA alumni who served on the SNMA’s national Board of Directors during medical school. The section membership is making a sincere commitment to the SNMA through a mentoring program and participating in regional and national conferences.

The agenda of the Postgraduate Physician Section is ambitious and yet absolutely necessary. It is imperative that the NMA – from the local societies and regions to the national level – put emphasis on the recruitment of medical students, postgraduate and newly practicing physicians if we are to continue to be the nation’s leading organization representing physicians of African descent and the communities we serve. There is much work to be done!

Any postgraduate physicians and medical students interested in the Postgraduate Physician Section may e-mail nmapostgrad-chair@yahoo.com.

J. Nadine Gracia, MD, is chair of the NMA’s Postgraduate Physician Section.

Experts Predict Physician Shortage as Baby Boomers Age

By George Dawson, MD

In November 2003, the federal Council on Graduate Medical Education predicted a future shortage of more than 85,000 physicians, if current trends in medical education and physician work force continue.

Earlier in the 1980s, this same advisory council during the predicted an oversupply.

The American population continues to grow and our longevity expands, and those factors combined with newer physicians wanting less strenuous work schedules and “fuller lifestyles” point toward an inevitable shortage of physicians.

For African-American physicians, the combination of factors listed above along with historically anemic representation in medicine

via discriminatory practices in medical education has worsened our plight.

It must be noted, however, that some medical manpower relief for our community was gained via social programs in the form of affirmative action. However, during the last two decades these programs have come under withering political assault.

In fact, minority representation in allopathic medical schools declined 7 percent during this period, according information from the GME. Currently, African Americans constitute less than 2 percent of the American physician work force but 12.5 percent of the American population.

The imposition of managed care in the

business of healthcare and the subsequent changes made it harder, at least economically, for some physicians already in the work force.

Only recently have we seen some measure of relief from the social reversals and reinvigorated racial hostilities in academia, as evidenced by the partial victory of the affirmative action programs at the University of Michigan.

It is likely, now that last year’s Michigan Supreme Court decision in effect reversed the 1996 anti-affirmative action ruling of *Hopwood v. University of Texas Law School*, that race could become a relevant component in the application and admission process for professional education. This possibly will shore up the anemic number of African-American professionals.

Guest Commentary

INSIDE THE NMA



Denard Fobbs, MD, Drew University College of Medicine President Art Fleming, MD, Ron Anderson, MD, and past NMA board member Paris Bransford, MD, prepare to attend Dr. Fobbs' presentation, "Physician, Heal Thyself."

NMA, Auxiliary Join Forces During Presidential Retreat

NMA President Randall W. Maxey, MD, and ANMA President Pamela Freeman Fobbs, JD, led a joint retreat in Amelia Island, Fla., over the Martin Luther King Memorial weekend to address health disparities.

Both associations held strategic planning sessions about NMA's and ANMA's mission to eliminate health disparities among African Americans and other underserved populations.

Warren Jones, MD, assistant vice chancellor for multicultural affairs at the University of Mississippi, presented a lecture on "Patient-Physician Relationship," with Denard Fobbs, MD, director of Lifepoint Wellness Institute, presenting a lecture entitled "Physicians Heal Thyself."

NMA Region II sponsored a smoking cessation workshop with Lawrence Robinson, MD, deputy health commissioner for the city of Philadelphia; Charyn Sutton, president of ONYX Group of Philadelphia; NMA Past President Tracy Walton Jr., MD; and Region II Chair Sandra McGruder-Jackson, MD.

Willarda Edwards, MD, chairwoman of NMA's Board of Trustees, proposed that the two organizations make this retreat an annual event, focusing on identifying strategies to address health disparities. Participants agreed unanimously.

Eleven continuing medical education hours were awarded for this event, which included several seminars.



Below, Willarda Edwards, MD, chair of NMA's Board of Trustees, left, and Sarah Harrison, vice president of AstraZeneca Pharmaceuticals, right, visit with Fobbs after a presentation. Above, ANMA President Pam Fobbs greets NMA President Randall W. Maxey, MD.



NIH Accepting Nominations for Pioneer Award Program

The National Institutes of Health invites nominations for the NIH Director's Pioneer Award (NDPA), a key component of the NIH Roadmap for Medical Research.

"The face of biomedical research is changing," said NIH Director Elias A. Zerhouni. "To keep pace, we must cross the traditional disciplinary boundaries of science and medicine to bring forward new conceptual frameworks and methodologies that will speed scientific discovery and improve health."

The Director's Pioneer Award will encourage investigators in the biomedical, behavioral and social sciences, physical and chemical sciences, computer sciences, mathematics and engineering to take on creative, unexplored avenues of research related to the improvement of human health.

While the research that will be funded may carry uncertain outcomes, the award will provide investigators with the resources and flexibility needed to pursue truly groundbreaking discoveries.

"Historically, leaps in knowledge have frequently resulted from exceptional minds willing and able to explore ideas that were considered risky at their inception," Dr. Zerhouni said. "We're seeking truly visionary thinkers who are able to make those leaps

The NIH Director's Pioneer program will fund five to 10 awards of up to \$500,000 per year for five years. For more information or to submit a nomination, visit www.nihroadmap.nih.gov.

and change the current paradigms of medical research."

In fiscal year 2004, the NDPA program will fund five to 10 awards of up to \$500,000 direct costs per year for five years.

The program is not intended to support ongoing research projects or to expand the funding of persons already well supported. Investigators at early stages of their careers and those who previously have not applied for NIH support especially are encouraged.

Nominations will be accepted from through midnight April 1 EST.

For more information or to submit a nomination, visit the NIH Director's Pioneer Award Web site at www.nihroadmap.nih.gov/highrisk/initiatives/pioneer.

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We take the lead in providing meaningful information to our members and to the public.

We take the lead in representing the interest of more than 25,000 African American physicians in all medical specialties.

We have nearly 100 affiliate societies throughout the nation and in U.S. territories and our information and resources are accessible internationally through the NMA website.

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POLICY NEWS

WHO Issues Guidelines for Herbal Medicines

United Nations health organization hopes to improve the safety and sustainability of herbs as they grow in popularity.

With growing reports of adverse effects from herbal medicines and the risk that over-harvesting could lead to the extinction of endangered species, the United Nations health agency recently issued guidelines for good agricultural and collection practices in an industry estimated to be worth more than \$60 billion a year.

The World Health Organization guidelines are intended for national governments to ensure that the production of herbal medicines – which can be the natural, readily available answer to some ailments – is safe, posing no threat to either people or the environment.

Herbal medicines are growing in popularity in wealthy countries and their use remains widespread in developing regions, but poor quality of raw plant materials and wrong identification of plant species are a major cause of adverse effects. Cultivating, collecting and classifying plants correctly are therefore of the utmost importance for the quality and safety of products, the Geneva-based WHO said in a news release.

The Guidelines on Good Agricultural and Collection Practices for Medicinal Plants also warn that the growing market and its great commercial benefit might pose a threat to biodiversity through over-harvesting of raw materials for medicines and natural health care products.

If not controlled, these practices may lead to the extinction of endangered species and the destruction of natural habitats and resources.

The guidelines cover the spectrum of cultivation and collection, including site selection, climate and soil considerations and identification of seeds and plants, as well as the main post-harvest operations and legal

At-Risk Medicinal Plants

At the top of the “at-risk list” of endangered species of medicinal plants are:



Wild American Ginseng



Black Cohosh



Echinacea



Goldenseal



Kava Kava



Slippery Elm

issues such as national and regional laws on quality standards, patent status and benefits sharing.

Among the risks highlighted are inadvertent contamination by microbial or chemical agents and misidentification of plants or intentional adulteration. In this context, the report cites cases of serious cardiac arrhythmias reported in the United States in 1997

after the accidental substitution of plantain, to be used as a dietary supplement, with *Digitalis lanata*, generally used for heart conditions.

Among endangered medicinal plants the guidelines mentioned the reported rapid decline due to increasing demand of wild ginseng used for digestive conditions resulting from nervous disorders.

IOM: Too Few Minorities in Health Care

Some U.S. minority populations are underrepresented in health care professions, a situation that could prove problematic because minority health providers “are significantly more likely than their white peers to serve minority and medically underserved communities,” according to a recent Institute of Medicine report.

According to the report, “In the Nation’s Compelling Interest: Ensuring Diversity in the Health Care Workforce,” Latinos represent 12 percent of U.S. residents but 3.5 percent of doctors, 3.4 percent of psychologists and 2 percent of nurses.

One-eighth of U.S. residents are African-American but 1/20th of U.S. physicians and dentists are African-American, the Las Vegas Sun reports. American Indians also are underrepresented in health care professions, the report says.

About 19.8 percent of medical school graduates are Asian or Pacific Islander, a larger proportion than their percentage of the U.S. population, according to the report.

The report recommends that health education institutions and accreditation groups include more minorities on their review boards and consider race, ethnicity and language skills in their admissions processes.

Further, federal, state and local governments should increase funding for programs that increase diversity in health professions and educational institutions, according to the report. The report is available online at www.iom.edu.

Survey: Some Doctors Leaving..... *Continued from page 1*

Additionally, the NMA is provided with unique insight from its membership regarding its organizational capacity, perceptions and the needs of its members.

The NMA held a focus group with two committees in the Board of Trustees and is drafting an action plan based on the findings. The NMA’s leadership is committed to continuing to listen to the voice of its members and shaping policy around the input from physicians around the country.

According to the study, the top three most important stated activities that medical associations should focus on are:

- ♦ advocate on tort reform
- ♦ advocate on behalf of patients to improve access to health insurance
- ♦ advocate for overall changes in physician reimbursement.

Some physicians indicated they have altered their practice habits by decreasing new patients and limiting patients from certain payors.

In addition, more than half of respondents

personally have experienced a problem or annoyance with reimbursement during the last six months and generally are not satisfied with how the problems were handled.

A large percentage of physicians (65 percent) had difficulty paying for professional medical liability insurance for 2003 and cited it as the biggest problem faced for the year, a major or a minor problem.

The report also indicated a decrease in confidence by physicians in the profession and that a significant number of physicians have left practice or are considering leaving practice within the next 12 months.

This could be especially damaging to minority populations and patients living in urban communities as the majority of the respondents practice in an urban setting. The findings will be published in the *Journal of the National Medical Association*.

NMA Immediate Past President L. Natalie Carroll, MD, and Trustee Sharon Allison-Otley, MD, are principal investigators of the study.

Act to Focus on Prevention..... *Continued from page 1*

“This, as the language affirms, is critical to any effort to eliminate health disparities,” Dr. Maxey said. “In addition, the legislation’s focus on prevention and best practices in disease management should serve us well. The proposal to develop an Internet clearinghouse to reduce medical errors, and increase cultural competency is also a giant step in the right direction.

“The increased support for ‘pipeline’ programs that ultimately increase the number of minority healthcare professionals is also a very welcome affirmation of the work we do every day,” he added.

Ultimate success will only be realized, Dr. Maxey cautioned, when fewer minority patients are dying from cardiovascular disease, HIV/AIDS and cancer, and when there are fewer complications from diabetes.

“When there are more minority doctors to take care of the health care needs of vulnerable populations, and health care of equal high quality is available to all who need it, then we can all heave a collective sigh of relief.”

In Support of the Act

In addition to the NMA, the “Closing the Health Care Gap Act” has garnered the support of health organizations and professionals, including:

- ♦ the Interamerican College of Physicians and Surgeons
- ♦ the Association of Minority Health Professional Schools
- ♦ the National Hispanic Medical Association
- ♦ the National Conference for Community Justice
- ♦ former U.S. Health and Human Services Secretary and Morehouse School of Medicine President Emeritus Louis W. Sullivan, MD
- ♦ former Surgeon General David Satcher, MD
- ♦ Morehouse School of Medicine President James R. Gavin III, MD
- ♦ Meharry Medical School President John Maupin, MD.

POLICY NEWS

Fraternities Promote Mentoring

Leaders of Omega Psi Phi and Kappa Alpha Psi fraternities sponsored a meeting in January that outlined the detrimental effect of the declining numbers of African-American physicians and dentists and recommended mentoring as a way to combat the problem.

NMA President Randall Maxey, MD, a speaker at the Atlanta meeting, encouraged the fraternities to help prepare and recruit more minorities into medicine by combining efforts to serve as mentors.

The meeting was organized by the Health Initiatives Committee of Omega Psi Phi, chaired by Charles Christopher, MD, of Austin, Texas. Co-organizer Ed Wilson, MD, of Los Angeles, represented Kappa Alpha Psi and participated in a panel discussion with Dr. Maxey. Other presenters included Romell Madison, DDS, of New Orleans, representing the National Dental Association; Allen Mosley, admissions director of Meharry Medical College; and medical students who emphasized the significance of mentoring in their own journey toward becoming physicians.

Several participants agreed to form a consortium to establish a national mentoring academy to address the disparity gap in minority admissions to medical and dental schools. Initial consortium partners represent the NMA, the NDA, Omega Psi Phi, Kappa Alpha Psi, Alpha Phi Alpha, and the Centers for Disease Control and Prevention.

In his remarks, Dr. Maxey cited numerous health disparities that plague the nation's health care system and especially adversely impact underserved communities.

"Minority populations do not have access to life-saving, affordable and quality health care largely because of the absence of health-

care professionals who look like them, are committed to serving them, or who are culturally competent to meet their healthcare needs," he said.

He added that a major cause of disparities in health care is due to the lack of diversity in the nation's healthcare work force.

Dr. Maxey said that parity of diversity requires the health professions to reflect America's minority population in numbers at least equal to their number in the nation's general population.

