

National  
Medical  
Association

News



Spring/Summer 2003

An Official News Magazine of the National Medical Association

## HHS secretary: Minority health a top priority

By **Tommy G. Thompson**  
*Secretary of Health and Human Services*

The Department of Health and Human Services is charged with serving all Americans, and so we take a special interest in making sure that all Americans have equal access and equal quality when it comes to health care, regardless of race or ethnic background. We've come a long



**Thompson**

way in our great country, but there is still a "health gap" between minority Americans and the rest of the country. Too often, minorities have lower than average life expectancies, less access to quality care, and more to fear from preventable diseases. I'd like to give you a brief overview of our efforts to make that health gap go away.

A close look at some of the challenges minority communities face reveal some grim facts:

Heart disease is the leading cause of death for all racial and ethnic groups in the United States. In 1999, rates of death from cardiovascular disease were about 30 percent higher among African American adults than among white adults.

In women, overweight and obesity are higher among members of racial and ethnic minority populations than in non-Hispanic white

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## LaBelle brings 'New Attitude' to convention

By **Jessica Carter**  
*Managing Editor, NMA News*

After losing all three of her sisters to cancer before their 44th birthdays, legendary soul singer Patti LaBelle felt a need to fight the deadly disease. And for the past seven years, she's made sure she won't be "on her own" in the struggle through her support of minority medical students and the NMA.

The journey began in 1996, when the Flori Roberts division of Patti LaBelle Cosmetics and Fragrances joined with Ivax Personal Care Products Group and the NMA to raise funds for cancer research. That effort snowballed into the establishment of the Patti LaBelle Cancer Research and Medical Education Scholarship Fund.

Two years later, with so many organizations raising money for cancer research, the cause was refocused to training minority doctors and the fund was renamed the Patti LaBelle Medical Education Scholarship Fund. Administered through the NMA, the endowment has allowed for five scholarships to be awarded to students at medical schools

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### CONVENTION PREVIEW

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## NMA, Gallup to survey African-American physicians

From Staff Reports

The National Medical Association is pleased to announce an agreement with The Gallup Organization, one of the world's most respected and trusted research consulting companies, to survey a vitally important issue: the plight of African-American physicians.

Over the past few months, leaders from NMA and Gallup have been diligently working on a program that will uncover how "engaged" minority physicians are with their profession, their individual

practices and how those practices differ from their peers. The goal of this research program to measure the engagement level of minority physicians and to link those to actual outcomes of minority physician practices.

"Gallup's unprecedented research in healthcare — namely in the area of physician engagement — should help us really define how minority physicians are faring in this very volatile environment both in comparison to their peers and to themselves," said L. Natalie Carroll, MD, pres-

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# Inside the NMA

## Second 'Take A Loved One to the Doctor Day' set

□ Set for Sept. 16, the annual event aims to raise minority awareness of the importance of taking charge of their health.

By Yvonne Johns  
and Lovell Brigham  
Special to NMA News

Many of us find ourselves caught up in the daily routine of work, home and family and may not take the time to give proper attention to our health or those around us. The U.S. Department of Health and Human Services (HHS) and the ABC Radio Networks are encouraging all of us to participate in "Take a Loved One to the Doctor Day" on Sept. 16. ABC Radio Networks personality Tom Joyner will again serve as honorary chair for the event.

"Take a Loved One to the Doctor Day," now planned for the third Tuesday of each September, has become a key element of the department's overall health disparities campaign, "Closing the Health Gap."

The focus of the day is to encourage individuals to take charge of their health by visiting a health professional (a doctor, a nurse, a nurse practitioner, or another health provider), making an appointment for a visit, attending a health event in the community or helping a friend, neighbor, or family member do the same.

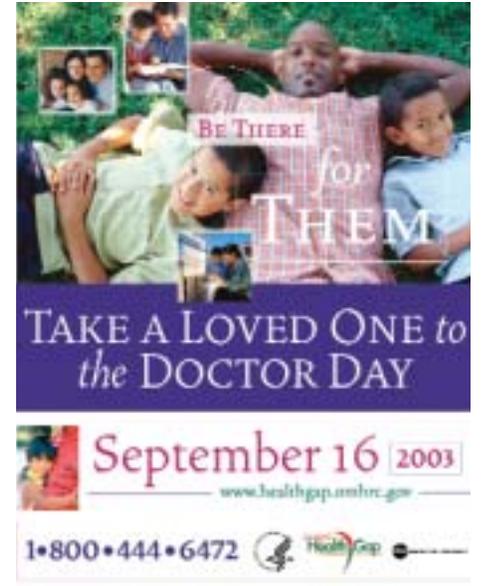
Serious diseases and health conditions affect racial and ethnic minority populations at far greater rates than other Americans. For example, stroke is the third leading cause of death in the United States, killing 167,000 Americans each year. African Americans have more strokes at earlier ages, are more likely to die from them and experience worse

levels of recovery than other racial groups, according to the National Institute of Neurological Disorders and Stroke.

HHS and the ABC Radio Networks joined forces in 2002 for the first "Take a Loved One to the Doctor Day" to focus on improving African-American health. More than 400 national, state and local partners from 200 communities participated in last year's event. Based upon this success, the campaign is now being expanded to include other racial and ethnic groups.

HHS encourages organizations to become partners in this year's event by visiting [www.healthgap.omhrc.gov](http://www.healthgap.omhrc.gov).

Organizations or individuals may also contact the Office of Minority Health Resource Center to speak to an information specialist or request campaign information and materials to help communities organize local health events at 800-444-6472.



## Clinical trials allow minority physicians to make an IMPACT

We prescribe and consume medicines because we know our well-being, and the health of our patients often depend upon them. Yet, how often do we give consideration to how these medicines are developed?

Medicines are approved and marketed primarily on the basis of data derived from clinical trials. How often do we consider whether the information provided in label applies to us?

Unfortunately, African Americans have not routinely participated in trials of new medicines to the extent necessary to understand how to use them safely and effectively in this segment of the American population.

Since it is well known that different ethnic and racial groups may respond differently to medicines, African Americans may be subject to preventable morbidity and mortality from the treatments they receive and unsubstantiated expectations of benefit. Both may contribute to health disparities.

In January 2000, NMA initiated an effort to develop and implement strategies to address the issue of African-American clinical trial participation. The strategic goal is to improve the validity of clinical trials data supporting the use of medicines in African-American patients.

This group met with multiple industry sponsors to gain support for use of minority investigators in clinical trials of new medicines. In addition, many discussions were held with FDA, other government agencies, and members of the U.S. Congress to advo-

**WHAT ARE YOU DOING?**  
E-mail your stories and suggestions to  
[NMAnews@NMAnet.org](mailto:NMAnews@NMAnet.org).

cate changes in policies to promote better understanding of risks and benefits of medicines in our diverse population of patients prior to their approval.

A major part of this strategy was the development and implementation of Project IMPACT (Improve Minority Participation and Awareness of Clinical Trials). Project IMPACT is actively engaged in the education of minority physicians about clinical research. The goal is to develop them to become investigators and to know enough about clinical research to advise their patients appropriately regarding participation.

Furthermore, Project IMPACT encourages all physicians caring for minority patients to be aware of the information supporting the safety and effectiveness of medications in minority patients prior to prescribing to assure the best therapy.

Project IMPACT is also actively involved in the education of minority consumers about clinical research, its value to them, and the measures that are in place to protect them. This information is communicated by presentations at health fairs, major meetings and other venues, posters, brochures and an educational video presentation.

A major milestone encouraged by the efforts of Project IMPACT was the January 2003 issuance by the FDA of Guidance for Industry on the Collection of Race and Ethnicity Data in Clinical Trials. Though it fails to provide requirements for diversity of patient representation, it represents an important step in raising awareness of the need.

## Howard added to national asthma research team

Howard University's College of Medicine is one of eight medical facilities to participate in a nationwide research network working to reduce and prevent asthma in inner-city children, a group that suffers disproportionately from the disease.

Under a six-year, \$55.8 million contract awarded from the National Institute of

Allergy and Infectious Disease (NIAID), the research network, known as the Inner-City Asthma Consortium (ICAC), will conduct clinical trials to evaluate the effectiveness of promising immune-based asthma treatments in inner-city children.

For further information, visit [www.howard.edu](http://www.howard.edu).

## Conventions focus on the future of African Americans

Three national groups – the National Bar Association, the National Urban League and the NAACP – have planned summer gatherings that focus on African-Americans' well being.

New Orleans will be the host city for the National Bar Association's 78th Annual Convention, to be held Aug. 2-9 at the Hilton New Orleans Riverside.

In addition, this is the year of the Seventh Quadrennial Black Congress on Health, Law and Economics. Groups attending include the National Black Nurses Association, the National Dental Association and the Association of Black Psychologists.

By attending the joint Town Hall Meeting on Saturday, Aug. 2, convention attendees will have the rare opportunity to interact with African-American leaders from these diverse industries. For more information, visit [www.nationalbar.org](http://www.nationalbar.org).

The National Urban League's annual conference, "The Black Family: Building on Its Resilience," will be held in Pittsburgh July 26-30. Speakers include: Willie Gary, chairman and CEO of MBC Television Network; Michael Eric Dyson, ordained Baptist minister, author and professor of African American Studies at the University of Pennsylvania; and George Frazier, author of "Success Runs in Our Race." For information, see [www.nul.org](http://www.nul.org).

The NAACP's 94th Annual Convention, themed "Having Our Say," will be held July 12-17 in Miami Beach, Fla. Health-specific activities include a Critical Issues Symposium on Health followed by a "Healthy Brunch" sponsored by the NAACP Health Department. The event also will include a Public Mass Meeting with keynote speaker Julian Bond of the NAACP National Board of Directors, a job fair, and a Plenary Session with NAACP President and CEO Kweisi Mfume. For more information, visit [www.naacp.org](http://www.naacp.org).

**National Medical Association News**

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# Inside the NMA

## NMA launches improved Web site for members, public

By Jessica Carter  
Managing Editor, NMA News

If you've been online lately, you may have noticed some big changes to a familiar Web site.

The NMA's home page ([www.NMAnet.org](http://www.NMAnet.org)) recently underwent a facelift that staff and members of the Board of Trustees hope will make the site a more useful tool in communicating with members and the public.

Natalie Achong, MD, chair of NMA's Public Affairs Committee, said changes to the site had been in the works for about two years.

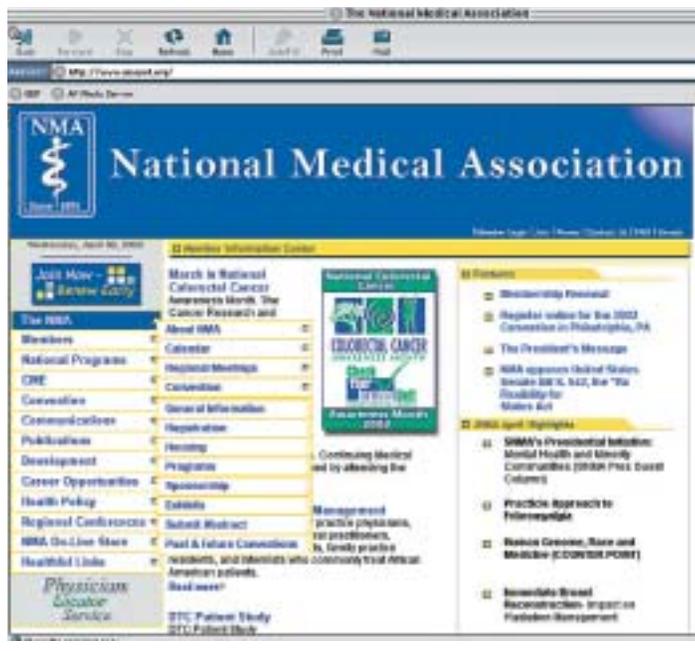
Complaints about the navigability, content and overall appearance of the Web site led to the changes, she said.

"We felt like we needed a better face to membership, potential members and the public in general," she said, adding that NMA has had the domain name for about three years.

The changes were spearheaded by Starrgate Corp., the same organization that maintains Web sites for NMA's Region 2 and Region 6.

The primary goal was to provide better access to information about NMA and member benefits, Achong said.

From the home page, visitors can find helpful pull-down menus to information about the NMA, national programs, continuing medical education programs, the annual Convention & Scientific Assembly, publications, career opportunities, health policy initiatives, regional conferences, the NMA's online store and links to other health resources.



**We felt like we needed a better face to membership, potential members and the public in general.**

**- Natalie Achong, MD  
Public Affairs chair**

In addition, popular features such as the Physician Locator Service are still available.

Another benefit to the new site design is the ability to sign up for programs and events, including the annual Convention & Scientific Assembly, to be held this August in Philadelphia.

The site also is being used as a powerful tool for recruiting new members to the organization.

It offers physicians an opportunity to read about member privileges and services. Current members also can log

on to the site to receive access to members-only benefits.

Potential members can sign up for membership to the association, something that wasn't possible in the past.

"You can also hyperlink to regional Web sites, there's more up-to-date information," Achong said. "Board members can go through discussion boards to communicate."

"There's a lot of capability."

In addition, the board is considering further improvements to the site.

Currently, only some titles of articles from the current

**Registration is currently being accepted on NMA's Web site for the 2003 Convention & Scientific Assembly, to be held Aug. 2-7 in Philadelphia. The post-convention meeting will be held in Bermuda. For more information or to register online, visit [www.NMAnet.org](http://www.NMAnet.org).**

Journal of the NMA are available on the site. But Achong said full text of each issue may be available to members at NMAnet.org for a fee in the future.

Achong said preliminary reports show an increase in the number of hits the Web site has received from new sources as compared to the old site.

So far, she added, response to the new site has been positive.

Visitors find the site easier to navigate and the content more current and easier to access.

Overall, the updated Web site should help improve the association's communication with the outside world.

"NMA has a face now," Achong said. "It's been received well from not only NMA membership and staff, but people that just access the site."

## Ask Me 3: Coalition's tools aid health literacy

By Jessica Carter  
Managing Editor

As an internist and geriatrician in private practice, Sharon Allison-Ottey, MD, sees the importance of clearly communicating health information to patients every day.

Literacy skills are a stronger predictor of an individual's health than age, income, employment status, education level or racial/ethnic group, according to the Partnership for Clear Health Communication. The group, a new coalition of 19 top health and civic organizations, including the NMA, unveiled



**Allison-Ottey**

an action agenda that addresses low "health literacy," or the ability to read, understand and act on health information.

"Many of us can share first-hand accounts of the impact of low health literacy on patients and understand the importance of promoting clear health communication," Allison-Ottey said.

Research indicates low health literacy may be an underlying factor in high use of some health care services as well as influencing health outcomes, according to the coalition. It is estimated to cost the U.S. health care system up to \$73 billion annually and puts 90 million people at risk for poor health outcomes.

The difficulty may be due to poor reading comprehension skills, the complexity of medical information or the format in which it is delivered.

The partnership has created an action agenda to promote awareness of and solutions to low health literacy and its effect on health outcome. The agenda includes:

- ◆ Educating patients and providers
- ◆ Developing and applying practical solutions to improve patient-provider communication
- ◆ Conducting nationally coordinated research to further define the health literacy issue and evaluate solutions.
- ◆ Increasing support for health literacy policy and funding.

"Effective communication tools are particularly critical when people of different cultures, ethnic and racial backgrounds need to exchange information in a way that all parties can understand and respond," said Allison-Ottey, chair of the NMA Health Literacy Task Force.

One tool that can help this process is "Ask Me 3," which promotes three simple but essential questions patients can ask their providers in every health care interaction:

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

For more information, visit [www.AskMe3.org](http://www.AskMe3.org).

## Survey: It will hopefully lead to more awareness ... *Continued from page 1*

ident of the NMA. "It is my mission to tell this story to as many people who need to listen to this."

Rick Blizzard, MD, and Larry Mallory MD, chief healthcare consultants for Gallup, added: "Gallup has studied many physician groups and practices over the past 20 years and we have determined that the 'engagement level' of the physician in their practice, in their profession and in their relationships with patients and healthcare organizations has a profound and measurable impact on the manner in which the doctor delivers care.

"Our intent is to link the level of engagement to the outcomes of the physician practice. It will hopefully lead to more awareness, greater leadership and

more success among minority physicians," they said.

NMA and Gallup will randomly select 4,000 minority physicians across the nation to participate in the study. Each physician will complete a written survey of approximately 70 questions relating to engagement, specific operations of their practice and overall opinions about the state of the minority physician.

Once the results are tabulated, Gallup will issue a report to the NMA. This report will include recommendations for action and specific steps leading to better outcomes.

"We all have very strong feelings about the medical profession," noted Sharon Allison-Ottey, MD. "However, we believe

the time has come to accurately assess and measure what is happening every day with our members. It is time we look at the data and reevaluate how we practice medicine.

"We know NMA members are proud and passionate about what they do every day, but we are not certain if other factors are diminishing that pride and passion. That's what we need to get a handle on, and I am pleased Gallup is working closely with us to find those answers."

NMA encourages all physicians to respond to the survey if it reaches your desk.

"I can say with certainty that this is the first research of its kind and I pledge to share the results with you when they become available," Dr. Carroll concluded.

# Inside the NMA

## NMA, Dairy Council partner on 3-A-Day

Special to NMA News

The NMA is partnering with other top health organizations to support the National Dairy Council's "3-A-Day of Dairy for Stronger Bones" campaign. The partnership provides an opportunity to address a growing calcium deficit in our communities.

Although most minority groups consume less calcium than recommended, this is particularly true for many African Americans who, according to the U.S. Department of Agriculture, are not meeting their recommended dietary allowances for calcium.

According to the USDA, more than 75 percent of African Americans are not meeting their daily calcium requirements.

Dairy plays a major role in reducing the risk of chronic diseases affecting African Americans. According to the National Osteoporosis Risk Assessment (NORA) study, the prevalence of this disease is greater among African Americans than previously thought. This is a problem that can be helped by encouraging your patients to include "3-A-Day of Dairy" as a part of their diet. In addition, substantial scientific evidence, including studies of African Americans, support calcium's hypotensive effect.

The "3-A-Day of Dairy" campaign encourages Americans to eat three servings of milk, cheese or yogurt a day to help build stronger bones and healthier bodies. The partnership with NMA will focus on improving the health of minority consumers by providing tools and information that promote positive eating behaviors. NDC will also support NMA's outreach to African-American communities to raise awareness of such key health issues as low calcium intake, lactose intolerance, hypertension and obesity.

"Education is vital to promoting improved health within our community. That is why we are working closely with the National Dairy Council to develop and provide free nutrition educational materials to members and patients about establishing positive eating behaviors and the importance of dairy in the diet," said NMA President L. Natalie Carroll, MD. "The rate of calcium intake in the African-American community continues to decline, it is important for us to form this strategic partnership, allowing NMA to increase its impact nationally."

Though lactose intolerance continues to challenge many African Americans' diets, the NDC advises health professionals that lactose intolerance does not necessarily mean dairy intolerance. Research finds that most people who are lactose intolerant can enjoy some dairy foods daily.

Because NMA and the NDC share a number of beliefs on nutrition, for more than four years the organizations have collaborated on several health initiatives. This year, in addition to the "3-A-Day of Dairy" program, the NMA and NDC will conduct a joint study on lactose intolerance and will share the findings at the NMA annual meeting in August.

For information, contact Ivonne Fuller, NMA's director of health policy, at NMA's national office or the National Dairy Council at [www.nationaldairyCouncil.org](http://www.nationaldairyCouncil.org).

## Next NMA News: 'Hurting Black Doctors'

In the next issue of NMA News, we will begin a series of articles on "Hurting Black Doctors" by renowned author Barbara A. Reynolds.

In her book "No, I Won't Shut Up," Reynolds examines "the demolition of health care providers of society's most underserved population" and documents cases in which African-American doctors have been unfairly imprisoned, forced into bankruptcy and harassed simply for providing health care to the poor.

"From Boston to Dayton, to Tampa to Detroit, health care providers are behind

bars serving sentences twice as long as the average murderer," she writes. "Doctors are sleeping in cars and abandoned buildings because some, after being forced to pay exorbitant fines to the government, are now homeless. Law enforcement officers with guns drawn have invaded medical offices, often finding no evidence of wrongdoing, but the mere terror of the invasion chases their patients away."

In the first article, we will look at the life of Sakiliba Mathlida Mines, a 50-year-old African-American licensed physician known to many through her family prac-

tice on Georgia Avenue in Washington, D.C.

Instead of serving her community, the mother of three is serving 21 months in the mental health unit of a federal prison for tax evasion.

Through letters to NMA Immediate Past President Lucille Norville Perez, the physician tells "a chilling story of how she became a victim in the now familiar demolition scheme federal authorities are waging against African-American doctors and others in the medical profession who treat poor people."

## Medical Briefs

### HHS to request waivers for foreign physicians

The HHS announced new regulations designed to help rural and other communities suffering from a shortage of health care providers.

The new rules will allow HHS to review applications from community health centers, rural hospitals and other health care providers to waive return-home requirements for foreign physicians who come to America for medical training so that they can remain in the country to practice in underserved areas. HHS would make recommendations on these requests to the State Department. The U.S. Immigration and Naturalization Service (INS) has the authority to grant waivers.

Normally under the State Department's J-1 visa program, foreigners who come to the United States for graduate medical education must return to their home countries for two years after they complete their training. However, the State Department may recommend to the INS that it grant waivers of that requirement when an interested government agency requests them to fulfill a legitimate public purpose.

In the past, the U.S. Department of Agriculture (USDA) served as the interested federal government agency that reviewed waiver applications to allow foreign doctors to serve in rural, underserved communities outside Appalachia, while the Appalachian Regional Commission played that role for Appalachian communities. With the new regulations, HHS now will take over the role formerly played by the USDA in handling applications for these J-1 waivers.

HHS will review the applications and verify the physicians' credentials through a federal credentialing process before making recommendations to the State Department. HHS also will coordinate its review

process with state health departments. HHS already reviews waiver requests involving foreign physicians working in high-level biomedical research projects of interest to the department.

"By helping review these waiver requests, we can help increase the supply of qualified physicians available to provide needed care in community health centers and other locations in rural communities and other underserved areas," Secretary Thompson said. "Their contribution is critical to the success of our broader efforts to expand Americans' access to care."

### Study: Finances cause more strokes in blacks

Mo' money is not the key. In fact the stress of maintaining the "income" and the daily challenge of addressing racism in the work and business arena, both subtle and blatant, probably contribute more to the early mortality of many so called "progressive blacks," according to a recent study.

According to a Yale University analysis of a large national study, African Americans have a higher rate of stroke than whites because of differences in income, Reuters reports.

Yale researchers analyzed data from the third National Health and Nutrition Examination Survey. Of 11,163 participants, 25 percent were black and 6 percent had a history of stroke.

For both blacks and whites, lower socioeconomic status was strongly associated with stroke risk, the report said, disproving a theory that African-Americans are genetically predisposed to strokes more than Caucasians.

### Blacks less likely to have hip replacement

African Americans are less likely than whites to receive hip

replacement surgery, according to a report by Reuters.

Based on rates of hip replacement surgery among Medicare recipients, whites were more likely to get the surgery than blacks. Women also underwent hip replacement more often than men, according to physicians at Toronto Western Hospital in Ontario.

The disparity between rates of hip replacement surgery in blacks and whites persisted even after removing the influence of other factors that could play a role, such as income and other diseases, the authors note.

And blacks who receive the procedure also appear to be at higher risk of complications as a result, relative to whites.

Other factors associated with complications after surgery included being older, male and having a low income, the authors report.

The biggest gap between whites and blacks was seen in rates of primary hip replacement, and fewer blacks may receive first-time hip replacement surgeries "because blacks have greater difficulty in accessing the proper health-care providers at the outset ... but once they have entered the medical system, the difficulty with accessing services (that is, for revision total hip replacement) is diminished," the authors suggest.

### Drug may prevent AIDS in African-Americans

Although trials of anticipated AIDS vaccine AIDSVAX show the drug failed to significantly reduce the rate of HIV infection in the general population, it may offer protection to blacks and Asians.

AIDSVAX reduced the rate of HIV infection by just 3.8 percent in 5,000 men and women considered at high risk in the United States, Canada, Puerto Rico and Netherlands. The vaccine was tested only against the

**Blacks and self-described others who got the vaccine had a 67 percent lower rate of infection than those who got a placebo shot.**

strains of the virus found in North America and Europe, so the findings do not apply to Africa and Asia, the regions hardest-hit by AIDS.

In the study, VaxGen pharmaceutical company gave injections of either the vaccine or placebo to 5,108 gay and bisexual men and 309 high-risk women. The trials began in 1998, and subjects were observed to see who went on to become infected with HIV, according to Reuters.

All the volunteers were told about safe sex practices such as using condoms to protect themselves and partners.

When VaxGen's figures were analyzed, they showed that Asians, blacks and self-described "others" who got the vaccine had a 67 percent lower rate of infection than those who got a placebo shot.

Only 498 blacks and Asians and "others" took part in the trial, so the significance of the result is difficult to interpret. Of all 5,000 volunteers, only 127 became infected with HIV – and only 25 among the blacks and Asians – which is too small a number of cases from which to draw any conclusions.

The company said blacks and Asians seemed to produce more antibodies against the virus than others, although critics said the sample size was too small.

The company and the U.S. Food and Drug Administration (FDA) were looking for evidence that the vaccine could act therapeutically to treat sufferers of the disease.