However, he pointed out that while African Americans, Hispanic Americans and American Indians represent more than 25 percent of the U.S. population, they comprise less than 14 percent of physicians, 9 percent of nurses, and only 5 percent of dentists.

Further, when looking at only African-American statistics, the data is even more dismal. He said that health disparities are made worse due to the dwindling number of African-American physicians and health professionals.

"Instead of increasing in number, as is desperately needed, we're going in the opposite direction," said Dr. Maxey. "We're becoming fewer in number." He said it is estimated that this year's entering class of medical students will have fewer than 100 African-American male students nationwide."

Dr. Maxey criticized the Bush administration's proposed 2004 budget that will cut or severely curtail several "pipeline" programs aimed at increasing diversity in the healthcare work force. These include programs that deal with Centers of Excellence, health careers opportunity, faculty loan repayment, primary care medicine and dentistry, health education



NMA President Randall Maxey, MD, center, talks with attendees at a meeting to discuss ways to increase the number of minorities in the medical field.

training, and public health work force development.

Rather than retreat from diversity programs, Dr. Maxey said, the nation needs to do more to strengthen them. "Pipeline programs seek to influence young African Americans and other minorities to pursue careers in health care by guiding and mentoring them long before they file their first medical school application," he said. "We recognize that mentoring is a part of insuring that a pipeline is secure and strong."

The Student National Medical Association coordinates programs that offer one-on-one instruction as well as group guidance and encouragement to high school and college students. Dr. Maxey said SNMA members have made it clear that mentoring and guidance make a tremendous difference in career choices and academic performance.

"We are extremely proud of the mentoring activities of our student members of the NMA," he said. "We encourage our physicians to

Sullivan Commission Looks to Increase Minority Students

Of the more than 16,000 new students who entered medical school this year, only 2,179 were African American, Hispanic or Native American. This is a drop of more than 5 percent, from last year.

Louis W. Sullivan, MD, chair of the Sullivan Commission of Diversity in the Healthcare Workforce and former U.S. Secretary of Health and Human Services, is alarmed by the dearth in the number of minority students entering medical schools.

The Sullivan Commission's mission is to find ways to curb a trend that has resulted in unequal access to a medical, dental or nursing education in the United States.

In an effort to identify solutions and boost the number of minorities entering the healthcare work force, the Sullivan Commission recently conduct-

ed testimony at a hearing in Los Angeles from health and education experts, high school students and health professionals are to prepare a final report. The report is slated to be released in April.

While African Americans, Hispanics and American Indians represent over 25 percent of the U.S. population, they comprise less than 9 percent of nurses, 6 percent of physicians and five percent of dentists.

Launched in April 2003, the 15-member commission includes key health, corporate, higher education and legal experts. The effort is administered by Duke University School of Medicine and Funded by W.K. Kellogg Foundation.

- Ramona Chube, MD

Reference:
The Philadelphia Tribune Health
December 9, 2003

follow their example and do more to make themselves available to young people who are considering careers in medicine."

Dr. Maxey pledged the support of the NMA to work with fraternities and any other interested groups in establishing a collaborative mentoring program. He said such an initiative could be an essential component in NMA's goal to increase the number of minority physicians and healthcare professionals.

"If we are to achieve parity of diversity in the American healthcare work force, it is essential that we strengthen existing medical facilities and training centers, advocate for much needed additional funding, and increase mentoring

opportunities on every level," he said.

Dr. Wilson, who serves as Kappa Alpha Psi's medical director, emphasized that mentoring can enable students to be better prepared to enter medical schools, and, once admitted, to finish. A longtime mentor himself, he suggested that the NMA form an alliance with advisors at undergraduate schools.

He said many college advisors do not properly counsel minority students about curriculum requirements, do not encourage them to pursue medical school, or are unaware of the special challenges that often confront minority students considering a career in medicine.

Prostate Screenings Necessary for Men Over 45..... Continued from page 1

educational grant from Sanofi-Synthelabo Inc., questioned 300 African-American men age 30 and older about prostate cancer risk factors and screening, as well as the effects of and treatments for the disease.

Results indicate only about 46 percent of the respondents who should be getting screened annually for prostate cancer – those age 45 and over – actually are doing so. As many as one-third had never been screened at all. In addition, only 40 percent of respondents recognize race as a risk factor for the disease.

"I would say that having been screened, and screened properly, saved my life," said entertainer and human rights advocate Harry Belafonte, who was diagnosed with prostate cancer in 1996 and has been free of the disease for more than seven years. "My task now is to get that word out to other men, and in particular, African-American men."

"The results of this survey show that we

Prostate Cancer Symptoms & Risk Factors

Even though patients with early-stage disease generally do not experience symptoms, there are several warning signs that may indicate the presence of prostate cancer:

- ◆ Difficulty starting urination or weak or interrupted urine flow
- ◆ Painful or burning urination
- ◆ Frequent and urgent need to urinate both day and night
- ◆ Urinary incontinence
- ◆ Impotence and painful ejaculation
- ◆ Blood in urine or semen

The following risk factors are often associated with the disease:

- ◆ **Age** – Prostate cancer is generally found in men over 55.
- ◆ **Family history.**
- ◆ **Race** – Prostate cancer is twice as common in African-American men as in white men.
- ◆ **Diet** – A diet high in fat may increase the risk of developing prostate cancer.

need to continue to encourage African-American men – and their spouses and families – to take an active role in their prostate health by recognizing risk factors, getting screened and understanding treatment

options," said NMA President Randall W. Maxey, MD. "We have an enormous opportunity to raise awareness and screening and, possibly, improve treatment and outcomes of the disease in our community."

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July 31 to
Aug. 5, 2004
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MEDICAL UPDATES

Campaign to 'Keep Asthma in Check'

In response to asthma's impact on the African-American community, national asthma education campaign Asthma Action America has launched a new initiative to help African Americans manage asthma more effectively.

The goal of the new initiative is to encourage African Americans who have asthma to take the Asthma Control Test and then discuss the results with their physician. The validated test features five questions, based on guidelines developed by the National Institutes of Health, which give people a quick and easy way to help gauge how their asthma is affecting them.

Dr. Michael LeNoir, former chair of NMA's Asthma and Allergy Section, and six-time Olympic medallist Jackie Joyner-Kersey are working with Asthma Action America and its 21 national supporting organizations to bring attention to the alarming impact of asthma on the African-American community.

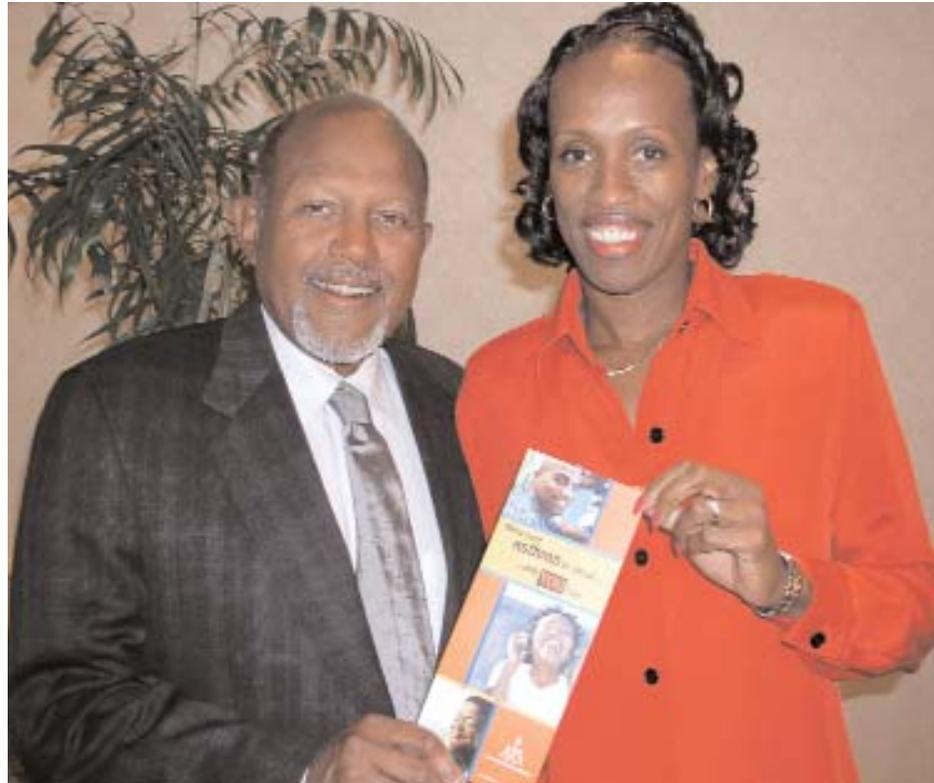
More than 3 million African Americans currently have asthma, and

African Americans are three times more likely than whites to be hospitalized for asthma or die from asthma. Though African Americans currently represent 12 percent of the U.S. population, they account for nearly 26 percent of all asthma deaths.

"These statistics are disturbing, but there are simple steps we can take now to begin to reverse these numbers for good," said LeNoir, a nationally recognized expert on inner-city asthma issues. "Asthma is a controllable disease and, with proper management, we can do much to reduce its impact on our community. Proper asthma management starts with good asthma education."

Lending her support to the campaign is Joyner-Kersey, who will narrate a series of public service announcements, scheduled to run on radio stations nationwide. In the PSAs, Joyner-Kersey tells of her own struggle with asthma and urges African Americans to take the Asthma Control Test and share the results with their doctor.

"When I was diagnosed with asthma, I thought I'd have to give up running," Joyner-



NMA Asthma and Allergy Section Chair Michael LeNoir and Olympic medalist Jackie Joyner-Kersey are working with Asthma Action America to raise awareness about the dangers of asthma.

The Asthma Control Test is available online now at AsthmaActionAmerica.org and is the centerpiece of the "Keep Your Asthma in Check" brochure, which is available free of charge by calling 1-800-377-9575.

Kersey said. "Asthma didn't stop me from competing. I learned that with the proper treatment, asthma doesn't have to stop you from doing what you want to do."

Through proper asthma management,

people with asthma can reduce their risk for serious symptoms, asthma attacks, and possibly long-term lung damage. Better control can also help reduce the large personal, societal and economic costs associated with the disease, which every year causes an estimated 5,000 deaths and results in \$14 billion in medical and indirect expenses in the country.

LeNoir urges everyone with asthma to take the Asthma Control Test, review the results with their doctor, and follow simple steps to get their asthma under control, including the following: avoiding asthma triggers; using inhaled anti-inflammatories where appropriate to prevent symptoms; working closely with healthcare professionals; regularly monitoring asthma control.

Disparities Found in Psychiatric Treatment

By Zia U. Wahid, MD
Special to NMA News

Mental disorders in the elderly are common. Approximately 20 percent of adults over the age of 55 years experience depression, anxiety, age-related memory problems or other disorders.

Treating psychiatric disorders in the elderly is difficult due to social, financial and biological reasons. This difficulty is especially true for ethnic minorities.

To look at whether Medicare Managed Care provide equal treatment for mental illness across races, researchers performed an observational study of 4,000 to approximately 5 million elderly enrolled in Medicare+ Choice plans in 1999. Rates of psychiatric inpatient discharges, length of stay, percentage of members receiving psychiatric services, rates of follow-up, optimum follow-up for medication management, and effective treatments in different settings were measured.

The researchers found that compared with whites, minorities received substantially less follow-up after hospitalization for mental health. Minorities also had lower rates of antidepressant medication management for newly diagnosed episodes of depression and lower rates for optimum practitioner contacts and effective continuation-phase treatment.

These disparities persisted even after adjustment for age, sex, plan model, profit status, and region of country.

Reference:

Beth Virnig, PhD, MPH; Zhen Huang, MS; Nicole Lurie, MD, MSPH; Dorothea Musgraves, MPH; A. Marshall CcBean, MD, MSc; Bryan Dowd, PhD: Does Medicare Managed Care Provide Equal Treatment for Mental Illness Across Races? Archives of General Psychiatry, 2004; February; 61; 201-205.