– compiled by  
Lucille N. Perez, MD  
NMA News Editor

# Medical Updates

## Guidelines set treatment of black patients with high blood pressure

❑ **Recommendations address major killer of black people, urging doctors to use new rules in blood pressure management.**

The International Society on Hypertension in Blacks (ISHIB) and the nation's leading medical experts have developed the first-ever guidelines for treating high blood pressure in African Americans. The recommendations, "Management of High Blood Pressure in African Americans" were published in the March 10 edition of the Archives of Internal Medicine. African Americans are significantly more likely to die of high blood pressure than the general public because current treatment strategies have primarily been unsuccessful. The recommendations urge health care providers to manage high blood pressure in Blacks in three new ways:

- ◆ ISHIB advises that many African Americans will need to start on at least two medications in order to successfully lower their blood pressure
- ◆ ISHIB recommends a lower blood pressure target of 130/80 mm Hg for African Americans with high blood pressure and other conditions like heart disease, kidney disorders or diabetes
- ◆ ISHIB suggests that African Americans with diabetes should receive medications that have been shown to slow the progression of kidney disease such as ACE inhibitors or angiotensin II receptor blockers (ARBs), as part of their combination of medications

"On average, one African American dies from high blood pressure every hour, yet barely a quarter of hypertensive African Americans has the disease under control," said John Flack, MD, president of ISHIB and chief quality officer at Wayne State University in Detroit, Mich. "ISHIB developed these recommendations – with the participation of the nation's most prominent high blood pressure experts – to give health care providers the tools to manage high blood

pressure appropriately in African Americans and save lives."

The recommendations are endorsed by some of the nation's leading health organizations: the American Heart Association, the Association of Black Cardiologists, the Consortium for Southeastern Hypertension Control and the National Medical Association.

### Reduce blood pressure goal

Nearly 40 percent of African Americans suffer from heart disease and 13 percent have diabetes. Thirty-two percent of people on dialysis due to kidney failure are African American. Because high blood pressure contributes to all of these conditions or makes them worse, ISHIB is urging health care providers to act more aggressively to lower the blood pressure of patients with these disorders – especially those with diabetes and/or kidney disease – to less than 130/80 mm Hg. This is a significant change from the previous standard of 140/90 mm Hg (for most patients) and 130/85 mmHg (for those with diabetes) recommended in 1997 by the federal government.

### Use the "15 Over 10" rule

Numerous clinical studies, including the recently completed Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT), demonstrate that many African American patients will require two or more medications to reach target blood pressure goals and reduce their risk of heart attacks, strokes and kidney disease.

ISHIB recommends that healthcare providers and patients follow the "15 over 10 rule." This means that any patient with a systolic (upper number) blood pressure greater than or equal to 15 mm Hg and a diastolic (lower number) blood pressure greater than or equal to 10 mm Hg above the desired goal should start on two medications instead of one.

For example, a patient (without diabetes, kidney or heart disease) whose target is less than 140/90 mm Hg, but who

**For more information about African American hypertension, please contact ISHIB at (404) 875-6263 or visit [www.ishib.org](http://www.ishib.org).**

has a blood pressure of 155/100 mm Hg or greater, would be a candidate for combination therapy.

When more than one medication is required, ISHIB recommends that physicians use low doses of high blood pressure medications from two different classes. Combinations of commonly prescribed medications might include: ACE inhibitors; ARBs; calcium channel blockers (CCBs); or diuretics (water pills). ACE inhibitors and ARBs are recommended for patients with diabetes or kidney disease.

### Emphasize lifestyle modifications

ISHIB recommends health care providers urge their patients to engage regularly in appropriate exercise, moderate their alcohol intake and avoid tobacco. In addition, ISHIB has endorsed the Dietary Approaches to Stop Hypertension (DASH) diet. In carefully conducted clinical studies, this diet was shown to lower blood pressure significantly, especially in African Americans. The DASH diet is rich in fruits, vegetables and fiber. It also emphasizes the consumption of low-fat dairy foods, meat and poultry.

"For too long, African Americans have not received appropriate treatment for their high blood pressure because of a lack of knowledge about medications, diet and other factors," said Elijah Saunders, MD, a founder of ISHIB and head of the division of hypertension at the University of Maryland Medical Center in Baltimore. "ISHIB's guidance is clear: assess patients' risk for heart and kidney disease, follow the DASH diet and prescribe a combination of medications to get to the recommended blood pressure level. Our hope is that these recommendations will help health care providers save the lives of thousands of African Americans with high blood pressure."

## The Genomics Revolution: Developments changing the future of medicine

By Beverly M. Gaines, MD  
Special to NMA News

From Dr. Daniel Hale Williams' daring foray into open-heart surgery to Dr. Charles Drew's pioneering work in blood banking to Dr. Ben Carson's innovations in pediatric neurosurgery, African-American physicians have been at the forefront of many revolutionary changes in medicine. Now, we stand on the verge of a medical revolution that promises to be the most dramatic yet — the dawning of the genomic era.

In April, coinciding with the 50th anniversary of the description of DNA's double helix by James Watson and Francis Crick, the National Human Genome Research Institute (NHGRI) announced the essential completion of the human genome sequence and unveiled a new vision for genomics research.

Many frontline physicians will be tempted to view these genomic achievements as strictly scientific milestones, irrelevant to the daily demands of clinical practice. However, to do so would be a grave error. If we fail to recognize the power of genomics to transform medicine and to affect society, we will be doing a major disservice to our patients, our profession and our people.

Genomics, the study of the functions and interactions of all genes in an organism's genome, has profound implications for patients seen by all medical specialties.

Genetic and physical maps produced by the Human Genome Project have already greatly speeded the identification of genes

**Genomic medicine offers us the chance to shine a bright light into our ignorance of many diseases.**

**- Francis Collins, MD  
NHGRI director**

involved in relatively rare, single-gene disorders, such as holoprosencephaly. Now, armed with the finished human genome sequence, researchers are searching for the genetic variations that contribute to common human diseases, such as cancer, diabetes and heart disease. In addition, they hope to find genetic variations that have an apparent relationship to health and wellness.

"Many aspects of genomic medicine are coming quickly. So, how do we incorporate genomic medicine into preventing, diagnosing, treating and curing diseases?" NHGRI Director Francis Collins, MD, asked a workshop for the scientific section chairs of the NMA, officers of the Student National Medical Association, officers of the Black Graduate Student Association and the Deans of the Historically Black Medical Schools.

The two-day workshop, "Genome Medicine: The New Frontier of Clinical Care," was hosted by the NHGRI, the National Institute of Child Health and Human Development (NICHD) and the Office of the Director for the National Institutes of Health (NIH) at the NIH's campus in Bethesda, Md. The event was a step in the growing collabora-

tive relationship among the NHGRI, NIH and NMA that dates back to the 2000 Annual Meeting of the NMA in Washington, D.C.

In her remarks to the workshop, NICHD Deputy Director (then Acting Deputy Director of NIH) Yvonne Maddox, MD, said, "This meeting is a milestone in NIH history. To gather so many esteemed leaders of the NMA is an opportunity to discuss issues in genomic medicine and what we can do with the enormous amount of genomic data."

Collins explained that once a gene that causes or contributes to disease is found, the first clinical applications are usually new or improved diagnostic tests. In some instances, predictive genetic tests also may allow patients who wish to learn about their personal disease susceptibility to take preventive measures, such as modifying their diets or increasing radiographic screening.

A rapidly emerging branch of genomics, known as pharmacogenomics, also promises to have a far-reaching impact on medicine. Identification of genes that influence individual responsiveness to specific drugs should open the door to predictive tests that will enable physicians to tailor prescribing practices to each patient's genetic profile.

"The current 'one-size fits all' approach to managing patients will become a thing of the past," commented Collins, who has served as the leader of the Human Genome Project's multidisciplinary, multinational effort for the past decade.

As an example, Collins cited the development of a genetic test that can tell clinicians

whether a child with acute lymphoblastic leukemia (ALL) will suffer toxic side effects from a common chemotherapy agent, 6-Mercaptopurine (6-MP). If the genetic test indicates dangerous side effects are likely, a lower dose of the drug can be administered.

The human genome sequence also provides a valuable tool for biomedical science to expand its limited understanding of the underpinnings of human health and disease. "Genomic medicine offers us the chance to shine a bright light into our ignorance of many diseases," said Collins, noting that such knowledge should pave the way for the development of therapies precisely targeted at crucial disease pathways.

Despite the bright outlook, genomic medicine cannot be considered a success unless its applications are developed in partnership with a wide range of communities and are used to benefit all population groups.

As NMA Immediate Past President Lucille Perez, MD, puts it: "We want a piece of the human genome. We don't want to continue with business as usual."

Since the workshop, the NMA has identified a number of potential areas of collaboration with NHGRI. They include educating African-American physicians in the area of human genomics and establishing programs to increase the number of African-Americans involved in genomic research. The NMA also wants to improve efforts to disseminate information on genomic research conferences, research opportunities, fellowships, internships and funding opportunities.

# President's Year in Review

## Presidential update: An open letter from L. Natalie Carroll

By L. Natalie Carroll, MD  
NMA President

I wanted to give you an update on several important issues and developments and outline how the NMA has been actively engaged.

As you may be aware, one of my major "talking points" over the past several months has centered on the soaring cost of medical liability insurance.

This is not a problem confined to a few high-risk specialties. While it is not uncommon for obstetricians and neurosurgeons to pay \$200,000 and more for yearly insurance premiums, doctors across the board are also severely impacted. I have had the opportunity to meet with physicians and health care workers in many areas of the country, and it has become evident that the medical profession is in dire need of major surgery in the area of tort reform.

The outrageous rates for medical liability insurance are dismantling our health care system. Many doctors in private practice and small clinics have reluctantly laid aside their stethoscopes. They simply can no longer afford to practice medicine. Consequently, patients are left with fewer medical choices, forced to travel greater distances to attain health care, and often must pay more for less service.

Because we live in a highly litigious society, malpractice premiums have become exorbitant. This has created a booming industry for certain corporate entities and personal injury lawyers but represents a losing proposition for most doctors and patients. While accountability in the medical profession is of paramount importance, the reality is that capricious lawsuits and outrageous settlements have ravaged the health care system and led to higher insurance premiums.

Increasingly, medical decisions are based on bottom-line economics and "just in case" procedures. In the rush for "cover," physicians make decisions that may not always be in the best interest of the patient.

At the NMA we are working with diverse groups of individuals and organizations that have called for an overhaul of this present system that so adversely impacts doctors and patients. We must not allow corporate interests and political posturing to stand in the way of quality affordable health care. We must demand strong tort reform that would improve patient access to medical services, provide relief to physicians from unreasonable liability rates and eliminate the costs and unwarranted procedures linked to "just in case" medicine.

On another front, the NMA has entered into an agreement with the Gallup Organization to survey the condition of African-American physicians. In recent months, leaders from NMA and Gallup have worked on a survey instrument that will assess the level of engagement by minority physicians and determine how that relates to actual outcomes of minority physician practices.

We think this survey will help us define



**NMA President L. Natalie Carroll, MD, addresses the audience during the unveiling of the Partners of the Heart campaign at the Library of Congress in Washington, D.C.**

how minority physicians are faring – economically and emotionally — in comparison to their peers and each other. The survey will enable the NMA to determine how best to assist physicians in this volatile economic environment.

Gallup was selected to work on this project because of its highly regarded reputation as an experienced polling organization, and its unprecedented research in healthcare. Gallup has studied many physician groups and practices over the past 20 years and has determined that the "engagement level" of physicians in their practice, their profession, and relationships with patients and healthcare organizations has a profound impact on how they deliver care.

NMA and Gallup will randomly select 4,000 minority physicians across the nation. Each physician will complete a written survey of approximately 70 questions relating to engagement, operations of practice and opinions about the state of the minority physician. Once the results are tabulated, Gallup will issue a report that will include recommendations for action and specific steps leading to better outcomes.

If you are one of the "chosen" participants, I urge you to respond to the survey. The data from this research is extremely important as we evaluate how we practice medicine and look at ways of improvement. It is our hope that the results of the survey will lead to more awareness, lead-

ership and success among minority physicians.

Regarding the case of Grutter v. University of Michigan now before the U.S. Supreme Court, the NMA has made known its strong support of the amicus brief filed by the Association of American Medical Colleges. In a letter to the AAMC as well as via pronouncements through the media, the NMA has voiced deep concern about the implications of this case due to its potential impact on the numbers of African Americans entering the field of medicine.

We vigorously applaud the efforts of the University of Michigan to achieve a more diverse student body that is reflective of the national population. We also fully concur with the AAMC position that "to prohibit admissions committees from taking race into account will have severe adverse consequences for American society."

Indeed, the NMA opposes any attempt to prohibit institutions of higher learning from considering the significance of racial diversity in the applications process. Such action would sharply reduce the resources and opportunities that are used to increase the number of minority medical and pre-medical students in training.

It should be noted that the 2002 Institute of Medicine Report "Unequal Treatment" recommended efforts to increase the applicant pool of qualified minority students as a way to eliminate

health disparities. We believe that any successful legal challenge that would disallow race as a factor in the admissions process would result in a disservice to the African-American community and, ultimately, to the nation at large.

Eliminating health disparities remains the primary mission of the NMA and we support any efforts to achieve this goal. We were pleased at the announcement in early March that Aetna, one of the nation's leading health providers, has embarked on a series of initiatives to assess racial and ethnic disparities in health care. As a part of this effort, Aetna will develop interventions aimed at improving the quality of care for its minority members.

Aetna has developed a coordinated data collection system that is designed to enhance understanding about the cultural diversity and language preferences of its membership and participating physicians. With this knowledge, the company should be well positioned to provide equal access to all its members, ultimately enhancing the diagnosis, treatment and quality of life for minorities.

The NMA Research and Development Committee can provide assistance to this initiative by Aetna by helping to formulate practices and procedures that will lead to better health delivery system. At the NMA we have long documented the disparities in health care. Recently, the Department of Health and Human Services acknowledged that compelling evidence shows that ethnic and racial gaps in health care persist and, in some cases, have widened among African Americans, Hispanics, American Indians, Alaska Natives and Pacific Islanders, when compared to the U.S. population as a whole.

Aetna will collect its data on race, ethnicity and language through a process that is voluntary and self-identifying. It has begun gathering information from self- and fully-insured HMO members and Medicare+Choice members. All individually identifiable information is considered confidential and is subject to the company's policies and procedures concerning privacy and security.

A second data collection initiative is focused on understanding the race and ethnicity of Aetna's network of participating physicians. Again, participation is voluntary. The collection of this information will allow Aetna to address the cultural competency of its network of participating physicians and their ability to meet the racial, ethnic, cultural and linguistic needs and preferences of its member population.

While data collection is critical, there comes a time for action to implement recommendations and to move forward with change. We look forward to analyzing the results of Aetna's research grants earmarked for projects that identify and test practical means of reducing racial disparities in health status and the delivery of medical care. We applaud the efforts of Aetna to deal with this important issue and encourage the allocation of more funding directly to minority communities.

# President's Year in Review

## Carroll's Presidency: A Look Back



*Photo by Debra Meeks*  
NMA Speaker of the House Carla Ortique, MD, installs L. Natalie Carroll, MD, as the 103rd president of the National Medical Association.

It is important for the NMA to interface with health insurance companies, trade organizations, the pharmaceutical industry and Medicare and Medicaid to address issues related to fair compensation for physicians and other crucial elements of a more just health care system. We may need to go to Capitol Hill in a massive show of force to educate Congress and the American people that it is imperative to revamp this current structure that is so riddled with inequities.

- L. Natalie Carroll, MD,  
speaking during her installation as the NMA's 103rd president on Aug. 7, 2002, in Honolulu, Hawaii



Dr. Carroll receives an honorary degree from Lake Forest College during the spring 2003 commencement ceremony.



*Photo by Debra Meeks*  
Hawaii Gov. Benjamin Cayetano greets Dr. Carroll, then president-elect, during the annual Opening Ceremony and Awards Ceremony at the 2002 convention.



Dr. Carroll speaks about the NMA's determination to fight marijuana use during a press conference.



Dr. Carroll meets with Randall Maxey, MD, right, and U.S. Sen. Bill Frist, MD, (R-Tenn.), center, and members of the Alliance of Minority Medical Associations at the recent Minority Health Month Dinner.

# Meet the Presidential Candidates

## The Candidates Speak

### Presidential hopefuls share their views on the future of the NMA

#### WINSTON PRICE, MD

Hometown: Brooklyn, NY

##### Why are you running for president of the NMA?

I want to be a catalyst in helping to position the NMA to be competitive with other organizations in the 21st century and to become the unquestioned authority and resource on African-American health. This will involve building stronger relationships with key allies in the health care arena and government. I also want to help the organization maximize efficiency and promulgate the things that we do well without straining our tight budget and staff resources.

##### What is your platform?

My platform is unique in that it essentially encompasses the prioritized issues and mandates of the HOD. I intend to focus on projects and programs that have been approved by the HOD and BOT that require ongoing thrust and implementation. A tight interface with the SOH of Delegates and the COB will assure that we stay on target. My focus on Computer Competency and Technology in Medicine will only be addressed as it aligns with and reinforces the over-arching programs of the NMA. We have an obligation to assure implementation of focused priorities and to stay on track with our refined strategic plan. We must avoid the tendency to become diffuse in our efforts and thus lose valuable ground in the task at hand.

##### What are your qualifications? What assets do you bring to this office?

I have a broad experience in health care that spans clinical administration, private practice, managed care as a medical director, physician regulatory involvement with the National Committee for Quality Assurance and physician misconduct work for more than 12 years with the New York State Professional Medical Conduct Board. I also know

**Essentially my message to the members is: We can, we must, we will.**

the NMA as an active member for 25 years.

##### What are the most critical issues facing African-American physicians?

The need for major tort reform (involving not only the cap on pain and suffering but also the need for premium reduction and development of catastrophic funds for certain illnesses), improved reimbursement guidelines that take burden of illness for our sicker population into consideration, relief for high student loan balances for those returning to the inner city as well as rural areas to practice, and improved mechanisms and funding levels to address ethnic and racial disparities.

The passage of a universal health insurance bill that covers everyone with adequate mental health, prescription drugs, dental and preventive health benefits. Black physicians also need to be given greater involvement in the upper management levels of health care within the regulatory, disciplinary, legislative and clinical arena. Lastly, we must assure greater black student enrollment in medical schools and greater financial support for their medical education.

##### In your opinion, what are some of the challenges and opportunities facing the NMA?

Challenges: The NMA will be challenged over the next decade with competing interests by physicians in a situation where reimbursement dollars are shrinking. This will put a potentially inordinate strain on NMA membership if measures are not taken over the next few



years to assure alignment of our programs with student, resident and young physician needs as well as established doctors. The ever-increasing incidence of HIV/AIDS, diabetes, asthma and cancer in the black population will continue to erode available resource dollars over the next decade if alternate funding streams are not identified.

Opportunities: Because of the common problems facing the Latino and Native American populations we have an opportunity to pool some of our initiatives to strengthen our stance before the government and other regulatory agencies. With increased collaboration of projects with the black churches and other houses of worship, our outreach efforts toward changing risky lifestyle behaviors can be maximized. The available technology of computers and telecommunications will also enhance the NMA's outreach capabilities to both physicians and to communities for health education and advocacy. We have to seize this opportunity.

##### Do you have a personal message you would like to convey to NMA members?

Essentially my message to the members is: We can, we must, we will. I believe we must evolve from a process of business as usual and emerge with new focus, improved collaboration between the components of our organization and renewed strength. To do anything less will leave our organization crippled and in jeopardy of extinction. I pledge my undying energy to see that this demise of the NMA does not occur.

#### GILBERT PARKS, MD

Hometown: Topeka, KS

##### Why are you running for president of the NMA?

I have a lifetime of experience working with organizations and assisting them in achieving their goals. I have worked with the NMA in leadership and non-leadership positions for over 25 years. I want to combine my experiences and love of this organization to work to achieve our goal of improving the health of African-American people. The NMA needs proven leadership at this crucial period in our history as we continue the struggle to empower our people.

##### What is your platform?

Provide leadership to:

- ◆ Attract competent, we trained staff, programs and revenue.
- ◆ Increase African American financial contributions to support the leadership role of the NMA.
- ◆ Improve the effectiveness of the NMA in government – federal, state and local.
- ◆ Improve the image of the NMA.
- ◆ Improve relationships with the foundation community, enhancing financial support of the NMA's mission.
- ◆ Improve relationship with the federal government.
- ◆ Develop programs to help physicians to survive and thrive.
- ◆ Improve and build new relationships in the corporate community.
- ◆ Articulate the policies determined by the House of Delegates of the NMA.
- ◆ Foster cooperation between all components in planning and implementing NMA policies and programs.

##### What are your qualifications? What assets do you bring to this office?

I bring to the office of president of the NMA a long history of leadership in health and the broader community. I worked as a consultant to the Health Brain Trust of the Black Congressional Caucus, Office of Minority Health of HHS, Howard University Department of Psychiatry, and Morehouse School of

**We must be just as effective in the political and financial arenas as in the art of medicine.**

Medicine Division of Excellence of Healthcare.

I served as chairman of the board of a financial institution for 12 years, chairman of the Black Caucus of the Democratic Party of Kansas nine years, and a consultant to candidates for public office at the state, local and national levels. I'm recognized as a leader in the business community, having served with a state business development organization and a community development cooperation.

I was instrumental in the inception, establishing and development of the SNMA, serving as the second chairman of the board of the SNMA from 1973-74. I have continued over the years to be a supporter both financially and with my presence.

I have served in the NMA House of Delegates for more than 15 years and as chairman and a member of the Board of Trustees of Region V.

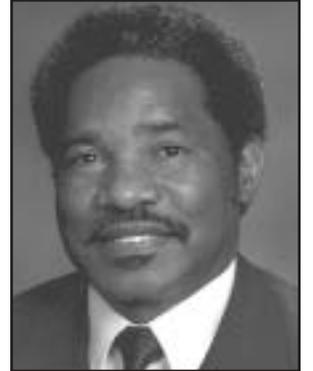
I was chairman of the Board of Trustees from 1999 to 2000, and I am the only person to have served as the chairman of the Board of Trustees of both the SNMA and the NMA.

I am Board Certified in Psychiatry and Neurology and I am a Fellow of the American Psychiatric Association. I am one of the founders of the World Association of Psychiatrists of African Decent.

I have traveled to approximately 40 countries in Africa, the Caribbean and Central America both studying and lecturing. I am involved in a leadership role in an organization that provides supplies, medications and services to nations such as Haiti.

##### What are the most critical issues facing African-American physicians?

The most critical issue facing African American physicians is the decreasing



number of African American physicians. While recruiting new physicians we need to improve our ability to survive and practice the art of medicine effectively for our communities. We must be able to support our families with a quality of life that will encourage and inspire others to follow our career choice.

##### In your opinion, what are some of the challenges and opportunities facing the NMA?

One of the greatest challenges to the NMA is to improve our image as a physician service organization. We must produce opportunities with programs that protect the interest of our members.

NMA is challenged to design programs to better serve our medical students and young physicians and to collaborate with many organizations, particularly African American-member organizations and African American-focused groups regardless of their racial composition.

##### Do you have a personal message you would like to convey to NMA members?

It is up to us to lead the way and give the direction to the practice of the art of medicine for African American communities. We must be just as effective in the political and financial arenas as in the art of medicine.

Most importantly we must lead the world in an effort to eliminate the adverse effects of hundreds of years of neglect, abuse and ill treatment of our people.

We must confront the forces that have retarded the healthy development of our people. Fifty years from now we will be known as the era that saw the need and met the challenge forcibly and effectively. If we don't who will? Together we can do it.

# 2003 Convention Preview

## One convention, six days, Countless Choices

❑ In addition to scientific sessions, tons of special events await convention attendees in Philly.

By Jessica Carter  
Managing Editor, NMA News

Anyone who has attended the NMA Annual Convention and Scientific Assembly knows the event is as much as you make of it. This year's event, set for Aug. 2-7 at the Philadelphia Marriott in the "City of Brotherly Love."

Below are a few of the highlights of the upcoming convention:

- ♦ **Opening and Awards Ceremony and Opening Reception** (Saturday): NMA welcomes participants and recognizes recipients at the Opening Ceremony and Awards Ceremony. The awards to be conferred include the Scrolls of Merit, Practitioner of the Year, Meritorious Achievement, Local Society of the Year and Corporate Circle. Scholarship recipients also will be recognized.
- ♦ **NMA/Patti LaBelle Medical Education Scholarship Benefit Concert** (Sunday): LaBelle will present a special concert to benefit the scholarship fund in her name..
- ♦ **Golf Tournament** (Sunday): NMA's golf tournament promises enjoyment and challenges to golfers of all skill levels. The tournament will have a shotgun start. Pre-registration is required.
- ♦ **Tennis Tournament** (Sunday): Get into the swing of things at outdoor tennis courts. Men, women, and mixed doubles tournaments will be held. Pre-registration is required.
- ♦ **Alumni Dinners and Receptions** (Monday): Catch up with classmates and pay tribute to professors during this social opportunity.
- ♦ **President's Ball** (Tuesday): This year's President's Ball will take place at the Lowes Hotel in the beautiful Regency Ballroom. It will be a tribute to NMA's 103rd president, L. Natalie Carroll, MD. Advance ticket purchase is recommended for this sell-out event.
- ♦ **Presidential Reception and Installation** (Wednesday): The formal installation of

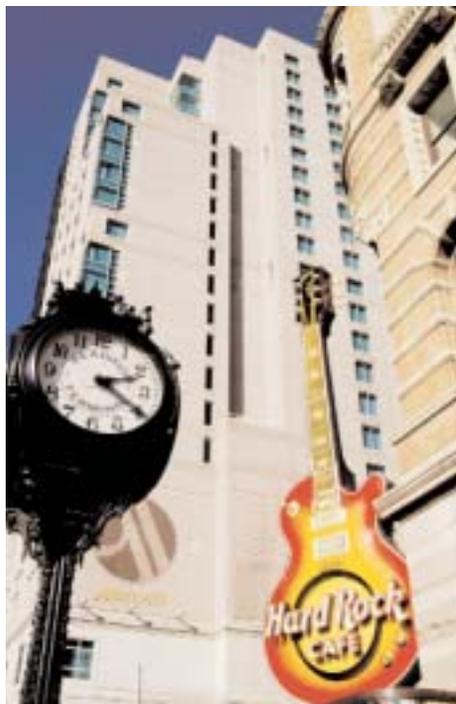


Photo by Jim McWilliams/Philadelphia Convention & Visitors Bureau

The Philadelphia Marriott, site of NMA's upcoming convention, features easy access to the Pennsylvania Convention Center Complex via a connected skywalk. Convenient dining opportunities are available at the Marriott's restaurants, the Hard Rock Cafe and the historical Reading Terminal Market.

the president has become an historic NMA tradition. Witness the installation of NMA's 104th president, Randall W. Maxey, MD, and the ceremonial passage of the Past President's cane. Renew your commitment to the practice of medicine, in the NMA tradition, by taking the Oath of Imhotep with your colleagues.