Highlights from Upcoming Issues of the JNMA

APRIL

- ♦ Comparison of Antireflux Surgery Among Ethnicity
- ♦ Hypertension and Concomitant Diseases: Guide for Evidence-Based Therapy
- ♦ Global Health Disparities: Crisis in the Diaspora
- ♦ Chronic Disease Control in African-American Faith-Based Communities: Opportunities and Challenges
- ♦ Diabetes, Depression, and Healthcare Utilization in Low-Income Primary Care Setting
- ♦ Youth Homicide Racial Disparities: Gender, Years, and Cause
- ♦ Community Health Workers and Home Based Care Programs for HIV Clients
- ♦ Frequency of Osteoporosis

- in Older African-American Women
- ♦ Expectations of Blood Pressure Management in Hypertensive African-American Patients
- ♦ Application of BMI Principles in a Model Elementary School: Implications for Childhood Obesity
- ♦ Inequality and Adolescent Violence: An Exploration of Community, Family, Individual Factors

MAY

- ♦ Region of Residence in the United States and Hypertension Incidence: the NHANES I Epidemiologic Follow-up Study
- ♦ Natural History of Multifocal Solitary Fibrous

- Tumors of the Pleura
- ♦ Serum Ferritin Levels and Transferrin Saturation in Prostate Cancer Patients
- ♦ Developing Effective Approaches in Breast and Colorectal Cancer Risk
- ♦ Communication for African-American and Hispanic Women
- ♦ Chatting Behavior and Patient Satisfaction in the Outpatient Encounter
- ♦ Cervico-Mediastinal Tuberculous Lymphadenitis Presenting as Prolonged Fever of Unknown Origin
- ♦ Coronary Heart Disease, Chronic Inflammation, and Pathogenic Social Hierarchy: a Biological Limit to Possible Reductions in Morbidity and Mortality

- ♦ Awareness of Hypertension and its Determinants Among Hypertensive Patients
- ♦ Dyspepsia in African-American and Hispanic Patients
- ♦ March of Dimes Prematurity Campaign: Call to Action

JUNE

- ♦ Kidney Disease in the Hispanic Population: Facing the Growing Challenge
- ♦ Disparities in Prevalence Rates for Lung, Colorectal, Breast, and Prostate Cancers in Maryland Medicaid
- ♦ Naturalistic Study of Factors Influencing African-American Men's Prostate Cancer Screening Behavior
- ♦ Prevalence Comparison of First Degree Atrioventricular

- Block in African-American and Caucasian Patients
- ♦ Meharry's Past Presidents
- ♦ Metabolic Syndrome X in Type 2 Diabetics
- ♦ Cardiovascular Risk Factors in Type 2 Diabetics with Clinical Diabetic Nephropathy
- ♦ Renal Failure in Patient with Autosomal Dominant Polycystic Kidney Disease and Co-Existing Dermato-Polyomyositis
- ♦ Acute Cardiovascular Responses to Tobacco smoking among African-American Adolescents
- ♦ Smoking Cessation Practices of Physicians
- ♦ Ethnic Differences in Satisfaction and Quality of Life in Veterans with Ischemic Heart Disease

MEDICAL UPDATES

Encourage Patients to Eat More Fruits and Vegetables

Every day, physicians and other health care professionals see African-American men who suffer the reality of health disparities.

African-American men have the highest death rates from diet-related chronic diseases compared with other ethnic or racial groups. They also experience a disproportionate burden of serious health problems associated with these diseases.

Consider:

- ♦ African-American men have the highest rates of many cancers and have about 1.5 times the mortality rate as white men.

- ♦ African-American men are twice as likely as white men to develop diabetes.

- ♦ 36 percent of African-American men have high blood pressure.

- ♦ African-American men age 35

to 44 have twice the mortality rate from heart disease than white men.

These diet-related diseases may be avoidable with simple lifestyle changes. There is a well-established link between healthy lifestyles — including physical activity and eating a healthy diet rich in fruits and vegetables — and a lower risk for disease.

A healthy diet is rich in fruits and vegetables and emphasizes whole grains. A healthy diet also includes moderate amounts of fish, poultry, and nuts and limited amounts of red meat, sweets, and sugar-containing beverages and is low in saturated fat and cholesterol.

To promote good health and reduce the risk for chronic disease, the National Cancer Institute recommends that men eat nine servings of fruits and vegetables a day

as part of an active lifestyle.

Yet African American men eat only three servings of fruits and vegetables a day on average, only one-third of the nine servings recommended.

“As primary care providers, we need to encourage our male patients to eat a healthier diet and be more physically active,” said Terry Mason, MD, of Mercy Hospital in Chicago.

One serving of fruits and vegetables should fit within the palm of a hand. A serving is a medium piece of fruit; ½ cup of raw or cooked, cut-up fruit or vegetable; 1 cup of leafy greens; ¼ cup of dried fruit; 6 ounces of 100% juice; or ½ cup of cooked beans or peas.

As part of a national initiative to encourage African-American men to increase their fruit and vegetable

Guide to Getting Enough

Recommended daily servings of fruits and vegetables:

	Vegetables	Fruits	Total
Children ages 2 to 6, some women, some older adults.	3	2	5
Children over age 6, teenage girls, active women, some men.	4	3	7
Teenage boys, active men	5	4	9

Source: United States Department of Agriculture/Department of Health and Human Services, Dietary Guidelines for Americans 2000

consumption, the National Cancer Institute is offering a patient education brochure: “Men: Eat 9 A Day.” This brochure is available in bulk

for physicians’ offices for free. To order the brochure, call 1-800-4-CANCER. For more information, visit www.9aday.cancer.gov.

Medical Briefs

Organ Transplant Rates Improving Among African Americans

In light of the many disparities African American have endured in the health care system, a report in the *New England Journal of Medicine* has some good news on ameliorating these problems.

As a result of new rules for testing transplant compatibility among the general population, as recommended by the American government in May 2003, kidney transplant rates increased among African Americans by 7.2 percent. Experts explained that if they removed the HLA-B matching criteria for transplant compatibility, the rates of transplants in non-whites would increase accordingly, and it did.

Presumably, based on these new criteria, we can expect more accessibility to transplants for African Americans, if similar changes are made in other areas of transplant medicine.

- George Dawson, MD

Reference:

1. Roberts JP, Wolfe RA, Bragg-Gresham JL, Rush SH, Wynn JJ, Distant DA, et al. Effect of Changing the Priority for HLA Matching on the Rates and Outcomes of Kidney Transplantation in Minority Groups. *The New England Journal of Medicine*. February 5, 2004. vol.350; no.6; 545-551.

Report Shows Increase in Med School Applicants

According to the Association of American Medical Colleges (AAMC), almost 35,000 persons applied to medical school in the 2003-04 school year compared with 33,625 last year. This is a 3.4 percent increase for the first time in six years.

The number of female applicants, (17,672) made up more than half of medical school applicants for the first time. The number of black applicants overall rose almost 5 percent to 2,736, but the

number of blacks who entered medical school declined by 6 percent to 1,056.

Black female applicants increased by almost 10 percent to 1,904. Hispanic applicants increased by less than 2 percent to 2,483, while the number who entered medical school declined by almost 4 percent to 1,089. The applicant pool included 26,160 persons who were applying to medical school for the first time.

The data also showed that the sharp decline in male applicants, a trend that started in 1997, leveled off this year with a total of 17,113 applicants, which was slightly more than last year. The number of applicants to medical school peaked at around 47,000 in 1996 and reached the lowest point last year.

- Ramona Chube, MD

Reference:

American Family Physician Newsletter Jan 1, 2004/vol 69/no.1.

Black Women Less Likely to Follow Up After Abnormal Mammograms

Early screening and regular follow-up are best tools against morbidity and mortality associated with breast cancer. A study by Drs. Jon F. Kerner, Michael Yedidia and Deborah Padgett looked at the rate of follow-up by black women who have an abnormal result from mammogram.

The researchers found that over 25 percent of black women who have abnormal results from mammograms or clinical breast exams still had not resolved the diagnosis with follow-up tests six months later. This finding is of great significance because delays of this magnitude may compromise survival. It has been established that for women ultimately determined to have breast cancer, delays of 3-6 months are associated with lower survival rates than women who have shorter

delays.

In this timely study, black women with prior breast abnormalities or with higher levels of cancer anxiety were about half as likely as others to resolve the diagnosis in 3-6 months.

On the other hand, women who reported being told what was to happen next and those who remembered receiving the results of their mammograms were significantly more likely to have diagnostic resolution within three months.

The researchers assessed the association between patient and health care system factors and diagnostic resolution of the abnormal findings within 3-6 months. Nearly 37 percent of women reported some kind of symptom at the time of the abnormal finding. Overall, 39 percent of the women were without diagnostic resolution within three months and 28 percent within six months. Neither socioeconomic status nor system barriers were associated with timely diagnostic resolution.

The researcher recommended improving communication during the mammogram process, particularly if women have had a prior breast abnormality, and ensuring that the patient is told about the next steps to take and fully understands the importance of quick follow-up.

- Zia Wahid, MD

Reference:

1. Jon F. Kerner, Ph.D., Michael Yedidia, Ph.D., Deborah Padgett, Ph.D., et al. Realizing the promise of breast cancer screening: Clinical follow-up after abnormal screening among black women; *Preventive Medicine* 37, pp. 92-101, 2003.

Community-Based Programs May Help Reduce Hypertension

There is higher rate of morbidity and mortality associated with hypertension in African Americans. Lower socioeconomic status, urban living and reduced access to health care are some of the

factors resulting in this disparity.

In West Baltimore, a community-based program partnered with an academic health center and train community health workers to make home visits and do community outreach to reduce hypertension.

Nearly 800 men and women were recruited in the study, 37 percent of whom suffered from hypertension. The researchers randomly assigned 387 patients to a more intensive group of education and support and 402 patients to a less intensive group. The less intensive group received a home visit from a nurse-supervised community health worker trained in blood pressure measurement, monitoring, education, follow-up and community outreach.

Community health workers explained hypertension and its treatment and the importance of following treatment and achieving a target blood pressure. They provided information on access to free community care for those who needed it. Each participant received a card to record dates and BP levels and a pamphlet that emphasized self-care behaviors.

The more intensive intervention added five home visits conducted over a 30-month period, as well as more extensive education, counseling and outreach.

Although both programs significantly decreased blood pressure at the 40-month follow-up, the differences between the groups were insignificant. Blood pressure control doubled for both groups. The percentage of individuals with normal blood pressure increased by 12 percent in the more intensive group and 14 percent in the less intensive group.

- Zia Wahid, MD

References:

1. Agency for Health Research and Quality; Publication No. 04-R003

2. David M. Levine, MD, Lee R. Bone, R.N., M.P.H., Martha N. Hill, R.N., Ph.D., et al. The effectiveness of a community/academic health center partnership in decreasing the level of blood pressure in an urban African-American population; *Ethnicity & Disease* 2003 13, pp. 354-361.

LIPITOR® (Atorvastatin Calcium) Tablets

Brief Summary of Prescribing Information

CONTRAINDICATIONS: Active liver disease or unexplained persistent elevations of serum transaminases.

Hypersensitivity to any component of this medication. **Pregnancy and Lactation** — Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. ATORVASTATIN SHOULD BE ADMINISTERED TO WOMEN OF CHILDBEARING AGE ONLY WHEN SUCH PATIENTS ARE HIGHLY UNLIKELY TO CONCEIVE AND HAVE BEEN INFORMED OF THE POTENTIAL HAZARDS. If the patient becomes pregnant while taking this drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS: Liver Dysfunction — HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. **Persistent elevations (>3 times the upper limit of normal [ULN] occurring on 2 or more occasions) in serum transaminases occurred in 0.7% of patients who received atorvastatin in clinical trials. The incidence of these abnormalities was 0.2%, 0.2%, 0.6%, and 2.3% for 10, 20, 40, and 80 mg, respectively.** One patient in clinical trials developed jaundice. Increases in liver function tests (LFT) in other patients were not associated with jaundice or other clinical signs or symptoms. Upon dose reduction, drug interruption, or discontinuation, transaminase levels returned to or near pretreatment levels without sequelae. Eighteen of 30 patients with persistent LFT elevations continued treatment with a reduced dose of atorvastatin. **It is recommended that liver function tests be performed prior to and at 12 weeks following both the initiation of therapy and any elevation of dose, and periodically (eg, semiannually) thereafter.** Liver enzyme changes generally occur in the first 3 months of treatment with atorvastatin. Patients who develop increased transaminase levels should be monitored until the abnormalities resolve. Should an increase in ALT or AST of >3 times ULN persist, reduction of dose or withdrawal of atorvastatin is recommended. Atorvastatin should be used with caution in patients who consume substantial quantities of alcohol and/or have a history of liver disease. Active liver disease or unexplained persistent transaminase elevations are contraindications to the use of atorvastatin (see CONTRAINDICATIONS). **Skeletal Muscle** — **Rare cases of rhabdomyolysis with acute renal failure secondary to myoglobinuria have been reported with atorvastatin and with other drugs in this class.** Uncomplicated myalgia has been reported in atorvastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aches or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values >10 times ULN, should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. Atorvastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. The risk of myopathy during treatment with drugs in this class is increased with concurrent administration of cyclosporine, fibric acid derivatives, erythromycin, niacin, or azole antifungals. Physicians considering combined therapy with atorvastatin and fibric acid derivatives, erythromycin, immunosuppressive drugs, azole antifungals, or lipid-lowering doses of niacin should carefully weigh the potential benefits and risks and should carefully monitor patients for any signs or symptoms of muscle pain, tenderness, or weakness, particularly during the initial months of therapy and during any periods of upward dosage titration of either drug. Periodic creatine phosphokinase (CPK) determinations may be considered in such situations, but there is no assurance that such monitoring will prevent the occurrence of severe myopathy. **Atorvastatin therapy should be temporarily withheld or discontinued in any patient with an acute, serious condition suggestive of a myopathy or having a risk factor predisposing to the development of renal failure secondary to rhabdomyolysis (eg, severe acute infection, hypotension, major surgery, trauma, severe metabolic, endocrine and electrolyte disorders, and uncontrolled seizures).**

PRECAUTIONS: General — Before instituting therapy with atorvastatin, an attempt should be made to control hypercholesterolemia with appropriate diet, exercise, and weight reduction in obese patients, and to treat other underlying medical problems (see INDICATIONS AND USAGE in full prescribing information). **Information for Patients** — Patients should be advised to report promptly unexplained muscle pain, tenderness, or weakness, particularly if accompanied by malaise or fever. **Drug Interactions** — The risk of myopathy during treatment with drugs of this class is increased with concurrent administration of cyclosporine, fibric acid derivatives, niacin (nicotinic acid), erythromycin, azole antifungals (see WARNINGS, Skeletal Muscle). **Antacid:** When atorvastatin and Maalox® TC suspension were coadministered, plasma concentrations of atorvastatin decreased approximately 35%. However, LDL-C reduction was not altered. **Antipyryne:** Because atorvastatin does not affect the pharmacokinetics of antipyryne, interactions with other drugs metabolized via the same cytochrome isozymes are not expected. **Colestipol:** Plasma concentrations of atorvastatin decreased approximately 25% when colestipol and atorvastatin were coadministered. However, LDL-C reduction was greater when atorvastatin and colestipol were coadministered than when either drug was given alone. **Cimetidine:** Atorvastatin plasma concentrations and LDL-C reduction were not altered by coadministration of cimetidine. **Digoxin:** When multiple doses of atorvastatin and digoxin were coadministered, steady-state plasma digoxin concentrations increased by approximately 20%. Patients taking digoxin should be monitored appropriately. **Erythromycin:** In healthy individuals, plasma concentrations of atorvastatin increased approximately 40% with coadministration of atorvastatin and erythromycin, a known inhibitor of cytochrome P450 3A4 (see WARNINGS, Skeletal Muscle). **Oral Contraceptives:** Coadministration of atorvastatin and an oral contraceptive increased AUC values for norethindrone and ethinyl estradiol by approximately 30% and 20%. These increases should be considered when selecting an oral contraceptive for a woman taking atorvastatin.