- ♦ **Urology Prostate Awareness Program and Concert** (Sunday through Wednesday):

Free testing for prostate cancer will be available to all convention attendees in the exhibit hall. Anyone fully tested will receive a VIP ticket to the Prostate Cancer Awareness Concert, set for Wednesday night.

For more information, see [www.NMAnet.org](http://www.NMAnet.org).

## SECTION BY SECTION

Some of the activities the sections have planned for the 2003 Annual Convention and Scientific Assembly, set for Aug. 2-7.

Throughout the Diaspora and the role of NMA physicians and other health care providers.

### AEROSPACE AND MILITARY MEDICINE

The section opens with the annual Roselyn Epps Symposium: Bioterrorism: Medical Preparedness and Homeland Defense Initiatives. Other timely topics include a combined with Dermatology on Cutaneous Side Effects of the Smallpox Vaccine and another combined session with Physical Medicine and Rehabilitation on Rehabilitative Services and the War on Terrorism.

### ALLERGY, IMMUNOLOGY AND ASTHMA

Practical Approach to Asthma Management, an asthma management certification course, will take attendees through the conditions epidemiology, pathogenesis, diagnosis, assessment and management, pharmacotherapy, emergency room and hospital management, and barriers to optimal care.

Combined sessions with Otolaryngology will examine the complications of Gastro Esophageal Reflux Disease and sleep apnea, and another combined session with Pediatrics and Dermatology will discuss pediatric dermatitis and other related issues.

### ANESTHESIOLOGY

Program not available at press time

### BASIC SCIENCE

Program not available at press time

### COMMUNITY MEDICINE AND PUBLIC HEALTH

This year, Community Medicine and Public Health will focus on Medical Preparedness and Alternative Treatment Tools for Homeland Defense, The Effects of Racism and the Reprioritizing of Illness Care Delivery to Health and Wellness Promotion and Health Needs

### DERMATOLOGY

A breakfast sponsored by L Oreal on Tuesday will look at ethnic cosmetics, including Approach to the Cosmetic Patient — Selected Cases and Panel Discussions. Other panel topics throughout the conference include advances in the use of Botox, male liposuction and a lasers update. Combined sessions to be held with Aerospace and Military Medicine as well as Allergy, Immunology and Asthma.

### EMERGENCY MEDICINE

A combined session with Psychiatry will look at Management of the Acute Psychiatric Emergencies. A look at the business side of the ER includes sessions on legal challenges, asset protection and wealth preservation. An Emergency Medicine Year in Review is planned for Monday. Combined sessions planned with ENT and Anesthesiology.

### FAMILY PRACTICE

The section's activities open with a Minority Medical Student Initiative Lecture/Breakfast Program that includes an introduction to Family Medicine, An Abbreviated History of the Family Practice Section of the National Medical Association, Inc: 1970-2002, and Current History and Achievements of the Family Practice Section 2001-2003. Women will be the topic of a session on perimenopause and osteoporosis. Timely topics include Severe Acute Respiratory Syndrome (SARS) and an Obesity Symposium on Management of Obesity in Your Practice. Also, watch for a Nutrition Symposium on 5-A-Day For Better Health.

### INTERNAL MEDICINE

As usual, Advanced Cardiac Life Support certification and re-certification courses will be available, and the section

See Section, page 10

## LaBelle: Singer also works for AIDS Council, Cancer Institute... *Continued from page 1*

such as Meharry and Harvard.

Aside from her generous financial contributions to the cause, LaBelle has performed before sold-out audiences at the NMA's Annual Convention and Scientific Assembly. The Philadelphia resident will perform in her home town at this year's convention Aug. 2-7.

"I am excited about being at home. This is my seventh year and I look forward to this year's concert," Labelle said in a release. "I've invited some of my friends such as Will Smith, Jada Pinkett, Jill Scott, Damon Wayans, and my family to this year's concert. I am hopeful that we can televise this

year's concert to acquaint more people (with) what we have been doing."

Although sponsorships for this event run high and tickets sell for no less than \$175 each, her benefit concert continues to be the highest attended event of the convention.

The endowment will remain in her name and an annual scholarship will be given long after LaBelle puts down her microphone.

Perhaps more than any other contemporary entertainer, LaBelle is known for giving as much of herself offstage as on.

In addition to her work with NMA, the singer contributes her

**For information about The Patti LaBelle Medical Education Scholarship Fund, contact Michelle Bellamy-Buck at 773-551-4286 or the NMA at 800-662-0554.**

celebrity to the National Minority AIDS Council and the National Cancer Institute. For her work on behalf of cancer awareness, a special research laboratory was dedicated in her honor at the Sylvester Comprehensive Care Center at the University of Miami. She also serves as spokeswoman for the American Diabetes Association.

The singer affirmed her commitment to health with "Patti LaBelle's

Lite Cuisine: Over 100 Dishes With To-Die-For Taste Made With To-Live-For Recipes," published in April by Gotham Books.

LaBelle recorded her first million-selling hit, "I Sold My Heart to the Junkman," in 1961. Since then she has scored hits such as "Lady Marmalade," "New Attitude" and "On My Own," starred in a one-woman Broadway show and created her own prime-time TV series.

In her more than 30 years in show business, she has earned eight Grammy nominations and the 1992 Grammy Award for Best R&B Vocal Performance; seven NAACP Image Awards (including the coveted

Entertainer of the Year Award); three Emmy nominations; two American Music Awards; and a Cable Ace Award.

She received an honorary doctorate from Boston's Berklee College of Music and her own star on the Hollywood Boulevard "Walk of Fame." LaBelle is the only recording artist whose star was paid for entirely by fans.

Despite these accolades, LaBelle says her most important roles in life are that of wife to Armstead Edwards, her longtime manager, and mother to her three sons and the two children of her late sister, Jackie.

# 2003 Convention Preview

## For the whole family ANMA offers spouses, kids exciting opportunities

By Jessica Carter  
Managing Editor, NMA News

While the physicians are catching up on the latest technologies and discussing issues related to their respective fields, hundreds of spouses will be busy with their own work – furthering the NMA's mission.

The Auxiliary to the NMA has a full slate of activities for the 2003 convention. Its theme is "Preserving Partnerships as We Address Healthcare Disparities in the 21st Century."

Registration will take place Saturday at the Philadelphia Marriott Hotel, with an opening reception and ribbon cutting for the Marketplace that evening.

Sunday will see the annual NMA/ANMA Prayer Breakfast as well as continuing registration. The formal opening for the ANMA's 66th Annual Convention and House of Delegates will take place that afternoon, with a delegate/ANMA member reception following.

The ANMA House of

Delegates will host a continental breakfast Monday morning. A "Youth Health Forum," part of the National African-American Youth Initiative/Project Sun, will be held as well.

Events Tuesday and Wednesday include the Jazz Show/Scholarship Luncheon and voting for the ANMA's 2003-04 officers. On Thursday, the organization will install its 66th president and the elected officers for the upcoming year. Chairwoman Mauree W. Ayton will oversee a post-convention meeting of the ANMA Board of Directors to close out the event Thursday.

The Marketplace will be open Saturday through Thursday.

ANMA President Janis O. Hadnott and General Convention Chair Janet Turner invite all interested parties to call 202-371-1674 for more information.

While their parents work, the children of NMA members will have big chances to play during Camp NMAzing, the official youth program of the NMA convention.



Photo by Edward Savaria Jr./Philadelphia Convention & Visitors Bureau

**Founded in 1976, The African American Museum in Philadelphia is committed to telling the story of African Americans and collecting, preserving and interpreting their material and intellectual culture in Philadelphia, the Delaware Valley, the Commonwealth of Pennsylvania and the Americas.**

Sponsored by the Auxiliary to the NMA, Camp NMAzing will delight kids ages 3 to 18 with a packed schedule of enriching activities in Philadelphia. The youth will take mule-drawn canal boat rides and visit historic

hotspots such as Valley Forge, the African-American Museum in Philadelphia, the Liberty Bell and Independence Hall.

Some other the destinations awaiting kids with Camp NMAzing include: Crayola

Factory, Franklin Institute, Liberty Park, Dorney Park, Constitution Center, Wildwater Kingdom, Freedom Theatre and the Mutter Museum.

For more information, visit [www.NMAnet.org](http://www.NMAnet.org).

## SECTION BY SECTION

Continued from page 9

will present the 15th Annual Walter M. Booker Symposium in conjunction with the Association of Black Cardiologists. A Practice Management for the Internist session will be presented by the Institute for Health Care Excellence (formerly known as Managed Care Institute), and focuses Sunday will include critical care, pulmonary diseases, endocrinology, nephrology and SARS. Other topics through the course of the convention include sickle cell, gastroenterology, fibromyalgia, irritable bowel syndrome and the National Marrow Donor Program's Stem Cell and Organ Transplant Update.

### MEDICAL ADMINISTRATORS

The one-day session will include discussions on Physician Leaders in Health Service Delivery Organizations, The Impact of Consumerism on Health Services and the Economics of Health Disparity Elimination. A timely topic includes Public Health

Leadership in the Era of Terrorism.

### NEUROLOGY/ NEUROSURGERY

A combined session on pain with Anesthesiology, Physical Medicine and Family Practice will focus on topics such as Evaluation and Treatment of Headaches and Surgery Treatment of Back Pain.

The Calvin Calhoun, MD, Symposium will focus on all areas of epilepsy in adult and children, including The Role of Continuous Monitoring in Epilepsy Diagnosis, Modern Treatment Options for Medical Management of Epilepsy, Surgical Epilepsy: Diagnosis and Outcomes and Gender Issues in Epilepsy Management.

Cerebrovascular disease and stroke prevention are other planned topics of discussion.

### OBSTETRICS AND GYNECOLOGY

Practice Management and Medical/Legal Issues for the Obstetrician Gynecologist will take a look at the business side,

including medical fraud/abuse and HIPAA, coding updates for OB/GYN practices and an OB/GYN Practitioner's Perspective on Surviving in the Managed Care Era.

Sessions will examine contemporary research in the field, as well as contemporary issues in contraception and menopause.

Reproductive Endocrinology and Infertility will break down common endocrine disorders affecting pregnancy.

### OPHTHALMOLOGY

A postgraduate course will look at The Brain in Eye Disorders, including Normal Tension Glaucoma: The Glaucomatologist's Perspective, 30 Years of Pearls in Evaluating Brain and Eye Disorders and the selection of the Rabb-Venable Ophthalmology Award.

The Retina-Vitreous Section will host a session on Monday, and Tuesday will be filled with lectures from the Glaucoma and Cornea/External Disease sections. HIPAA, medical fraud and technology will be some of the business aspects discussed during the convention.

### ORTHOPAEDIC SURGERY

Program not available at press time

### OTOLARYNGOLOGY

Program not available at press time

### PATHOLOGY

Program not available at press time

### PEDIATRICS

Pediatric Advance Life Support (PALS) Training will be available, but pre-registration is required. Monday will see the presentation of the Billie Wright Adams, MD Scholarship recipients, as well as a combined session with Allergy, Dermatology and ENT. Tuesday's Nutrition Symposium will look at lactose intolerance and the Proper Vegan Diet.

Another combined session with PM&R and Orthopedic will look at The Role of the Pediatrician as Team Physician and Be Physically Active Every Day: Prescription for Healthy Children, as well as a hands-on

workshop on sports injuries. On the final day, pediatricians can look at hot topics in pediatrics and adolescent care such as mental health, alternative treatments for ADHD and violence in children.

### PHYSICAL MEDICINE AND REHABILITATION

A combined session with Family Practice will examine The Use of CranioSacral Therapy in the Enhancement of Natural Health. A post-graduate course covers Spasticity, from advance techniques in spasticity management to an overview of spasticity and Botox. Pain-related sessions include treatment for carpal tunnel and low-back pain, and a combined session with Internal Medicine, Rheumatology and Orthopedics will look at Osteoarthritis/Rheumatoid Arthritis.

### PLASTIC AND RECONSTRUCTIVE SURGERY

The section will open with an

Continued on next page

# 2003 Convention Preview

## Special session to focus on immunization study

“Bridging Gaps: Improving Immunization Rates in Ethnic and Minority Populations” will be the topic of a special National Foundation for Infectious Diseases (NFID) Session the Family Practice section will sponsor Tuesday during the NMA’s 2003 Annual Convention and Scientific Assembly.

The hour-long program will highlight two newly issued NFID reports that address a disparity problem among adolescent and adult ethnic and minority populations, showing that disparities in immunization remains an important public health concern. The reports also show childhood immunization rates in some urban areas with large minority populations are lower than the general population.

Three 15-minute presentations will be delivered by leading experts in the field of infec-

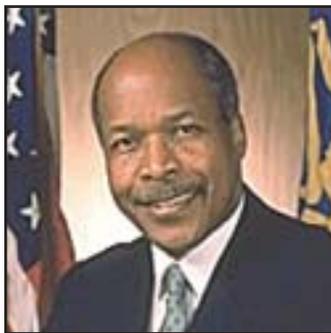
tious disease, immunizations, public health and pediatrics, who served as key contributors to the newly issued NFID reports.

Experts include:

- ◆ Lance E. Rodewald, MD, director of the Immunization Services Division and National Immunization Program (NIP), Centers for Disease Control and Prevention/HHS in Atlanta
- ◆ Henry Pacheco, MD, scientific consultant for National Council of La Raza (NCLR) in Plano, Texas
- ◆ Louis Sullivan, MD, former HHS secretary and president emeritus of Morehouse School of Medicine in Atlanta.

The moderator is Rudolph E. Jackson, MD, professor of pediatrics and associate director of the Office of International Health Programs at Morehouse.

The faculty for this session will cover pertinent aspects



**Louis Sullivan, MD**

aimed at improving immunization rates among underserved populations and will address:

- ◆ CDC data describing major disparities in immunization coverage rates among racial and ethnic groups, including a review of national, regional and local gaps in pediatric, adolescent and adult populations with an emphasis on adolescent and adult immunization gaps.
- ◆ Barriers to full immunization

common to all racial and ethnic minority groups and specific barriers faced by underserved ethnic and minority populations.

- ◆ Strategies for improving disparities in immunization, the impact of culture and ethnicity on access to healthcare services, the importance of cultural competence in achieving optimal immunization rates, and practical tools and tips useful in “real life” practices.

A question-and-answer session will follow three presentations by an expert panel representing national health organizations and the CDC, who have experience in this important area of preventive healthcare. The program is made possible through an unrestricted educational grant from Aventis Pasteur.

## After the Convention

Don’t forget about NMA’s Post Convention activities, set for Friday and Saturday, Aug. 8-9, at the Fairmont South Hampton Resort in Bermuda. Topics on Friday include:

- ◆ Diabetes Certification Course
- ◆ Pain Management
- ◆ Physician Communication in Terminal Care
- ◆ Patient Safety Enhancement
- ◆ Update on Minimal Invasive Surgery.

Saturday’s program includes:

- ◆ Mock Trial
- ◆ Diabetes Certification Course
- ◆ Erectile Deficiency
- ◆ Post Traumatic Syndrome (pertaining to Bioterrorism, Suicide, etc.)
- ◆ Critical Safety Issues in Minimal Surgery.

For more information or to register for Post Convention, call 800-662-0554 or visit [www.NMAnet.org](http://www.NMAnet.org).

## SECTION BY SECTION

Continued from page 10

Age Management Symposium, as well as professional development. Monday will offer discussions on body contouring and overcoming Difficult Cases in Aesthetic Surgery. Tuesday runs the gamut, with Cosmetic Surgery for the African American, as well as lectures on facial rejuvenation, breast enhancement, liposuction and abdominoplasty. A session on Scar Management in Patients of Color, with discussion of surgical and non-surgical methods, will wrap up the section’s activity.

### POSTGRADUATE PHYSICIAN PROGRAM

Medical Student Forum Scientific Sessions include: 80-hour work week, Clinical Skills Assessment and Medical Practice in the Future. Resident research presentations and posters will be seen, and a Health and Human Services Research Forum is scheduled for Monday.

### PSYCHIATRY AND BEHAVIORAL SCIENCES

Depression, including screenings and Buprenorphine training, will open the section. A combined session with Emergency Medicine discusses acute agitation’s diagnosis and treatment. Another combined session with Urology looks at the sexually depressed male, including erectile dysfunction and oral drugs. Diverse topics — substance abuse, computers in psychiatry, clinical research trials and chronic pain — round out the convention.

### RADIOLOGY

Program not available at press time

### SURGERY

Saturday will see a Laparoscopy workshop, followed by a combined Issues Forum with General Surgery, Surgical Oncology and Radiology. Other topics include trauma/critical care and a panel on women in surgery.

### UROLOGY

Voiding Dysfunction and Minimally Invasive Urological Surgery will be the topics of Monday’s sessions. A combined session with Uroradiology, GU Radiation Oncology and Diagnostic and Therapeutic Radiology will look at GU Oncology/Molecular Strategies.

Another interesting combined session with Behavioral Medicine will look at female sexual dysfunction and erectile dysfunction. A Prostate Cancer Awareness Concert will take place at 10 p.m. Wednesday.

### WOMEN’S HEALTH

Sunday’s highlight is the combined session with Women’s Health and the Auxiliary to the National Medical Association, Family Leadership Workshop: In-the-Round, as well as the Women in Medicine Luncheon and Awards Program.

The popular Vivian W. Pinn, MD, Symposium will offer a Review of Clinical Trials Relevant to Women’s Health and NIH Panel Discussion on Clinical Trials. A combined session with OB/GYN looks at breast cancer, and Community Medicine, the Council on Concerns of Women Physicians and Women’s Health co-sponsor a Health Power Luncheon on Tuesday. Childhood obesity is another topic.

**Your future is ringing.**

**NMA Annual Convention & Scientific Assembly**

**Aug. 2-7 in Philadelphia**

Visit [www.NMAnet.org](http://www.NMAnet.org) for information.

## News from Headquarters

# Give NMA the 'Gift of Life Insurance'

□ **New partnership with North Carolina Mutual Life Insurance allows supporters to take part in planned giving program.**

**By Jessica Carter**  
Managing Editor, NMA News

The NMA is joining in a nationwide trend that takes just a small effort to give a big donation.

NMA has joined with North Carolina Mutual Life Insurance Co. for a planned giving program. Members, friends and supporters may make the NMA the beneficiary of their life insurance policies as a way to make a sizeable future gift and

ensure the organization is able to remain viable far into the future.

"As the NMA moves forward to implement its five-year strategic plan, developing meaningful partnerships with the private sector will offer additional opportunities to expand our programs and improve services to the NMA membership," said L. Natalie Carroll, MD, NMA president. "Our partnership with North Carolina Mutual Life Insurance Company to develop a Planned Giving Program is one such opportunity."

Traditionally, bequests through wills have been a significant source of financial support to charitable organizations. Through the "Gift of Life Insurance," NMA hopes to retain its status as one of

**For more information on NMA's planned giving program, The Gift of Life Insurance, visit [www.NMAnet.org](http://www.NMAnet.org) or call 1-800-662-0554.**

the nation's premier medical organizations and further its mission.

"Your gifts will support research, professional education and training for our physicians, and other educational activities through public discussion groups, forums, panels and lectures," Carroll said. "The National Medical Association is dedicated to improving medical services and health care within our communities.

Establishing charitable and educational programs that foster and promote community health will further enhance our efforts."

Donors may choose which programs and services benefit from their bequests.

North Carolina Mutual Life Insurance has served the needs of African-American communities for more than 104 years, and its common goals of promoting community awareness and eliminating disparities in African-American communities make its partnership with the even more special.

Carroll encourages anyone who wishes to continue the NMA's mission to get involved in the program.

"Let your legacy continue through the 'Gift of Life Insurance,'" she said.

## New executive director: a different kind of drummer

### James Barnes tackles big issues in first months

**By Linda Curtis O Bannon, MD**  
Special to NMA News

James G. Barnes, DPA, an accomplished handball player and ex-Marine, knows the importance of timing – whether executing a play on the handball court, a drum roll or a military drill.

That timing extended to his decision to take on the role of executive director of the National Medical Association. When queried – why you? Why now? – he confidently states, "First, because of my education, training and comprehensive experience in health services administration, and working with complex organizations. Second, I was not new to many members of the Board of Trustees and the House of Delegates because of my work and presentations on organizational reform and the corporate audit. Third, I think the Board of Trustees recognized that the association needed leadership that would bring positive change to the organization and accomplish many of the organizational requirements cited in both the Reform Project and the corporate audit."

Armed with some very impressive credentials, Dr. Barnes has marched right into the role of executive director of the NMA, and apparently has not missed a beat.

His first days on the job in October 2002 began by taking a comprehensive organizational analysis of all aspects of the association to determine problem areas, infrastructure needs and staffing requirements. As a result, NMA is making major organizational changes and revisions that initially focus on policies, procedures and guidelines that will affect the behavior of the entire association. The net effect of these changes will increase accountability, efficiency and financial stability.

**In our discussion with members attending the recent Board of Trustees and Interim meeting of the House of Delegates, your plans and activities for the new NMA's presented in your executive director's report were very well received. What in-house steps have been taken to improve the staff and increase morale?**

Aggressive steps have been instituted to improve overall communications among and between the staff. For example, we have instituted monthly brown bag lunches. During the brown bag lunch a staff member presents an educational program to the entire staff. These programs fill both a staff educational need as well as improve our staff communications.

Further, we have regular staff meetings at all levels. We have also



instituted PERT, a program and management tracking system throughout the association, to increase accountability and efficiency. We have established measurable objectives for each operating division. In addition, we have recruited key essential staff in critical staff areas. Of equal importance, we have just established the association's first Employee of the Month and other employee recognition programs. All of these program efforts have caused positive improvements in our staff.

**Tell us more about your background and your work before joining the NMA.**

I have more than 30 years of experience in both the public and private sectors. I have a doctorate in Public Administration and Health Services Administration from George Washington University. I started my private sector consulting practice in practice management, working with physician and dental

practices. This work led to development and analysis programs in group practice management and specialized work in the development of alternative financing structures (HMOs, PPOs, HIOs) and community health center programs, hospitals and academic health centers. My public sector career includes a number of years in the Department of Health and Human Services and other significant high-level government appointments.

**What do you view as your most significant accomplishment?**

In the first 120 days we (took) giant steps toward establishing needed infrastructure, building team management concepts and establishing fiscal controls throughout the association. Equally important is the positive change in employee morale that will have a positive effect on productivity, accountability and efficiency.

**In your report to the Board of Trustees, you referred to the "new" National Medical Association. Why the need for a "new" NMA?**

The National Medical Association has been at the forefront of addressing the needs of African-American physicians for over 100 years. The NMA has developed an outstanding Scientific Assembly in conjunction with the annual meeting each year, and over the years has developed many outstanding programs in support of its

mission.

However, in the presence of these many accomplishments there are additional achievements to be attained in the organization. The new NMA seeks to enhance our overall image of the association, grow our membership, establish fiscal soundness, develop measurable programs to be implemented through our network to stop the expanding gap in health care disparities, and implement long-term measurable programs that will close the gap in these critical disease areas.

**Where do you see yourself in the hierarchy in relation to the leadership of the organization?**

The role of the executive director is to manage and operate the day-to-day business affairs of the association, to support the initiatives of the House of Delegates and the Board of Trustees, to structure and implement programs in support of the mission of the association, to develop and implement operating policies, procedures and guidelines to protect the integrity of the institution.

**What fact about the NMA would you like to promote?**

The NMA will complete its mission when it becomes a household word. NMA members who have had family and friends' lives shortened prematurely due to health care disparities can join NMA in the fight to significantly reduce the gaps in health care. It will take all the support we can muster to fight this fight.

## What would you like to see your NMA accomplish?

Send letters to the editor to: Editor-in-Chief, NMA News, 1012 Tenth St., NW, Washington, D.C. 20001; fax (202) 371-1162; or e-mail [NMAnews@NMAnet.org](mailto:NMAnews@NMAnet.org).

## Aetna sets plan to track disparities in health care

Aetna Inc. recently announced a series of initiatives it has undertaken to assess and track racial and ethnic disparities in health care and to develop interventions that improve the quality of care for minority members.

The company has developed a coordinated, multidimensional approach comprised of a variety of research, educational, data collection and supporting initiatives designed to enhance understanding of the cultural diversity and language preferences of its membership and participating physicians. Aetna expects that better understanding of disparities among racial and ethnic groups will enable it to target educational and outreach programs to specific member populations.

"Aetna is committed to improving the health of all of our members by working closely with physicians," Aetna Chairman and CEO John W. Rowe, MD, said. "Reducing the gap in health care among minority populations is one of the most obvious targets for health care improvement in the United States. The scientific community and the federal government have acknowledged that systematic efforts on the part of insurers such as Aetna can have a dramatic impact on disparities in health care, and I am very proud of the initiatives that we have undertaken to date.