Warfarin: Atorvastatin had no clinically significant effect on prothrombin time when administered to patients receiving chronic warfarin treatment. **Endocrine Function** — HMG-CoA reductase inhibitors interfere with cholesterol synthesis and theoretically might blunt adrenal and/or gonadal steroid production. Clinical studies have shown that atorvastatin does not reduce basal plasma cortisol concentration or impair adrenal reserve. The effects of HMG-CoA reductase inhibitors on male fertility have not been studied in adequate numbers of patients. The effects, if any, on the pituitary-gonadal axis in premenopausal women are unknown. Caution should be exercised if an HMG-CoA reductase inhibitor is administered concomitantly with drugs that may decrease the levels or activity of endogenous steroid hormones, such as ketoconazole, spironolactone, and cimetidine. **CNS Toxicity** — Brain hemorrhage was seen in a female dog treated for 3 months at 120 mg/kg/day. Brain hemorrhage and optic nerve vacuolation were seen in another female dog that was sacrificed in moribund condition after 11 weeks of escalating doses up to 280 mg/kg/day. The 120 mg/kg dose resulted in a systemic exposure approximately 16 times the human plasma area-under-the-curve (AUC, 0-24 hours) based on the maximum human dose of 80 mg/day. A single tonic convulsion was seen in each of 2 male dogs (one treated at 10 mg/kg/day and one at 120 mg/kg/day) in a 2-year study. No CNS lesions have been observed in mice after chronic treatment for up to 2 years at doses up to 400 mg/kg/day or in rats at doses up to 100 mg/kg/day. These doses were 6 to 11 times (mouse) and 8 to 16 times (rat) the human AUC (0-24) based on the maximum recommended human dose of 80 mg/day. CNS vascular lesions, characterized by perivascular hemorrhages, edema, and mononuclear cell infiltration of perivascular spaces, have been observed in dogs treated with other members of this class. A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion at a dose that produced plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose. **Carcinogenesis, Mutagenesis, Impairment of Fertility** — In a 2-year carcinogenicity study in rats at dose levels of 10, 30, and 100 mg/kg/day, 2 rare tumors were found in muscle in high-dose females: in one, there was a rhabdomyosarcoma and, in another, there was a fibrosarcoma. This dose represents a plasma AUC (0-24) value of approximately 16 times the mean human plasma drug exposure after an 80 mg oral dose. A 2-year carcinogenicity study in mice given 100, 200, or 400 mg/kg/day resulted in a significant increase in liver adenomas in high-dose males and liver carcinomas in high-dose females. These findings occurred at plasma AUC (0-24) values of approximately 6 times the mean human plasma drug exposure after an 80 mg oral dose. *In vitro*, atorvastatin was not mutagenic or clastogenic in the following tests with and without metabolic activation: the Ames test with *Salmonella typhimurium* and *Escherichia coli*, the HGPRT forward mutation assay in Chinese hamster lung cells, and the chromosomal aberration assay in Chinese hamster lung cells. Atorvastatin was negative in the *in vivo* mouse micronucleus test. Studies in rats performed at doses up to 175 mg/kg (15 times the human exposure) produced no changes in fertility. There was aplasia and aspermia in the epididymis of 2 of 10 rats treated with 100 mg/kg/day of atorvastatin for 3 months (16 times the human AUC at the 80 mg dose); testis weights were significantly lower at 30 and 100 mg/kg and epididymal weight was lower at 100 mg/kg. Male rats given 100 mg/kg/day for 11 weeks prior to mating had decreased sperm motility, spermatid head concentration, and increased abnormal sperm. Atorvastatin caused no adverse effects on semen parameters, or reproductive organ histopathology in dogs given doses of 10, 40, or 120 mg/kg for two years. **Pregnancy** — **Pregnancy Category X: See CONTRAINDICATIONS.** Safety in pregnant women has not been established. Atorvastatin crosses the rat placenta and reaches a level in fetal liver equivalent to that of maternal plasma. Atorvastatin was not teratogenic in rats at doses up to 300 mg/kg/day or in rabbits at doses up to 100 mg/kg/day. These doses resulted in multiples of about 30 times (rat) or 20 times (rabbit) the human exposure based on surface area (mg/m²). In a study in rats given 20, 100, or 225 mg/kg/day, from gestation day 7 through to lactation day 21 (weaning), there was decreased pup survival at birth, neonate, weaning, and maturity in pups of mothers dosed with 225 mg/kg/day. Body weight was decreased on days 4 and 21 in pups of mothers dosed at 100 mg/kg/day; pup body weight was decreased at birth and at days 4, 21, and 91 at 225 mg/kg/day. Pup development was delayed (rotorod performance at 100 mg/kg/day and acoustic startle at 225 mg/kg/day; pinnae detachment and eye opening at 225 mg/kg/day). These doses correspond to 6 times (100

mg/kg) and 22 times (225 mg/kg) the human AUC at 80 mg/day. Rare reports of congenital anomalies have been received following intrauterine exposure to HMG-CoA reductase inhibitors. There has been one report of severe congenital bony deformity, tracheo-esophageal fistula, and anal atresia (VATER association) in a baby born to a woman who took lovastatin with dextroamphetamine sulfate during the first trimester of pregnancy. LIPITOR should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking LIPITOR, it should be discontinued and the patient advised again as to the potential hazards to the fetus. **Nursing Mothers** — Nursing rat pups had plasma and liver drug levels of 50% and 40%, respectively, of that in their mother's milk. Because of the potential for adverse reactions in nursing infants, women taking LIPITOR should not breast-feed (see CONTRAINDICATIONS). **Pediatric Use** — Safety and effectiveness in patients 10-17 years of age with heterozygous familial hypercholesterolemia have been evaluated in controlled clinical trials of 6 months duration in adolescent boys and postmenarchal girls. Patients treated with LIPITOR had an adverse experience profile generally similar to that of patients treated with placebo, the most common adverse experiences observed in both groups, regardless of causality assessment, were infections. **Doses greater than 20 mg have not been studied in this patient population.** In this limited controlled study, there was no detectable effect on growth or sexual maturation in boys or on menstrual cycle length in girls. See CLINICAL PHARMACOLOGY, *Clinical Studies* section in full prescribing information; ADVERSE REACTIONS, *Pediatric Patients*; and DOSAGE AND ADMINISTRATION, *Pediatric patients (10-17 years of age) with Heterozygous Familial Hypercholesterolemia* in full prescribing information. Adolescent females should be counseled on appropriate contraceptive methods while on LIPITOR therapy (see CONTRAINDICATIONS and PRECAUTIONS, *Pregnancy*). **LIPITOR has not been studied in controlled clinical trials involving pre-pubertal patients or patients younger than 10 years of age.** Clinical efficacy with doses up to 80 mg/day for 1 year have been evaluated in an uncontrolled study of patients with homozygous FH including 8 pediatric patients. See CLINICAL PHARMACOLOGY, *Clinical Studies in Homozygous Familial Hypercholesterolemia* in full prescribing information. **Geriatric Use** — The safety and efficacy of atorvastatin (10-80 mg) in the geriatric population (≥ 65 years of age) was evaluated in the ACCESS study. In this 54-week open-label trial, 1,958 patients initiated therapy with atorvastatin 10 mg. Of these, 835 were elderly (≥ 65 years) and 1,123 were non-elderly. The mean change in LDL-C from baseline after 6 weeks of treatment with atorvastatin 10 mg was -38.2% in the elderly patients versus -34.6% in the non-elderly group. The rates of discontinuation due to adverse events were similar between the two age groups. There were no differences in clinically relevant laboratory abnormalities between the age groups.

ADVERSE REACTIONS: LIPITOR is generally well-tolerated. Adverse reactions have usually been mild and transient. In controlled clinical studies of 2502 patients, <2% of patients were discontinued due to adverse experiences attributable to atorvastatin. The most frequent adverse events thought to be related to atorvastatin were constipation, flatulence, dyspepsia, and abdominal pain. **Clinical Adverse Experiences** — Adverse experiences reported in ≥2% of patients in placebo-controlled clinical studies of atorvastatin, regardless of causality assessment, are shown in the following table.

BODY SYSTEM Adverse Event	Adverse Events in Placebo-Controlled Studies (% of Patients)				
	Placebo N = 270	Atorvastatin 10 mg N = 863	Atorvastatin 20 mg N = 36	Atorvastatin 40 mg N = 79	Atorvastatin 80 mg N = 94
BODY AS A WHOLE					
Infection	10.0	10.3	2.8	10.1	7.4
Headache	7.0	5.4	16.7	2.5	6.4
Accidental Injury	3.7	4.2	0.0	1.3	3.2
Flu Syndrome	1.9	2.2	0.0	2.5	3.2
Abdominal Pain	0.7	2.8	0.0	3.8	2.1
Back Pain	3.0	2.8	0.0	3.8	1.1
Allergic Reaction	2.6	0.9	2.8	1.3	0.0
Asthenia	1.9	2.2	0.0	3.8	0.0
DIGESTIVE SYSTEM					
Constipation	1.8	2.1	0.0	2.5	1.1
Diarrhea	1.5	2.7	0.0	3.8	5.3
Dyspepsia	4.1	2.3	2.8	1.3	2.1
Flatulence	3.3	2.1	2.8	1.3	1.1
RESPIRATORY SYSTEM					
Sinusitis	2.6	2.8	0.0	2.5	6.4
Pharyngitis	1.5	2.5	0.0	1.3	2.1
SKIN AND APPENDAGES					
Rash	0.7	3.9	2.8	3.8	1.1
MUSCULOSKELETAL SYSTEM					
Arthralgia	1.5	2.0	0.0	5.1	0.0
Myalgia	1.1	3.2	5.6	1.3	0.0

The following adverse events were reported, regardless of causality assessment in patients treated with atorvastatin in clinical trials. The events in *italics* occurred in ≥2% of patients and the events in plain type occurred in <2% of patients.

Body as a Whole: *Chest pain*, face edema, fever, neck rigidity, malaise, photosensitivity reaction, generalized edema. **Digestive System:** *Nausea*, gastroenteritis, liver function tests abnormal, colitis, vomiting, gastritis, dry mouth, rectal hemorrhage, esophagitis, eructation, glossitis, mouth ulceration, anorexia, increased appetite, stomatitis, biliary pain, cheilitis, duodenal ulcer, dysphagia, enteritis, melena, gum hemorrhage, stomach ulcer, tenesmus, ulcerative stomatitis, hepatitis, pancreatitis, cholestatic jaundice. **Respiratory System:** *Bronchitis, rhinitis, pneumonia, dyspnea, asthma, epistaxis.* **Nervous System:** *Insomnia, dizziness, paresthesia, somnolence, amnesia, abnormal dreams, libido decreased, emotional lability, incoordination, peripheral neuropathy, torticollis, facial paralysis, hyperkinesia, depression, hypesthesia, hypertonia.* **Musculoskeletal System:** *Arthritis*, leg cramps, bursitis, tenosynovitis, myasthenia, tendinosis contracture, myositis. **Skin and Appendages:** Pruritus, contact dermatitis, alopecia, dry skin, sweating, acne, urticaria, eczema, seborrhea, skin ulcer. **Urogenital System:** *Urinary tract infection*, urinary frequency, cystitis, hematuria, impotence, dysuria, kidney calculus, nocturia, epididymitis, fibrocystic breast, vaginal hemorrhage, albuminuria, breast enlargement, metrorrhagia, nephritis, urinary incontinence, urinary retention, urinary urgency, abnormal ejaculation, uterine hemorrhage. **Special Senses:** Amblyopia, tinnitus, dry eyes, refraction disorder, eye hemorrhage, deafness, glaucoma, parosmia, taste loss, taste perversion. **Cardiovascular System:** Palpitation, vasodilatation, syncope, migraine, postural hypotension, phlebitis, arrhythmia, angina pectoris, hypertension. **Metabolic and Nutritional Disorders:** *Peripheral edema*, hyperglycemia, creatine phosphokinase increased, gout, weight gain, hypoglycemia. **Hemic and Lymphatic System:** Ecchymosis, anemia, lymphadenopathy, thrombocytopenia, petechia.

Postintroduction Reports — Adverse events associated with LIPITOR therapy reported since market introduction, that are not listed above, regardless of causality assessment, include the following: anaphylaxis, angioneurotic edema, bullous rashes (including erythema multiforme, Stevens-Johnson syndrome, and toxic epidermal necrolysis), and rhabdomyolysis. **Pediatric Patients (ages 10-17 years)** In a 26-week controlled study in boys and postmenarchal girls (n=140), the safety and tolerability profile of LIPITOR 10 to 20 mg daily was generally similar to that of placebo (see CLINICAL PHARMACOLOGY, *Clinical Studies* section in full prescribing information and PRECAUTIONS, *Pediatric Use*).

OVERDOSAGE: There is no specific treatment for atorvastatin overdose. In the event of an overdose, the patient should be treated symptomatically, and supportive measures instituted as required. Due to extensive drug binding to plasma proteins, hemodialysis is not expected to significantly enhance atorvastatin clearance.

Please see full prescribing information for additional information about LIPITOR.

Ⓡ only

Pharmaceuticals

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Rev. 2, November 2002



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10 



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Power to help patients meet their lipid goals

When used with diet and exercise to reduce LDL-C and TG and increase HDL-C



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Important information:

LIPITOR[®] (atorvastatin calcium) is indicated as an adjunct to diet to reduce elevated total-C, LDL-C, apo B, and TG levels and to increase HDL-C in patients with primary hypercholesterolemia (heterozygous familial and nonfamilial) and mixed dyslipidemia. LIPITOR is contraindicated in patients with hypersensitivity to any component of this medication; in patients with active liver disease or unexplained persistent elevations of serum transaminases; in women during pregnancy and in nursing mothers.

With any statin, tell patients to promptly report muscle pain, tenderness, or weakness. Discontinue drug if myopathy is suspected, if creatine phosphokinase (CPK) levels rise markedly, or if the patient has risk factors for rhabdomyolysis.

It is recommended that liver function tests be performed prior to and 12 weeks following both the initiation of therapy and any elevation of dose, and periodically thereafter.

In clinical trials, the most common adverse events were constipation, flatulence, dyspepsia, and abdominal pain.

The effect of LIPITOR on cardiovascular morbidity and mortality has not been determined.

Please see brief summary of prescribing information on adjacent page.

Tablets not shown to scale.

MANAGING YOUR PRACTICE

Getting the Most From This Year's Tax Breaks

□ You can reduce the amount you owe, if you know where to look. Here's help.

By Dennis Murray
Medical Economics

EDITOR'S NOTE – This article was reprinted with permission from the Feb. 6 issue of *Medical Economics*. For more, visit www.memag.com.

Things look brighter for physicians this tax season. If you've grown accustomed to being squeezed by the IRS, you'll appreciate some new tax breaks that went into effect last May. These come in addition to other, often-overlooked ways to reduce your tax bill.

We asked nine certified public accountants to tell us about the tax breaks they consider most important and where you can claim them on Form 1040 and its schedules. Even if you plan to hire someone to do your tax return, what the experts share here may alert you to opportunities to raise with your accountant or that you could take advantage of in the future with a little planning.

FORM 1040

♦ **Open an IRA for a nonworking spouse.** "Many doctors assume they can't get a deduction for IRA contributions, but that's not always the case," says CPA Mary McGrath, of Cozad Asset Management in Champaign, IL. As long as your adjusted gross income for 2003 is \$150,000 or less, you can deduct contributions to an IRA set up for an unemployed spouse. You must choose a traditional IRA, though, not a Roth IRA. Because Roth IRAs are funded with after-tax dollars, contributions to them aren't deductible. (However, withdrawals from a Roth are tax-free if you're older than 59 1/2 and have had the account for more than five years.) Your spouse can put up to \$3,000 into the IRA if he or she is younger than 50—\$3,500 if 50 or older. Enter the amount on Line 24 of your Form 1040.

♦ **Establish and fund a retirement plan.** Even if you're young and saddled with debt, a self-employed doctor should fund a retirement plan; it earns you a deduction on Line 30 of your Form 1040. The earlier you start, the better, because the more time you have in the stock market, the more time your money has to grow.

If you haven't contributed to a retirement plan for 2003, you generally have until April 15 to do so. If you're self-employed or in a partnership, you can open a SEP IRA with any major bank, brokerage house, or mutual fund company and contribute 20 percent of your net income (minus half your self-employment tax), to a maximum of \$40,000. Slightly different rules for contributions and deductions may apply to different types of retirement plans, so consult with a tax professional as soon as possible.

♦ **Take another look at the standard deduction.** Relief has finally arrived for married couples who file jointly. The basic standard deduction is now \$9,500—double the amount for single taxpayers—compared with \$7,850 last year. Previously, marrieds who filed jointly paid more tax as a couple than

Don't Miss These Hidden Deductions

You may be entitled to more tax write-offs than you thought. Some of your expenses for 2003 may be deductible interest payments hiding under other labels. The following list will help identify them. But remember: To be deductible, they must relate to your home, business, or investments.

♦ **Settlement charges on a new home.** If you bought or sold a home last year, you probably wrote one check to cover all your settlement charges. They may have included mortgage interest paid by the closing agent on your behalf. In that case, the settlement statement will show the amount. If it's not reflected in the year-end summary Form 1098 the lender sent you, deduct it on your tax return as "Home-mortgage interest not reported on Form 1098."

♦ **Late-payment charges.** These are sometimes tacked on to past-due business loan payments or non-personal property taxes, either as service fees or as interest. If the charge is a percentage of the amount owed, it's usually considered to be deductible interest.

♦ **Prepayment penalties.** Some loan agreements penalize the borrower if he pays off the loan before its scheduled maturity. If you sold your house last year and incurred such a penalty, you're entitled to claim it as interest expense. Check the lender's statement to see whether it was included in the interest total. If not, add it to your write-off.

♦ **Advance interest.** Generally, you can't take a deduction on your 2003 return for interest paid last year that wasn't due until 2004 or later. But suppose you sent the bank your Jan. 1 mortgage payment in December before you went on a year-end vacation. Mortgage payments are for the month just ended, so the interest was actually for December and you paid it in that month. Hence, you can claim it as a 2003 expense.

♦ **"Points."** The extra money you pay the lender when you get a mortgage is usually considered advance or "prepaid" interest. In some cases, the full amount is deductible up front; in others, you have to amortize it over the term of the mortgage. If you've been amortizing the points you paid on a mortgage and you refinanced with a different lender or sold the property last year, you're entitled to an interest deduction on your 2003 return for the unamortized amount.

♦ **Insurance-policy loans.** If you borrow on a policy's cash value, for business or investment purposes, you can choose to have the interest added to the outstanding loan balance. If you repaid such a loan last year, all the accumulated interest is a 2003 deduction; you couldn't claim any of it previously, since you didn't actually pay it.

The rules on interest deductions aren't easy to follow. But your efforts in ferreting them out are likely to produce handsome tax savings. And you'll have the added satisfaction of knowing that Uncle Sam is sharing the expense of your loan.

— Vicki F. Brentnall, *Medical Economics*

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they would have if they were single and had filed individual returns.

"The new rule will save couples in the 25-35 percent tax brackets about \$1,000," says CPA Guy McPhail, of Zdenek Financial Planning in Flemington, NJ. If you're taking the standard deduction instead of itemizing, it goes on Line 37 of Form 1040. Alas, this year's bounty will probably be short-lived: Beginning in 2005, couples who file jointly will once again receive less than twice the amount as a single person.

SCHEDULE A

♦ **Count your boat as a second home.** Have you been daydreaming about lounging on your boat instead of worrying about tax deadlines? Maybe this'll get your attention: Interest on a loan used to purchase a boat, mobile home, or house trailer may be deductible on Line 11 of Schedule A. That's where you'd enter the amount if this interest wasn't reported to you on Form 1098, in which case it would go on Line 10. To qualify, any of these vehicles must have sleeping, cooking, and toilet facilities. The specific amenities needed aren't clearly defined, and the IRS is apt to question the deduction if your

return is audited. Check with your tax adviser.

♦ **Write off losses in a savings plan.** If you terminated a qualified tuition program (also known as a Section 529 plan) that lost money, you can deduct the loss as a miscellaneous itemized deduction on Schedule A, Line 27. Identify it as a "loss from termination of a college savings plan."

"Some physicians may have closed out accounts with a troubled firm such as Putnam or Strong in 2003 but don't realize that they can get a tax benefit from this," McGrath says. "Or maybe they've hesitated to close such accounts because they think they can't open new ones elsewhere. That needn't hold them back."

SCHEDULE C

♦ **Grab a tax break for hiring your kids.** If any of your children worked in your practice in 2003 and earned \$4,750 or less, you can take a deduction on Schedule C, Line 11, for the full amount you paid them. If they're under 18 and have no other income, they won't pay taxes, including those for Social Security and Medicare. (Note: This tax-saving strategy doesn't apply to incorporated practices.)

In case of an audit, you should be able to provide a written job description that covers the work your child did and a record of the hours he or she logged. Also, "You have to show that you paid a reasonable, going rate," McPhail says.

♦ **Claim credit for late-night meals.** Here's another tax break for self-employed physicians or those in partnerships: In certain cases, the full costs of meals and entertainment are fully deductible, rather than subject to the usual 50 percent limitation. For instance, if you keep the office open late a couple of nights a week and bring in dinner for your employees, you can add the full cost of these meals to the total on Line 24b of Schedule C.

The same full-deduction rule applies to social events held primarily for the benefit of rank-and-file employees: summer picnics, holiday parties, ball games, and the like, whether they take place at a local VFW hall or at a resort. The cost of food, beverages, entertainment, and the facility rental all qualify. "Plus, the value of the trip is not counted as compensation for the employees," says Guy McPhail.

SCHEDULE D

♦ **Don't cheat yourself on investment sales.** Many taxpayers fail to use the most advantageous tax basis when calculating the gains on stocks and mutual funds, which are reported on Schedule D, Lines 1 and 8. They pay more tax than they should, because they don't include in their basis reinvested distributions (capital gains and dividends) and sales charges.

Moreover, they don't realize that the best way to minimize taxes is to unload the most expensive shares first. Why? Because those have the highest basis, which lowers the amount of gain that will be taxed. (Even if you're selling to harvest a loss, it again makes sense to sell the most expensive shares first, as this will maximize the losses you can report.) Make sure to get written confirmation of your sales, in case you're audited and asked to show documentation.

♦ **Take advantage of lower capital gains rates.** As a corollary to the previous tip, if you realized long-term capital gains after May 5, 2003, you'll be taxed at the new low rate of 15 percent. (See Line 8, Schedule D.) "Long term" means you must have held the investment for longer than 12 months. If you didn't, the gains are taxed at your regular income rate, which can be as high as 35 percent. Capital gains that came on or before May 5, 2003, are taxed at the old capital gains rates: 20 percent for long-term gains and as much as 35 percent for short-term gains.

"Many taxpayers are going to have some long-term gains subject to the old rate and some long-term gains subject to the new one," says Sidney A. Blum, a CPA with Leonetti & Associates in Buffalo Grove, IL. "While the new, lower rate will help reduce tax bills, it's important not to assume that it applies to everything."

♦ **Dividend earners, take this big break.** Instead of paying your normal income tax rate on dividends, you'll pay just 15 percent this year, a difference of up to 20 percentage

MANAGING YOUR PRACTICE

Staff Must Be Willing to Handle Business of Medicine

Dear NMA News You Can Use,

I am a busy primary care physician and see about 25-30 patients per day. My patients have varied insurance types and naturally different copays and deductibles. My receptionist is very good and the patients seem to really like her, but she feels uncomfortable asking patients for payment. We have talked with her about this and she states that it has always been a problem for her and that if patients cannot pay their copay or deductible, she feels this should not stop them from seeing the doctor.

As with many practices, we are having problems with reimbursement and are carrying a significant accounts receivable balance. We do bill the patients, but to me sending a bill for a \$5 or \$10 copay is a waste of time and energy. If my receptionist does not collect at the time of service, we do send a bill. What do you suggest?

- Dr. Needing Every Penny
Baltimore, MD

Dear NMA Member,

I feel your pain; this is often a sticky subject in small to large medical practices. However, I ask that you look at this from a different view. You are contracted with insur-

News You Can Use

Sharon Allison-Ottey,
MD

ance companies, Medicare and others, and part of your agreement with them is that the patient will pay X amount at the time of service.

Did you know that not asking for and accepting the copay could cause you to be in breach of contract and put you at risk for legal action? There is no excuse for your staff not asking for payment at the time of service at every visit.

Perhaps you can begin to discuss this issue during your next staff meeting, asking your employees what would happen if they forgot to take money to the gas station, hair salon or barber. Chances are this would never happen, and you should have zero tolerance in your office as it could have a serious impact on your cash flow.

For instance if you see 125 patients per week and fail to collect a \$10 copay from just 15 percent of the patients at the time of the visit this would result in the loss of \$187.50 per week, \$750 per month and more than \$9,000 per year. If you continue the trend for five years it could add up to more than

"News You Can Use" is a new column in the NMA News that focuses on giving physicians practical information for their practices. E-mail questions to NMAnews@NMAnet.org.

\$45,000 loss revenue for your practice. However, the loss is actually more, including the cost of collecting the money (staff time, stamps, envelopes) and the potential ill will you face if the patient is turned over for collections.

My suggestion is to stop the problem at the door with training for the staff. I suggest including role-playing into your staff meetings and give options for how your staff will discuss finances with patients. To stress your point, ask if the employee would be willing to forego their paycheck, raise, bonus or Christmas gift as a result of the loss revenue. I would dare say that the attitude and reluctance will probably change overnight.

Practical tips:

- ♦ Train you staff to say something similar to the following: "Good morning, Ms. Smith. How are you? You are here for your

10 o'clock appointment. Has your insurance information changed? OK, good. How will you be taking care of your \$20 copay, cash, check or charge?" (There is not the option of, "Will you be paying your copay?" or "Can you pay today?" It is assumed that they will take care of the amount).