"A critical component of this effort is our pledge to use the data only for deter-

### RELATED STORY

❑ **FDA issues guidelines for racial and ethnic data collection in clinical trials**

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mining appropriate educational, outreach and quality improvement initiatives and not to determine eligibility, rating or claim payment."

Aetna's efforts to enhance health services and benefits support the U.S. Department of Health and Human Services' national initiative to eliminate racial and ethnic disparities in health care.

According to HHS, compelling evidence exists that ethnic and racial gaps in health care persist and, in some cases, have widened among minorities when compared to the U.S. population as a whole.

Research indicates that minorities suffer from certain diseases at significantly higher levels than the rate of white Americans. In an effort to close this gap, the federal government, under the leadership of HHS, is focusing its efforts on eliminating health status disparities in infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV infection, and child and adult immunizations.

"As the nation's only organization devoted to the needs of African-American physicians and their patients, we are



NMA President L. Natalie Carroll, MD, center, is seen with Aetna Inc. representatives Jennifer Lewis and Veronica Turner during a reception hosted by Aetna and the Houston Medical Forum, the local NMA chapter.

actively working to address the widespread racial and ethnic biases that exist today in the health care arena," Rowe added. "Aetna's efforts to gain greater understanding about the diversity of its membership and the cultural competency

of its participating physicians are encouraging. With this knowledge, Aetna will be well positioned to provide equal access to all their members ultimately enhancing the diagnosis, treatment and quality of life for minorities."

## HHS: Budget includes special programs to reduce HIV/AIDS... *Continued from page 1*

women. In men, Mexican-Americans have a higher prevalence of overweight and obesity than non-Hispanic men, while non-Hispanic white men have a greater prevalence than non-Hispanic black men. Approximately 300,000 U.S. deaths a year currently are associated with obesity and overweight. The total direct and indirect costs attributed to overweight and obesity amounted to \$117 billion in the year 2000.

The prevalence of diabetes is 70 percent higher among African Americans and nearly 100 percent higher among Hispanics than among whites.

As recently as 2000, African Americans and Hispanics accounted for roughly 75 percent of all adult AIDS cases, although they only comprise 25 percent of the U.S. population. African American and Hispanics also make up 81 percent of all pediatric AIDS cases.

I'm proud to report that we're working to change these terrible statistics. The Bush Administration is passionately committed to "Closing the Health Gap" between minorities and their fellow Americans.

HHS' Office of Minority Health (OMH), which has a fiscal year 2003 budget request of \$47 million, oversees the Department's Initiative to Eliminate Racial and Ethnic Disparities in Health. The OMH provides overall public health guidance to the department on issues affecting African Americans, Hispanic Americans, Asian Americans/Pacific Islanders and American Indians/Alaska Natives. In addition, in April 2002 we launched my Prevention Initiative, a comprehensive strategy to reduce the nation's burden of death, illness and disease through methods that greatly improve individual health and wellness, particularly for racial and ethnic minorities. Several HHS programs fall under these campaigns:

♦ Launched in November 2001, Closing the Health Gap is a health education and information campaign for

communities of color. Current activities are designed to integrate health messages into the regular programming of ABC Radio Networks, including the "Tom Joyner Morning Show." "Take A Loved One to the Doctor Day" is a part of this joint campaign. More than 400 partners signed on to "Take A Loved One to the Doctor Day." This includes a combination of national, state and local organizations.

♦ On July 31, 2002, HHS launched Racial and Ethnic Adult Disparities in Immunization Initiative (READII), a new adult immunization initiative to reduce racial and ethnic disparities in influenza and pneumococcal vaccination coverage for adults 65 years of age and older, focusing on African-American and Hispanic communities.

♦ Healthy People 2010 is a comprehensive set of health objectives for the nation, and includes two overarching goals of increasing the quality and years of life, and eliminating racial and ethnic disparities in health.

♦ The "VERB: It's What You Do" Youth Media Campaign, launched July 17, 2002, is a national, multi-cultural media campaign intended to promote physical activity and community involvement among 9- to 13-year-olds of all ethnicities.

♦ Healthy Communities Innovation Initiative: The President's fiscal year 2003 budget includes \$20 million for a new interdisciplinary services demonstration program that will focus on preventing diabetes, asthma and obesity through community systems of services, with special attention to eliminating racial and ethnic disparities in health.

♦ National Diabetes Education Program (NDEP): The NDEP is a program co-sponsored by HHS' National Institute of Diabetes and Digestive and Kidney Diseases of the National Institutes of Health and the Centers for Disease Control and Prevention and is a leading source for information about diabetes care and prevention. The

NDEP spreads its messages in English and Spanish and recent expansions to the campaign include "Si Tiene Diabetes, Cuide Su Corazón," aimed at helping Hispanic Americans better understand the need to control all aspects of their diabetes to help prevent heart disease.

That's just the tip of the iceberg when it comes to our commitment to minority health. We're also passionate about addressing one of the gravest threats minority communities face — HIV/AIDS.

HHS' fiscal year 2003 budget request includes special programs to reduce the disproportionate impact of HIV/AIDS in minority communities. These programs build on the department's core mission to protect and improve the health of vulnerable populations. The HIV/AIDS initiative, now funded at \$410 million, has more than doubled since it was first developed in 1999.

For example, the FY2003 requested appropriation for the Health Resources and Services Administration includes \$124 million for the Ryan White Comprehensive AIDS Resources Emergency Act. The Act addresses the unmet health needs of persons living with HIV/AIDS by funding primary health care and support services that enhance access to and retention in care. The total Ryan White appropriation for fiscal year 2002 is \$1.9 billion and helps provide services primarily to racial and ethnic minorities through local community health centers.

My friends, there is so very much we can do to close the health gap between minority communities and America at large. But we in the government cannot do it alone. President Bush has called upon the "Armies of Compassion" to rise up and help their neighbors. There is no doubt in my mind that every one of you in the National Medical Association is a foot soldier in that army. For that, you have my gratitude. Thank you for your passion for America's health.

May God bless you all.

# Managing Your Practice

## Life insurance trusts can minimize estate taxes

By Ira G. Turpin Jr.  
Financial Advisor

With the growth of assets in tax-deferred vehicles, more and more taxpayers are facing a retirement plan dilemma. This is not a problem of having too little for retirement. Rather, it is the problem of having too much – and facing the potential of having to give most of what remains at death to the government instead of the heirs or other beneficiaries.

Without proper planning, 80 percent or more of your accumulated retirement plan assets may end up in government coffers. After the double hammer of income tax and estate tax, your heirs or other beneficiaries get only a fraction of what took a lifetime to accumulate. There are several planning techniques available to minimize the confiscatory nature of this dilemma. These techniques range from fairly conservative to cutting edge aggressive.

The most conservative approach is very simple. Withdrawals are made from your qualified plan or IRA and current income tax is paid. The withdrawal proceeds are then used to fund an Irrevocable Life Insurance Trust (ILIT) with the appropriate heirs designated as beneficiaries. This is also called a Wealth Replacement Trust. The proceeds of the life insurance pass to your heirs free of estate tax.

To establish this strategy as an appropriate alternative, several important questions must be addressed in the initial phase of the planning process: 1) what are your retirement income needs; 2) are retirement assets available to maintain your living standards; and 3) what is the primary objective – to benefit yourself, your spouse or your heirs?

Consider the following example of how the ILIT might be utilized: David is 63 years old and recently retired. He rolled over his entire \$1.4 million balance from his 401(k)/profit sharing plan into an IRA. His spouse is also 63 and has her own IRA with an account balance of \$800,000. They have an additional \$1.2 million in after-tax investments. Their house is paid for and they anticipate being able to live off the income from her IRA and the \$1.2 million investment portfolio. The intent is to pass the assets in his IRA to their six grandchildren. They are astonished to learn that most

of this will end up with the government – not with their heirs.

David establishes the ILIT with the grandchildren as beneficiaries. He elects to take an annual distribution of \$200,000, which is subject to income tax. He and his wife are in the 34 percent tax bracket, which would result in a net of \$132,000. As husband and wife, they are allowed to make annual gifts of up to \$11,000 without any gift tax consequence, so \$22,000 may be given to each of the six grandchildren annually as beneficiaries of the trust. A “Crummey” letter, which establishes a gift as being a present



**Turpin**

interest, should be drafted in the gifting process.

The trust purchases a \$2 million second-to-die life insurance policy, designed to maximize the death benefit, on the lives of David and his wife. For purpose of discussion, the annual premium is \$132,000 to be paid over a five-year period, with the \$22,000 annual gifted assets used to pay the insurance premium. The length of payment could be varied depending on the number of beneficiaries to whom gifts are made.

In this case, the policy is paid up in five years. Using an assumed growth rate of 8 percent, the IRA will have grown back to \$1 million by the time David reaches 70 1/2 and starts to take required minimum distributions. When David and his wife are both deceased, the grandchildren will receive \$2 million free of both income and estate tax.

In summary, a life insurance trust is certainly an attractive alternative for an individual with a large IRA balance that they intend to pass along to heirs. Although many tax advisors subscribe to the theory of always maximizing deferral opportunities, this may be an instance in which it makes financial sense to bite the tax bullet now instead of putting it off into the future.

*Ira G. Turpin Jr. is a financial advisor with Turpin Martin Powell in Mitchellville, Md. He can be reached at 888-464-8880.*

## Separately managed accounts can help grow your wealth

By Michael L. Barnett  
Senior Vice President,  
Morgan Stanley

It seemed that all anyone needed was a modem and a point of view just a few short years ago, when the stock market was reaching all time highs and stock valuations were out of whack.

Alas, valuations were recalibrated. Investors are abandoning the self-directed approach to investing in favor of a more disciplined investing strategy. In fact, the total volume of online trades fell to 50.6 million by mid-2001, from a high of 82.3 million in mid-2000, a decline of 39 percent, according to the VIP Forum’s “Brokerage Report.”

What’s next? Many investors are turning to customized professional money management.

Until recently, professional portfolio management was reserved only for institutional investors and the super-wealthy. Now, with \$100,000 or more to invest, you can gain access to the talents that have managed the wealth of Fortune 500 CEOs and endowment and foundation boards.

### What is a separately managed account?

A separately managed account (SMA) is a professionally managed private portfolio of stocks and bonds that you own. This portfolio is actively managed and guided by a seasoned investment manager.

SMAs offer investors a process-oriented approach to investing, rather than a product sale.

The process begins with a financial advisor assessing your financial needs and goals. Your advisor then recommends a portfolio strategy customized to meet your needs. Once you agree with the strategy, a professional portfolio manager buys and sells stocks and bonds in your portfolio on your behalf.

Your financial advisor systematically monitors your portfolio’s performance. The SMA service is an ongoing process that enables you to monitor the health of your portfolio and adjusts it accordingly, all with the guidance of your financial advisor.

### The SMA advantage

Above all, a separately managed account enables you to own a portfolio customized for your changing and longer-term needs. Your stocks and bonds are managed, and monitored, by investment specialists.

If you are looking to grow wealth in a disciplined fashion, SMAs provide:

♦ **Access to expert money management talent.** Minimums are usually \$100,000 to \$300,000.

♦ **Customization.** A portfolio tailored to meet your long- and short-term cash needs. The customization process also enables you to indicate stocks you do not



**Barnett**

want held in the account for personal, social or environmental reasons.

♦ **Direct ownership of stocks and bonds.** A separately managed account enables the investor to own

outright a managed portfolio of stocks and bonds.

♦ **Tax efficiency.** Outright ownership of your securities means you can harvest capital gains and losses as you see fit for tax management purposes.

♦ **Account transparency.** There are no hidden fees. You do not incur transaction costs from the regular sale and purchase of stocks and bonds in the account. The fee is a pre-negotiated percentage of your portfolio balance, so the portfolio manager’s and your incentives are directly aligned. The fee is incurred quarterly.

♦ **Comprehensive reporting.** Your financial advisor regularly monitors the portfolio. You receive a detailed quarterly report of your account balance, asset allocation, and all the activities in the account during the period.

### The broader fit

Whether you are seeking to generate income or preserve your current lifestyle in retirement, a separately managed account enables you to better handle the wealth management process.

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*Michael L. Barnett can be reached at 800-488-4280, ext. 6511.*

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*Jim McWilliams/Philadelphia Convention & Visitors Bureau*

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# Federal Impact on Your Practice

## HIPAA: Traveling the road to compliance is tough, but needed

By Deborah Wilson

President/CEO

Diverse Healthcare Consultants Inc.

The Health Insurance Portability and Accountability Act, commonly referred to as HIPAA, was enacted in 1996 and has brought about major changes in the health care industry. The primary intent of the federal law was to improve the portability and continuity of health insurance coverage to protect workers who lose or change jobs. HIPAA contained provisions to simplify the administration of health insurance by standardizing the electronic transmission of certain transactions and the standards for privacy of patient health information.

The deadline to be in compliance with The Standards for Privacy of Patient Health Information or "The Privacy Rule" provision of the HIPAA federal legislation has come and gone, but it does not alleviate the provider from their responsibility to comply with the federal regulation. All covered entities that file claims electronically, which include healthcare providers, health plans and clearinghouses, are required to meet the deadline.