- ♦ Post a nice sign in the lobby/reception area, at the bottom of patient statements, in your newsletter and other places:

"All copays and deductibles are due at the time of service. We will be happy to accept cash, check or charge at check-in."

- ♦ Instruct your staff to use other methods when patients cannot pay at the time of service.

Instead of saying, "OK, we will bill you," have you staff give the patient a self-addressed, stamped envelope and ask them to mail payment later that day or a specific date that they agree upon. Or offer a payment plan.

- ♦ Offer to take a postdated check, but be sure to get a driver's license number and phone number.

- ♦ If you do bill the patient, make sure that your office manager or staff tell the patient that this is a courtesy to them for this visit only.

Even given the "zero tolerance" plan, it is important to remain com-

passionate to patients and make rational decisions. Your staff knows the patients and should have some latitude in how to handle certain situations. Empower your office manager to make the final decisions.

Finally, I must state that the physician should not get involved with this aspect of care. The staff should have this taken care of prior to you seeing the patient.

I also advise that sick patients not be turned away because of copay or balance issues. However, for patients that continue to abuse your policy, I suggest you send them a letter demanding payment. If the patient fails to pay or acknowledge your bill, he/she does not respect you, your services or the profession. You should consider terminating services to that patient according to your state's policies.

We often don't like to say it, but the practice of medicine is a business and should be run as such. You cannot meet your financial obligations if you continue to have high accounts receivable. Your practice deserves the respect of prompt payment for services rendered.

Practice consultant Sharon Allison-Ottey, MD, is CEO of COSHAR Medical Inc. and an expert in internal and geriatric medicine.

Laws Allow Break on SUVs... Continued from page 10

points. The rate is effective for dividends received after 2002 and before 2009, and must be reported on Line 23 of Schedule D.

Note that what you think may qualify as "dividends"—payments from savings banks and credit unions, for example—don't qualify for the lower rate. The 15 percent rate applies to dividends from stocks and stock mutual funds. Generally, dividends from REITs are excluded. There are also rules regarding how long you had to have held the security. Another wrinkle affects investors who hold dividend-paying stocks in margin accounts. If this describes you, consult your tax adviser.

FORM 4562

- ♦ **Juicier write-offs for practice upgrades.** If you made expensive improvements to your office space after May 5, 2003, you're in luck. On Line 14 of Form 4562, you can deduct half the cost of the improvements.

"This first-year bonus depreciation is available only for new office equipment and improvements made through the end of 2004," notes CPA Sherman Doll, of Thomas, Doll & Company in Walnut Creek, CA. So if you're contemplating any renovations that you haven't yet made, this is the year to make them. The IRS stipulates, however, that the improvements must be made to the interior of the structure, and to leased, nonresidential property, not to property you own.

The new tax law also lets you write off up to \$100,000 of the cost of new and used medical equipment as well as computer hardware

and software—up from \$25,000. The new increased expensing limit, combined with the first-year bonus depreciation, can be a real boon to some physicians. For instance, say you financed the purchase of new equipment costing \$175,000 in August of 2003. You can expense \$100,000, plus deduct half of the remaining \$75,000 as bonus depreciation.

"Since both provisions of the new tax law may not apply to the same assets, it may make more sense to expense certain assets first and then apply the 50 percent bonus depreciation to others," McPhail says.

- ♦ **Get a break on that gas-guzzler.** If you bought a new or used sports utility vehicle last year, you may elect to deduct the entire cost as a first-year expense. See Line 25 of Form 4562. But keep in mind these catches: First, the vehicle must have been used exclusively for business. Second, its gross weight must exceed 6,000 pounds. Examples of SUVs that tip the scales are the Cadillac Escalade, Ford Excursion, and GMC Yukon.

Be forewarned: If you take the full deduction and the IRS audits your return, it will probably scrutinize your business use of the vehicle. At the very least, you'll have to present a meticulous log of your business miles. "Doctors who used the vehicle to go to more than one office will have an easier time justifying the business use," says CPA Jan Neri, a partner at Filomeno & Company in West Hartford, CT. Commuting to your main office, she adds, isn't considered a business-related trip and therefore doesn't count toward business miles.

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We have a great meeting planned and hope to see you in San Diego!

Photo courtesy of Charlie Mann

MEMBERS ON THE MOVE

Odyssey to India: 'I Am Forever Changed'

By Linda D. Bradley, MD
Special to NMA News

My odyssey began in the City of Love, Agra, India, home to the seventh man-made wonder of the world, the Taj Mahal. How fitting that I would be invited to speak at the 47th All India Congress of Obstetrics & Gynaecology meeting hosted by Agra Obstetrical & Gynecological Society.

The Taj Mahal symbolizes India. It means "Crown Palace" and is a well preserved and architecturally stunning marble tomb that portrays the celebration of an enduring love of a husband to his beautiful wife who died at age 39 after giving birth to her 14th child.

I left Cleveland, Ohio, in early January for a 10-day meeting. It became much more than another "meeting." Getting there was relaxing — time to read, prepare lectures on my laptop and enjoy small talk with fellow passengers.

But my 20-hour plane trip on the way back to the United States provided ample time to reflect on all the smells, sights, sounds, cultural differences and experiences that I witnessed. I am forever changed by this journey.

Travel to the developing world requires that you strip yourself naked. You must take off the glasses of Western culture and begin to immerse yourself into a culture, religion and caste system that is very foreign to most Westerners.

At first, I kept asking myself, "How can millions and millions of people live in abject poverty? How can children be unschooled? How can dirt, and grime be commonplace?" These feelings were juxtaposed to the splendor of the Taj, Agra Fort and other palaces that I saw.

However, having dinner with fellow col-

leagues made me realize how earnest and self-sacrificing the Indian caregivers are.

Guest Commentary

Many who trained in the USA and Europe return to more squalid conditions, less technology and fewer supports than their training provided.

Having trained in the United States, one physician told me about his work week.

He was a young and very enthusiastic physician who had learned many minimally invasive gynecologic surgical procedures, including laparoscopic hysterectomy, operative hysteroscopy and endometrial ablation.

He traveled 8-10 hours by train twice a week to rural areas carrying three large duffel bags filled with all necessary surgical equipment. In remote settings, he offered the most high-tech procedures to local patients and, in addition, taught new procedures to local physicians.

It made me think twice about my whining about traveling to local ambulatory care facilities and our main hospital to provide services. My goodness — at best it is a 20-minute commute. It made me wonder whether I could step out of the ivory tower and provide care when instantaneous labs and other 24-hour services were not at my beck and call. Sometimes we all become too comfortable in our environments. It took a trip to India to awaken me.

Approximately 6,000 gynecologists were represented from all regions in India. Lectures in high-risk obstetrics, infertility, oncology and general gynecology were filled to capacity. The audience was alert and rapidly queried speakers during the question-and-answer sessions. I attended a live-teleconference surgery and observed six to eight surgical procedures, ranging from standard vagi-



Linda D. Bradley, MD, traveled to Agra, India, to participate in the 47th All India Congress of Obstetrics and Gynaecological meeting. She spoke on topics such as operative hysteroscopy, endometrial ablation and uterine fibroid embolization.

nal hysterectomy, "clampless" vaginal hysterectomy and hysteroscopy.

My contribution to the meeting included talks on operative hysteroscopy, endometrial ablation, hysteroscopic myomectomy and saline infusion sonography.

My lecture on uterine fibroid embolization (UFE) as an alternative to hysterectomy provided the most controversy and debate. Currently, UFE is not widely available in India, although many physicians are interested in embracing it. Several have sent me e-mails since the meeting to learn how to estab-

lish a UFE center of referral.

Additionally, I contributed three chapters to a book, "State of the Art Atlas of Endoscopic Surgery in Infertility and Gynecology," edited by Nutain Jain.

A gala reception followed with melodic Indian music, savory samosas, curries and lentils and provided the perfect ending to a journey indelibly etched in my memory. I hope to return in the future.

Linda D. Bradley, MD, is director of hysteroscopic services at the Cleveland Clinical Foundation. E-mail her at bradl@ccf.org.

Lenworth Johnson Blurring Color Line in Ophthalmology

By Jenna Isaacson
Columbia (Mo.) Daily Tribune

Lenworth Johnson, MD, knew as a kid that he wanted to be a physician, but until he watched an episode of "The Beverly Hillbillies," he didn't really know what kind.

When he heard a character on the show, Jethro, say he wanted to be a neurosurgeon, everything suddenly clicked.

"I knew I wanted to be a brain surgeon, but I didn't know the technical name," he says.

Dr. Johnson was born in Jamaica and came to the United States in 1966. Thirty-eight years later, he's an accomplished professor of ophthalmology and neurology at the University of Missouri-Columbia and the co-author of a recently published book, "Breaking the Color Line in Medicine: African Americans in Ophthalmology."

"There are not that many people in neuro-ophthalmology," Dr. Johnson says, estimating that only about 300 neuro-ophthalmologists in the United States practice his special-



"I wanted to know what could I do to increase the number of African Americans and minorities in ophthalmology. Mostly it's a book about people to encourage young folks to think about medicine and science."

**- Lenworth Johnson, MD
neuro-ophthalmologist**

ty. Additionally, of about 18,000 ophthalmologists in the United States, Dr. Johnson estimates that only about 300 are black.

So he went about writing a book to bring

attention to the need for more diversity in the profession.

"I wanted to know what could I do to increase the number of African-Americans and minorities in ophthalmology," he says. "Mostly it's a book about people to encourage young folks to think about medicine and science."

Dr. Johnson, who calls neuro-ophthalmology "the best field in medicine," says he enjoys his profession because it combines knowledge from several health fields.

"You have to know a lot about different aspects of medicine," he says. "Most people look at the eye doctor as not a real doctor. It's almost as if you're Sherlock Holmes — solving a mystery."

Dr. Johnson has been recognized as one of the "Best Doctors in America" by his peers in four different years. That national listing has brought him patients from across the country and around the world, including Florida, California, Germany and France. Although some of his patients seek him out for conditions that are difficult to treat, Dr. Johnson

says he hopes to help them see the bright side of things, no matter what.

"My goal is to let them walk out smiling, even if the disease process they have is grave," he says. "I make that a point."

Outside work, Dr. Johnson participates in a diversity program with kids from Parkade Elementary School each year, bringing them to his workplace and showing them around to help expose students to different cultures on a more personal level.

"The idea is to cut through the morass and learn to accept people for who they are," Dr. Johnson says. "They see patients with me."

His efforts to inspire more minorities to enter the medical field have not gone unnoticed. A North Carolina high school student e-mailed him a few months back to talk about his book and learn more about his field.

"It was just touching that the book made a difference in someone's life," he says. "The kids will be the future. If you don't take the time with young folks, the world won't get any better."

Reprinted from the Columbia (Mo.) Daily Tribune, www.showmenews.com.

MEMBERS ON THE MOVE



Holloway

Holloway to Head Research for L'Oreal

Victoria Holloway, MD, executive director of the L'Oreal Institute of Ethnic Hair and Skin Research, recently has been promoted to vice president of research and development for L'Oreal.

Dr. Holloway is a member of NMA, an active member of the Dermatology Section and serves on the Council on the Concerns of Women Physicians.

Dr. Holloway, a graduate of Harvard, Yale Medical School and the John

Hopkins School of Public Health, was hired to lead the Institute of

Ethnic Hair and Skin Research and is working hard to move L'Oreal's dream forward. The dream of a place where the most cutting edge, "technology-driven, safe and effective products for people of African descent" will be studied and created.

The Institute is the first of its kind for a beauty company: a facility wholly dedicated to researching and understanding the unique properties of the hair and skin of people of African descent. The institute recently received upwards of \$11 million for purchasing and renovating its new building in Chicago.

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'We Have a Responsibility'

□ **Dean of University of Arkansas College of Medicine stresses the importance of medical education changing with the needs of patients.**

By Jessica Carter
Managing Editor

When a patient meets with his physician, he often complains of a range of symptoms — many of which can seem unrelated.

Young physicians often are limited by a model of education that encourages them to specialize in one area, leaving them unprepared to deal with patients presenting with a variety of maladies.

"We typically train students in an organized, organ-system approach," said E. Albert Reece, MD, PhD, MBA, vice chancellor and dean at the University of Arkansas College of Medicine. "No one ever comes in and says, 'I have a biochemistry problem.'"

"Medicine is changing and, as a result, we have to change the curriculum accordingly," Dr. Reece said. "We have to teach ... in a more integrated fashion. This is not an attempt to make people be skilled at everything, but really to create a perspective that is broad enough that at least you can identify a variety of problems even though your particular field may be narrow," Dr. Reece said.

Dr. Reece is originally from Jamaica, West Indies. He earned his undergraduate degree from Long Island University, his medical degree from New York University School of Medicine, a PhD in biochemistry from the University of the West Indies, Kingston, Jamaica, and an MBA from Temple University.

He trained at Columbia University Presbyterian Hospital and Yale University School of Medicine, where he remained on the full-time faculty for almost 10 years before being recruited by Temple University School of Medicine in 1990. There he was the Abraham Roth Professor and Chairman of the Department of Obstetrics, Gynecology & Reproductive Sciences.

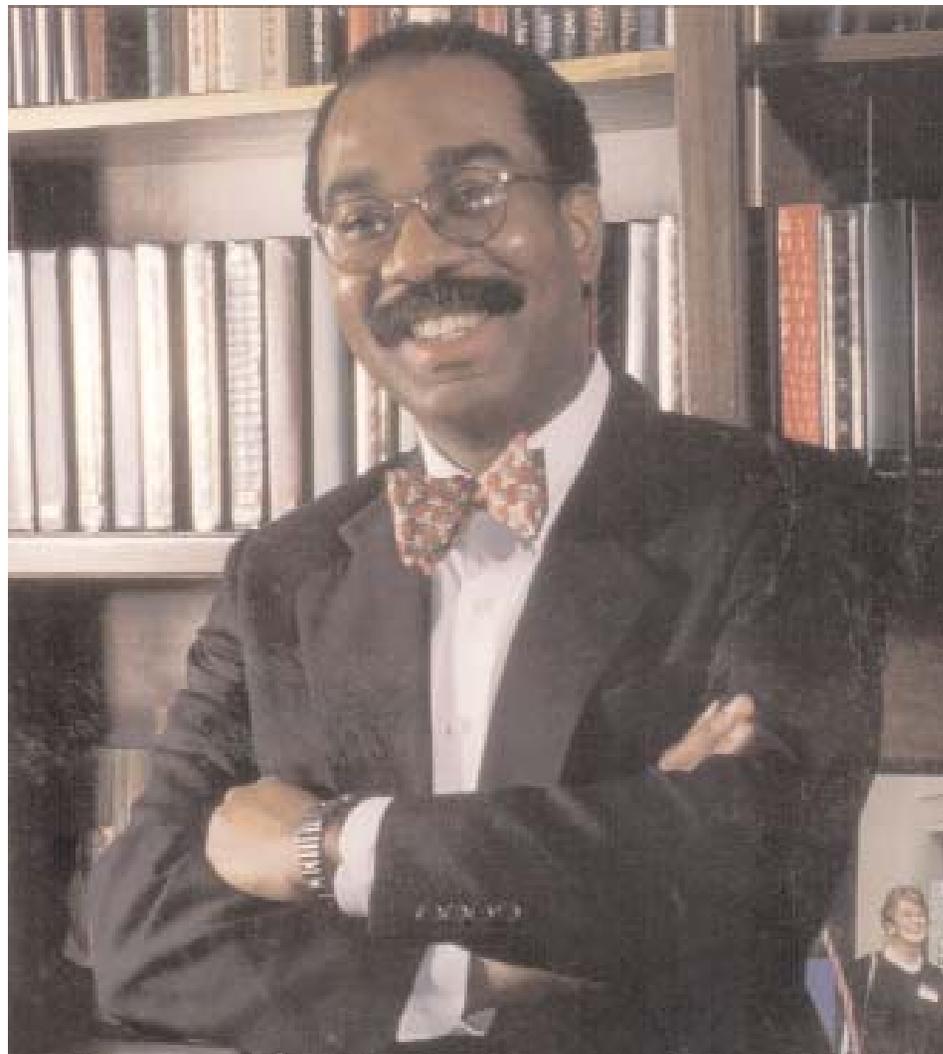
In July 2001, he joined the University of Arkansas College of Medicine. He oversees approximately 575 students, 600 residents and 900 faculty as dean and is a professor in the departments of Obstetrics/Gynecology, Medicine and Biochemistry and Molecular Biology.

Through his experience, Dr. Reece said one of the greatest continuing problems medical schools face is a decline in the number of applicants and, therefore, a decreasing pool of minority applicants.

Dr. Reece attributes this downward trend to several factors, but two in particular: greater opportunities in technology-related fields and the increasing complexity of the business of medicine.

Rising numbers of malpractice suits are causing concern, and many physicians are changing their practices, getting out of high-risk specialties or leaving medicine altogether.

"They're seeing their father or their relative or friend having to do those things, and it's not very attractive," Dr. Reece said.



"Medicine is changing and, as a result, we have to change the curriculum accordingly," said E. Albert Reece, MD, PhD, MBA, vice chancellor and dean at the University of Arkansas College of Medicine.

"I believe there has to be a major investment in research, and those research skills need to be taught at the level of student (and) resident and encouraged on the faculty level."

- E. Albert Reece, MD, PhD, MBA
Dean, University of Arkansas
College of Medicine

"There are many small brushfires here and now in medicine," he added. "It's not terribly worrisome because it's not a precipitous decline. I think we'll see a bounce again."

One thing the University of Arkansas is doing to combat the number of casualties along the way to a successful practice is increasing the ways students can learn more about the business aspect of the industry.

Lectures are offered on topics such as loan repayment, business decisions, setting up a practice and other business and life skills.

In addition, the university soon will introduce a combination MD/MBA degree. Requiring three summer sessions and one extra year, the dual degree will matriculate physicians with a lot more business savvy than the average MD.

But how does the college sell the program

to students already facing years of education?

"It sells itself because people who have the degree will show the value," he said.

In addition to his administrative responsibilities, Dr. Reece is actively involved in research and education. His research focuses on diabetes in pregnancy, birth defects and prenatal diagnosis.

In the past five years, the University of Arkansas medical school has doubled its research budget, in part due to the genomics wave that is sweeping medical institutions today.

"The future's here in a way, and that future is going to be a genomic revolution," Dr. Reece said. "I believe there has to be a major investment in research, and those research skills need to be taught at the level of student (and) resident and encouraged on the faculty level."

Medical school faculty should lead by example not only within the confines of education, but also within their communities. Most of Dr. Reece's faculty members also are involved with professional, academic or service organizations.

"I really believe that we live in a global world," Dr. Reece said. "I think we have an obligation, we have a responsibility to be more than just effective within our own tiny world."

"Our effectiveness as leaders is really to share with others ... it's to exercise some national leadership and involvement in various medical initiatives."

MEMBERS ON THE MOVE

DeBaun Awarded \$18.5 Million NIH Grant

Children across the world with sickle cell disease will benefit from an \$18.5 million grant awarded to researchers at Washington University School of Medicine in St. Louis to determine the effectiveness of blood transfusion therapy as a treatment for preventing silent strokes.

“Regardless of the outcome of the study, our results will change the standard of care for children with sickle cell disease throughout the world,” says principal investigator Michael R. DeBaun, MD, MPH, associate professor of pediatrics and of biostatistics at the School of Medicine and a pediatric hematologist at St. Louis Children’s Hospital.

“At the end of the study, we will know whether blood transfusion therapy will prevent silent strokes in children with sickle cell disease,” he said. “If there is a significant benefit, the standard of care will be changed for these vulnerable patients; and even if no benefit is detected, then patients will not be subject to unnecessary therapy.”

The National Institutes of Health grant – the most ever awarded to a pediatrician at Washington University School of Medicine – will fund a 6 fi-year international clinical trial at 22 sites, including ones in France, Canada and England. Dr. DeBaun and his staff will serve as the coordinating center for the international trial.

Silent strokes, which frequently go unrecognized, are one of the most serious afflictions associated with sickle cell disease. They can cause declines in school performance, increased forgetfulness and a diminished ability to follow even simple instructions.

Dr. DeBaun’s preliminary research over the past decade reveals that silent strokes

seriously affect children’s educational attainment and can lead to further neurological damage. His team has recently completed a pilot trial showing that blood transfusion therapy is a safe and potentially effective therapy for children with silent strokes.



DeBaun

“It is crucial to identify children with silent strokes because kids who have them are at a 24 percent risk over the next three years for further silent or overt strokes, which may leave physical defects and/or greater cognitive deficits. What we do not know is whether the benefits outweigh the risks of treatment,” Dr. DeBaun says.

For three years, Dr. DeBaun’s group will randomly allocate blood transfusion therapy to 50 percent of the study participants, and the other half will be observed. “If blood transfusion therapy is effective, the magnitude of this benefit for children with silent strokes will be tremendous,” Dr. DeBaun says.

The groundbreaking trial will enroll 1,880 children from around the world. All the children will have an MRI performed on their brains to detect silent strokes.

“We have a once in a lifetime opportunity to not only improve the quality of life for children currently afflicted with this disease,” Dr. DeBaun says, “but to also change the understanding of the disease for future generations of children and the pediatricians who treat them.”



The Bluff City Medical Society of Memphis, Tenn., held its 2003 Christmas Meeting and Reception on Dec. 20 at Elfo’s Restaurant in midtown Memphis. Richard Pearson, MD, a urologist, spoke about “New Treatments for Erectile Dysfunction.” Special commendations were extended to Kenneth Robinson, MD, who recently was named commissioner of health for the state of Tennessee. He gave a full report of his new position and opportunities.

Bailey Chosen as Ambassador to Africa

Rahn Bailey, MD, chair of NMA’s Psychiatry Section and assistant professor of psychiatry at the University of Texas, is one of 15 members of the Mental Health delegation selected to visit South Africa in the People to People Ambassador program.

This year’s program is headed by Pedro Ruiz, MD, professor and vice chair of the Department of Psychiatry and Behavioral Sciences at the University of Texas Medical School in Houston.

The delegation is scheduled to visit the

Johannesburg region, Cape Town, Victoria Falls and, time permitting, Zimbabwe in April.

The delegation will meet with South Africa’s leading mental health officials to exchange information about psychiatry care of chronically mental ill patients, substance abuse, counseling, the state of health and psychiatry issues related to female patients.

For additional information about the People to People Ambassador program, visit www.ambassadorprogram.org.

In Memorium

JOHN A. KENNEY JR., MD

John A. Kenney Jr., MD, a leading specialist in dermatological conditions afflicting African-Americans and former president of the NMA, died on Nov. 29 at his home in Washington. He was 89.

The cause of death was heart failure, said his daughter Anne Kenney of Brooklyn.

Dr. Kenney was one of the first black doctors to be formally trained in dermatology and developed the dermatology department of Howard University’s College of Medicine into a major research center, said William E. Matory, MD, a surgeon and the director of continuing medical education at the NMA.

When Dr. Kenney began his medical career, many white doctors refused to see black patients. Even those who did were not necessarily experienced in treating skin conditions common among African Americans, like shaving-associated dermatitis and vitiligo.

Because of Dr. Kenney’s prominence in the field, many colleagues referred to him as the dean of black dermatology.

Dr. Kenney’s father, John A. Kenney Sr., MD, was a prominent early member of the NMA as well as the medical director and chief surgeon at Tuskegee Institute’s general hospital and the personal doctor of the institute’s founder, Booker T. Washington.

After studying chemistry and biology at Bates College in Lewiston, Me., he received his medical degree in 1945 from Howard University. He later received training in dermatology at the University of Pennsylvania and the University of Michigan and joined the staff at University Hospital in Cleveland.

In 1961, he joined the faculty in the dermatology division at Howard and taught there for almost four decades.

Dr. Kenney waster of dermatology, one of the field’s highest hon a director of the American Academy of Dermatology, which in 1995 named him a masors.

He was also a member of the American Dermatological Association, the Society for Investigative Dermatology and the American Association for the Advancement of Science.

In 1963, he became president of the NMA

and remained active in it for many years. He practiced medicine until he was 85.

In addition to his daughter Anne, Dr. Kenney is survived by another daughter, Frances Kenney Moseley of Boston; a son, John III, of Washington; and a grandson. His wife of 57 years, Larcenia Ferne Wood Kenney, died three years ago.

From The New York Times, www.nytimes.com

OWEN C. DILLON, MD

Owen Christopher Dillon, MD, a native of Jamaica and orthopedic surgeon at the Veterans Administration Medical Center (VAMC) in Washington, DC, has died at the age of 69.

Dr. Dillon was the only son of Noel and Clementina Dillon, born in Kingston, Jamaica, on March 31, 1934.

He migrated to the United States two years after his high school graduation to study medicine, earning his undergraduate degree and MD from Harvard University. He did postgraduate training in the Howard University Orthopedic Surgery Program,

rotating through hospitals in Washington and Baltimore before leaving his training for a two-year tour in the military.

After being discharged as a major in 1971, he completed his residency and became employed by the VAMC as an orthopedic surgeon. At the same, he served as an instructor in orthopedic surgery at Howard University and maintained a private practice.

He retired from private practice and continued working at the VAMC until his retirement in July 2002.

He was a member of the District of Columbia Medical Society, the Medical Chirurgical Society of Washington, the NMA and the Washington Orthopedic Society. He was a founding member of the Caribbean American Intercultural Organization and also was a member of the Jamaica Nationals Association.

He is survived by his wife, Pauline Y. Titus-Dillon, MD; children Denyse S. Hamilton, Esq., and Paul C. Dillon, MD; one sister; six grandchildren; and several nieces and nephews.

Brief Summary
NORVASC® (amlodipine besylate) Tablets

For Oral Use

CONTRAINDICATIONS: NORVASC is contraindicated in patients with known sensitivity to amlodipine.

WARNINGS: Increased Angina and/or Myocardial Infarction: Rarely, patients, particularly those with severe obstructive coronary artery disease, have developed documented increased frequency, duration and/or severity of angina or acute myocardial infarction on starting calcium channel blocker therapy or at the time of dosage increase. The mechanism of this effect has not been elucidated.

PRECAUTIONS: General: Since the vasodilation induced by NORVASC is gradual in onset, acute hypotension has rarely been reported after oral administration of NORVASC. Nonetheless, caution should be exercised when administering NORVASC as with any other peripheral vasodilator particularly in patients with severe aortic stenosis.

Use in Patients with Congestive Heart Failure: In general, calcium channel blockers should be used with caution in patients with heart failure. NORVASC (5-10 mg per day) has been studied in a placebo-controlled trial of 1153 patients with NYHA Class III or IV heart failure on stable doses of ACE inhibitor, digoxin, and diuretics. Follow-up was at least 6 months, with a mean of about 14 months. There was no overall adverse effect on survival or cardiac morbidity (as defined by life-threatening arrhythmia, acute myocardial infarction, or hospitalization for worsened heart failure). NORVASC has been compared to placebo in four 8-12 week studies of patients with NYHA Class II/III heart failure, involving a total of 697 patients. In these studies, there was no evidence of worsened heart failure based on measures of exercise tolerance, NYHA classification, symptoms, or LVEF.

Beta-Blocker Withdrawal: NORVASC is not a beta-blocker and therefore gives no protection against the dangers of abrupt beta-blocker withdrawal; any such withdrawal should be by gradual reduction of the dose of beta-blocker.

Patients with Hepatic Failure: Since NORVASC is extensively metabolized by the liver and the plasma elimination half-life ($t_{1/2}$) is 56 hours in patients with impaired hepatic function, caution should be exercised when administering NORVASC to patients with severe hepatic impairment.

Drug Interactions: *In vitro* data in human plasma indicate that NORVASC has no effect on the protein binding of drugs tested (digoxin, phenytoin, warfarin, and indomethacin).

Special Studies: Effect of other agents on NORVASC: CIMETIDINE: co-administration of NORVASC with cimetidine did not alter the pharmacokinetics of NORVASC. GRAPEFRUIT JUICE: co-administration of 240 mL of grapefruit juice with a single oral dose of amlodipine 10 mg in 20 healthy volunteers had no significant effect on the pharmacokinetics of amlodipine. MAALOX (antacid): co-administration of the antacid Maalox with a single dose of NORVASC had no significant effect on the pharmacokinetics of NORVASC. SILDENAFIL: a single 100 mg dose of sildenafil (Viagra®) in subjects with essential hypertension had no effect on the pharmacokinetic parameters of NORVASC. When NORVASC and sildenafil were used in combination, each agent independently exerted its own blood pressure lowering effect.

Special Studies: Effect of NORVASC on other agents: ATORVASTATIN: co-administration of multiple 10 mg doses of NORVASC with 80 mg of atorvastatin resulted in no significant change in the steady state pharmacokinetic parameters of atorvastatin. DIGOXIN: co-administration of NORVASC with digoxin did not change serum digoxin levels or digoxin renal clearance in normal volunteers. ETHANOL (alcohol): single and multiple 10 mg doses of NORVASC had no significant effect on the pharmacokinetics of ethanol. WARFARIN: co-administration of NORVASC with warfarin did not change the warfarin prothrombin response time.

In clinical trials, NORVASC has been safely administered with thiazide diuretics, beta-blockers, angiotensin-converting enzyme inhibitors, long-acting nitrates, sublingual nitroglycerin, digoxin, warfarin, non-steroidal anti-inflammatory drugs, antibiotics, and oral hypoglycemic drugs.

Drug/Laboratory Test Interactions: None known.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Rats and mice treated with amlodipine in the diet for two years, at concentrations calculated to provide daily dosage levels of 0.5, 1.25, and 2.5 mg/kg/day showed no evidence of carcinogenicity. The highest dose (for mice, similar to, and for rats twice* the maximum recommended clinical dose of 10 mg on a mg/m² basis) was close to the maximum tolerated dose for mice but not for rats.

Mutagenicity studies revealed no drug related effects at either the gene or chromosome levels.

There was no effect on the fertility of rats treated with amlodipine (males for 64 days and females 14 days prior to mating) at doses up to 10 mg/kg/day (8 times* the maximum recommended human dose of 10 mg on a mg/m² basis).

Pregnancy Category C: No evidence of teratogenicity or other embryo/fetal toxicity was found when pregnant rats or rabbits were treated orally with up to 10 mg/kg amlodipine (respectively 8 times* and 23 times* the maximum recommended human dose of 10 mg on a mg/m² basis) during their respective periods of major organogenesis. However, litter size was significantly decreased (by about 50%) and the number of intrauterine deaths was significantly increased (about 5-fold) in rats administered 10 mg/kg amlodipine for 14 days before mating and throughout mating and gestation. Amlodipine has been shown to prolong both the gestation period and the duration of labor in rats at this dose. There are no adequate and well-controlled studies in pregnant women. Amlodipine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: It is not known whether amlodipine is excreted in human milk. In the absence of this information, it is recommended that nursing be discontinued while NORVASC is administered.

Pediatric Use: Safety and effectiveness of NORVASC in children have not been established.

Geriatric Use: Clinical studies of NORVASC did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy. Elderly patients have decreased clearance of amlodipine with a resulting increase of AUC of approximately 40-60%, and a lower initial dose may be required (see **DOSE AND ADMINISTRATION**).

ADVERSE REACTIONS: NORVASC has been evaluated for safety in more than 11,000 patients in U.S. and foreign clinical trials. In general, treatment with NORVASC was well-tolerated at doses up to 10 mg daily. Most adverse reactions reported during therapy with NORVASC were of mild or moderate severity. In controlled clinical trials directly comparing NORVASC (N=1730) in doses up to 10 mg to placebo (N=1250), discontinuation of NORVASC due to adverse reactions was required in only about 1.5% of patients and was not significantly different from placebo (about 1%). The most common side effects are headache and edema. The incidence (%) of side effects which occurred in a dose related manner are as follows: edema (1.8% at 2.5 mg, 3.0% at 5.0 mg, and 10.8% at 10.0 mg, compared with 0.6% placebo); dizziness (1.1% at 2.5 mg, 3.4% at 5.0 mg, and 3.4% at 10.0 mg, compared with 1.5% placebo); flushing (0.7% at 2.5 mg, 1.4% at 5.0 mg, and 2.6% at 10.0 mg, compared with 0.0% placebo); and palpitation (0.7% at 2.5 mg, 1.4% at 5.0 mg, and 4.5% at 10.0 mg, compared with 0.6% placebo).

Other adverse experiences which were not clearly dose related but which were reported with an incidence greater than 1.0% in placebo-controlled clinical trials include the following: headache (7.3%, compared with 7.8% placebo); fatigue (4.5%, compared with 2.8% placebo); nausea (2.9%, compared with 1.9% placebo); abdominal pain (1.6%, compared with 0.3% placebo); and somnolence (1.4%, compared with 0.6% placebo).

For several adverse experiences that appear to be drug and dose related, there was a greater incidence in women than men associated with amlodipine treatment as follows: edema (5.6% in men, 14.6% in women, compared with a placebo incidence in men of 1.4% and 5.1% in women); flushing (1.5% in men, 4.5% in women, compared with a placebo incidence of 0.3% in men and 0.9% in women); palpitations (1.4% in men, 3.3% in women, compared with a placebo incidence of 0.9% in men and 0.9% in women); and somnolence (1.3% in men, 1.6% in women, compared with a placebo incidence of 0.8% in men and 0.3% in women).

The following events occurred in $\leq 1\%$ but $>0.1\%$ of patients in controlled clinical trials or under conditions of open trials or marketing experience where a causal relationship is uncertain; they are listed to alert the physician to a possible relationship: **cardiovascular:** arrhythmia (including ventricular tachycardia and atrial fibrillation), bradycardia, chest pain, hypotension, peripheral ischemia, syncope, tachycardia, postural dizziness, postural hypotension, vasculitis; **central and peripheral nervous system:** hypoesthesia, neuropathy peripheral, paresthesia, tremor, vertigo; **gastrointestinal:** anorexia, constipation, dyspepsia,** dysphagia, diarrhea, flatulence, pancreatitis, vomiting, gingival hyperplasia; **general:** allergic reaction, asthenia,** back pain, hot flushes, malaise, pain, rigors, weight gain, weight decrease; **musculoskeletal system:** arthralgia, arthrosis, muscle cramps,** myalgia; **psychiatric:** sexual dysfunction (male** and female), insomnia, nervousness, depression, abnormal dreams, anxiety, depersonalization; **respiratory system:** dyspnea,** epistaxis; **skin and appendages:** angioedema, erythema multiforme, pruritus,** rash,** rash erythematous, rash maculopapular; **special senses:** abnormal vision, conjunctivitis, diplopia, eye pain, tinnitus; **urinary system:** micturition frequency, micturition disorder, nocturia; **autonomic nervous system:** dry mouth, sweating increased; **metabolic and nutritional:** hyperglycemia, thirst; **hemopoietic:** leukopenia, purpura, thrombocytopenia.

The following events occurred in $\leq 0.1\%$ of patients: cardiac failure, pulse irregularity, extrasystoles, skin discoloration, urticaria, skin dryness, alopecia, dermatitis, muscle weakness, twitching, ataxia, hypertonia, migraine, cold and clammy skin, apathy, agitation, amnesia, gastritis, increased appetite, loose stools, coughing, rhinitis, dysuria, polyuria, parosmia, taste perversion, abnormal visual accommodation, and xerophthalmia.

Other reactions occurred sporadically and cannot be distinguished from medications or concurrent disease states such as myocardial infarction and angina.

NORVASC therapy has not been associated with clinically significant changes in routine laboratory tests. No clinically relevant changes were noted in serum potassium, serum glucose, total triglycerides, total cholesterol, HDL cholesterol, uric acid, blood urea nitrogen, or creatinine.

The following postmarketing event has been reported infrequently where a causal relationship is uncertain: gynecomastia. In postmarketing experience, jaundice and hepatic enzyme elevations (mostly consistent with cholestasis or hepatitis) in some cases severe enough to require hospitalization have been reported in association with use of amlodipine.

NORVASC has been used safely in patients with chronic obstructive pulmonary disease, well-compensated congestive heart failure, peripheral vascular disease, diabetes mellitus, and abnormal lipid profiles.

OVERDOSAGE: Single oral doses of 40 mg/kg and 100 mg/kg in mice and rats, respectively, caused deaths. A single oral dose of 4 mg/kg or higher in dogs caused a marked peripheral vasodilation and hypotension.

Overdosage might be expected to cause excessive peripheral vasodilation with marked hypotension and possibly a reflex tachycardia. In humans, experience with intentional overdosage of NORVASC is limited. Reports of intentional overdosage include a patient who ingested 250 mg and was asymptomatic and was not hospitalized; another (120 mg) was hospitalized, underwent gastric lavage and remained normotensive; the third (105 mg) was hospitalized and had hypotension (90/50 mmHg) which normalized following plasma expansion. A patient who took 70 mg amlodipine and an unknown quantity of benzodiazepine in a suicide attempt developed shock which was refractory to treatment and died the following day with abnormally high benzodiazepine plasma concentration. A case of accidental drug overdose has been documented in a 19-month-old male who ingested 30 mg amlodipine (about 2 mg/kg). During the emergency room presentation, vital signs were stable with no evidence of hypotension, but a heart rate of 180 bpm. Ipecac was administered 3.5 hours after ingestion and on subsequent observation (overnight) no sequelae were noted.

If massive overdose should occur, active cardiac and respiratory monitoring should be instituted. Frequent blood pressure measurements are essential. Should hypotension occur, cardiovascular support including elevation of the extremities and the judicious administration of fluids should be initiated. If hypotension remains unresponsive to these conservative measures, administration of vasopressors (such as phenylephrine) should be considered with attention to circulating volume and urine output. Intravenous calcium gluconate may help to reverse the effects of calcium entry blockade. As NORVASC is highly protein bound, hemodialysis is not likely to be of benefit.

* Based on patient weight of 50 kg.

** These events occurred in less than 1% in placebo-controlled trials, but the incidence of these side effects was between 1% and 2% in all multiple dose studies.

More detailed professional information available on request.

Rev. 0 December 2001

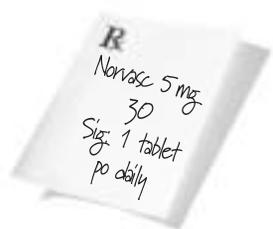
References: 1. Bakris GL, Williams M, Dworkin L, et al, for the National Kidney Foundation Hypertension and Diabetes Executive Committees Working Group. Preserving renal function in adults with hypertension and diabetes: a consensus approach. *Am J Kidney Dis*. 2000;36:646-661. 2. Data on file. Pfizer Inc., New York, NY. 3. Scott-Levin Formulary Drug Audit, Fall 2002. 4. IMS International Prescription Data (total prescriptions based on 35 countries moving annual total), March 2003; IMS National Prescription Audit (total prescriptions), 2002; IMS Health Services MIDAS Data (cumulative patient-days total), 1990-March 2003.

Once-Daily 5-mg and 10-mg tablets

NORVASC®

(amlodipine besylate)

THE MOST PRESCRIBED
CARDIOVASCULAR AGENT
IN THE WORLD^{4*}



⁴Among branded cardiovascular agents indicated for hypertension and/or angina.
NORVASC is indicated for hypertension and angina.

Norvasc:



First line?



Second line?



Third line?

Bottom line:

With no known drug interactions, excellent tolerability, and proven efficacy, NORVASC works well in virtually any kind of patient at any time.

It's common knowledge that drugs that lower BP lower the risk of stroke and myocardial infarction. It's also common knowledge that it takes multiple medications to get patients' BP down to where it needs to be.¹ That's why there's NORVASC.

NORVASC, indicated for the treatment of hypertension and angina, has no known drug interactions and can be used safely with other BP-lowering agents. NORVASC can also be used safely in all patient types, including patients with diabetes and kidney disease. And NORVASC delivers 24-hour BP-lowering efficacy regardless of patient type and provides additional BP reductions when used in combination with other BP-lowering agents.²

The most common side effects versus placebo were edema (8.3% vs 2.4%), headache (7.3% vs 7.8%), fatigue (4.5% vs 2.8%), and dizziness (3.2% vs 3.4%).

And when you consider that NORVASC is covered by 97% of plans, it's hard not to consider it for all of your patients with hypertension.³

Please see brief summary of prescribing information for NORVASC on the adjacent page.

Reductions you can count on™

Once-Daily 5-mg and 10-mg tablets
NORVASC[®]
(amlodipine besylate)