However, the covered entities that submitted an extension application with a compliance plan to the secretary of Health and Human Services by Oct. 16 have an additional six months to meet the compliance deadline for the Administrative Simplification (AS) provision of Oct. 16, 2003.

If an extension application was not submitted, you are currently non-compliant with the AS provision of the HIPAA federal legislation. There will be significant penalties and the potential for exclusion from Medicare in specific cases of HIPAA non-compliance.

The road less traveled is HIPAA compliance for many healthcare providers. There are obvious reasons why many African-American healthcare providers can not or will not travel down this road, which may include the high cost of malpractice insurance, being financially squeezed out by the HMOs, operating with a small office staff, the costs associated with upgrades to antiquated business processes or refusal to allow the federal government to dictate their day-to-day operations.

Although these may seem to be valid reasons not to comply with HIPAA, they do not alleviate the African-American healthcare provider of the responsibility to protect the privacy of their patient's health information.

The Privacy Rule creates national standards to protect an individual's medical records and other personal health information. The national standards establish safeguards to protect the confidentiality of medical information and prevent personal information from being shared for reasons other than to treat the patient. This is extremely important in today's "Information Age," where health information is held and transmitted electronically.

In traveling the road to HIPAA compliance there are a few key areas of interest to the healthcare provider:

- ♦ **Electronic Transactions, Code Sets and Identifiers.** There are specific national healthcare electronic transaction code

For more information about the National Standards to Protect the Privacy of Personal Health Information or to request a copy of the HIPAA Federal Register, visit [www.hhs.gov/ocr/hipaa/fedreg.html](http://www.hhs.gov/ocr/hipaa/fedreg.html). For information on Administrative Simplification, log on to [www.cms.hhs.gov/hipaa](http://www.cms.hhs.gov/hipaa).

sets and identifiers required of healthcare providers who submit claims electronically.

- ♦ **Security.** Although the Final Rule on security has not been released, it is a good business practice to establish safeguards for the physical security of patient health information.
- ♦ **Privacy of Patient Information.** Effective April 14, the healthcare provider must provide a Privacy Practices Notice to all existing or new patients regarding the right to access their medical records and request copies of their patient health information.

The following are key HIPAA compliance requirements:

- ♦ Designation of a privacy official
- ♦ Documentation of policies and procedures
- ♦ Designated forms associated with the policies and procedures
- ♦ Implementation of safeguards for confidentiality, unauthorized use and disclosure of patient health information
- ♦ Training of all employees in the work force.

The road to HIPAA compliance begins with an assessment of the current business operations, identifying what the business needs to be compliant and the associated risk. This is considered a "Gap Analysis & Risk Assessment."

The healthcare provider must develop "A Work Plan" before the implementation of the plan of action. The healthcare provider must identify and involve key personnel within the organization, identify available resources for implementation, determine a timeframe for testing and targeted completion date.

The final step is "The Implementation Plan". It is important for the healthcare provider to assign a responsible party within the organization to track and document the progress of the implementation plan, facilitate internal educational programs and develop policies and procedures based on the HIPAA regulations.

The road to HIPAA compliance is long and arduous. Although the road may seem paved with great expectations, it can lead to a dead end for those healthcare providers who are HIPAA non-compliant. There will be significant civil and/or criminal penalties for those healthcare providers who are HIPAA non-compliant, which include \$100 per person per violation up to total fines of \$250,000 and possible imprisonment.

Please note: Effective Oct. 16, Medicare will no longer accept paper claims, only electronic claims for reimbursement. If you have not started down the road to HIPAA compliance, start now!

## FDA issues guidance for racial data in clinical trials

Collecting racial and ethnic data using a standardized system will enhance the early identification of differences in responses between groups.

The U.S. Food and Drug Administration has published a draft Guidance for Industry to recommend categories for collecting effectiveness and safety data during clinical trials for ethnic and racial demographic groups.

FDA regulations require drug sponsors to present an analysis of data according to age, gender and race. An analysis of modifications of dose or dosage intervals for specific groups is also required when manufacturers submit a new drug application for approval by FDA. To accomplish this, FDA recommends that the drug manufacturers use the OMB race and ethnicity categories during clinical trial data collection to ensure consistency in evaluating potential differences in drug response among racial and ethnic groups.

Some differences in response to medical products have already been observed in distinct groups of the U.S. population. These differences may be attributable to intrinsic factors such as genetic differences; to extrinsic factors like diet, environmental exposure, socio-cultural issues, or to interactions between these factors. For example, in the United States, whites are more likely than people of African or Asian heritage to have low levels of an important enzyme (CYP2D6) that metabolizes antidepressants, antipsychotics and beta blockers.

Additionally, of some drugs in the psychotherapeutic class, slower enzyme metabolism has been observed in persons in the United States of Asian descent as compared to whites and blacks.

Although the regulations governing medical devices do not include requirements for the collection of demographic data comparable to those for drugs, for those cases in which race and ethnicity data are necessary to determine the safety and effectiveness of a device, FDA encourages sponsors to collect the data in accordance with the OMB information collection standards discussed in this guidance document. Sponsors are also encouraged to discuss any race or ethnicity issue with the appropriate review division within the Office of Device Evaluation, Center for Devices and Radiological Health, when developing their study protocols.

Collecting race and ethnicity data using standardized categories will enhance the early identification of differences in response among racial and ethnic groups during the evaluation of safety and effectiveness of FDA-regulated products.

Furthermore, collection of this data using standardized categories will facilitate comparisons across studies analyzed by FDA and with data collected by other federal agencies.

The draft guidance does not discuss increasing the number of studies in which certain groups are exposed to a product, nor does it discuss increasing the total number of participants involved in clinical trials.

## NMA bioterrorism task force uses grant for research, to educate members

Members of the NMA's Environmental Health and Bioterrorism Task Force (EHBTF) have been working to educate African-American physicians about topics such as SARS and smallpox since receiving a \$250,000

You are invited to attend the joint session of the EHBTF and the Emergency Medicine Section Aug. 6 at the NMA Annual Convention and Scientific Assembly in Philadelphia. See [www.NMAnet.org](http://www.NMAnet.org) for info.

bioterrorism planning grant from the Department of Health and Human Services last fall.

Task force members have given presentations at regional meetings addressing training objectives and topics such as lead in the environment and SARS (severe acute respiratory syndrome), risks of smallpox and bioterrorism lessons learned from anthrax.

NMA members also have been surveyed to begin to understand their state of preparedness awareness, training and involvement in local emergency planning activities.

"An infectious epidemic is only a plane ride away, and the practice of medicine has global implications like never before, said task force Chairman Albert Morris, MD, a

radiologist and secretary of the NMA Board of Trustees. "Preparedness, syndromic surveillance and risk communication are parameters that each of us must incorporate into our medical practices as we provide care to our

communities.

"It is imperative that physicians actively participate in communications network in an effort to receive the necessary health information alerts and updates, readiness education and training, thereby assisting in the rapid disease detection and treatment of our patients."

This spring, Pamela Bingham was named EHBTF bioterrorism grant project manager. Other members include Dr. Jewel Crawford, Dr. Valentine Burroughs, Ms. Chavone Moman-Nelson, Dr. Bruce Butler, Dr. Virginia Caine, Dr. Millicent Collins, Dr. Otis Cosby, Dr. Christopher Ervin, Dr. Marian Johnson-Thompson, Dr. Joseph McQuirter, Dr. Roland Pattillo, Dr. Marinelle Payton, Dr. Bailus Walker and Dr. Cynthia Warrick.

## Members on the Move

### Kington appointed deputy director of National Institutes of Health

National Institutes of Health Director Elias A. Zerhouni, MD, announced the appointment of Raymond S. Kington, MD, Ph.D., as the new deputy director of the NIH. "I am delighted to have Dr. Kington at my side as deputy director during this critical time for biomedical research," said Zerhouni. "He has shown great talent and has the right combination of skills and experience to help the NIH move forward in these revolutionary times for the biomedical sciences."



**Kington**

"NIH is the main engine behind med-

ical discovery in this country and it is a great honor to be given this opportunity," Kington said.

"I am looking forward to working with Dr. Zerhouni and the NIH leadership to help set the course for biomedical research in the 21st century."

Kington had served as NIH associate director for Behavioral and Social Sciences Research and director of the NIH Office of Behavioral and Social Sciences Research since November 2000.

He also served as the Acting director for the National Institute on Alcohol Abuse and Alcoholism (NIAAA) from January 2002 until September 2002.

He came to NIH from the Centers for Disease Control and Prevention (CDC). As director of the Division of Health Examination Statistics in the CDC's National Center for Health Statistics (NCHS), he led the National Health and Nutrition Examination Survey

(NHANES), a comprehensive, ongoing survey of the health status, health behaviors, and diet of people in the United States.

Before joining the CDC, Dr. Kington was a senior scientist at the RAND Corp., where he co-directed the Drew/RAND Center on Health and Aging.

He earned undergraduate and medical degrees from the University of Michigan and then completed his residency training in Internal Medicine at Michael Reese Medical Center in Chicago. He attended the University of Pennsylvania as a Robert Wood Johnson Clinical Scholar, earning his M.B.A. and his Ph.D. in Health Policy and Economics from The Wharton School.

Board-certified in Internal Medicine and Public Health and Preventive Medicine, Kington's research has focused on social factors as determinants of health.

### Drake named president of Alpha Omega Alpha honor society

Michael V. Drake, MD, vice president for health affairs at the University of California and a professor of ophthalmology at the University of California at San Francisco, has been named president of Alpha Omega Alpha, the national honor medical society dedicated to recognizing and perpetuating excellence in the medical profession.



**Drake**

"For a hundred years, Alpha Omega Alpha has played a unique role in American medical education by rewarding and celebrating excellence," Drake said. "As we enter the society's second century, I hope we will maintain our commitment to recognize high standards of medical science and care while also expanding our focus on broadening inclusiveness and access as hallmarks of the organization."

In his position as vice president for health Affairs at the University of California, Drake is responsible for long-range planning and general policy oversight, and acts as a liaison with the governing Board of Regents on behalf of the University's 14 health professions schools and their supporting teaching hospitals and medical centers.

He has oversight authority for three major statewide research programs — Breast Cancer, AIDS and Tobacco-related Disease — and a geriatrics academic program.

Drake, a graduate of the UCSF School of Medicine, previously was senior associate dean in the School of Medicine, vice chair of the Department of Ophthalmology, a practicing ophthalmologist and an active instructor at UCSF. He continues to practice and teach on a limited basis.

In 1998, he was elected to the National Academy of Science's Institute of Medicine.

### Henry Schein adds Sullivan to board of directors

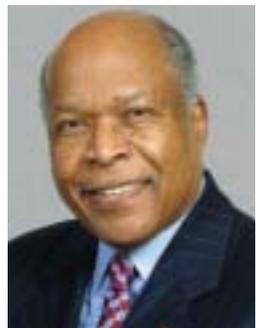
Henry Schein Inc., the largest provider of healthcare products and services to office-based practitioners in North America and Europe, recently added Louis W. Sullivan, MD, to its Board of Directors.

Dr. Sullivan is the former U.S. Secretary of Health and Human Services and the founding dean, director and president emeritus of Morehouse School of Medicine.

In addition to the Henry Schein Board, Sullivan currently serves on the boards of 3M Corp., Bristol-Myers Squibb Co., CIGNA Corp., Georgia-Pacific Corp., and United Therapeutics Corp.

He recently retired from the boards of General Motors Corp. and Household International.

"It is a pleasure to welcome Dr.



**Sullivan**

**Dr. Sullivan will be a panelist for Bridging Gaps: Improving Immunization Rates in Ethnic and Minority Populations during NMA's convention in Philadelphia Aug. 2-7.**

**See page 11.**

Sullivan to Henry Schein's Board of Directors," said Stanley M. Bergman, chairman, CEO and president of Henry Schein. "His wide-ranging experience in healthcare policy, practice and education is unique, and he brings first-hand knowl-

edge of corporate best practices as a seasoned board member of several world-class corporations."

"I am delighted to be joining the Henry Schein Board," said Dr. Sullivan. "The company's success and its reputation for delivering the highest quality products and services to the nation's office-based dentists, physicians and veterinarians certainly is impressive.

"But equally important are the company's dedication to integrity from a financial and regulatory standpoint, and its long-standing commitment to the healthcare providers it serves.

"I feel very comfortable being part of this organization, and look forward to helping it build upon this impressive heritage."

### Wilson first African-American dean of Texas Tech Health Sciences Center

M. Roy Wilson, MD, dean of the School of Medicine and vice president for health sciences at Creighton University, was named president of the Texas Tech University Health Sciences Center.

Wilson, the first black president of the center, was selected from more than 50 candidates in a nationwide search.

"I think what impressed me most about Roy was his love of his patients and teaching," Chancellor David Smith told the Lubbock Avalanche-Journal.

Wilson, 49, earned his bachelor of science degree in biology from Allegheny College in 1976 and his medical degree from Harvard Medical School in 1980. He did his residency in ophthalmology at the

Massachusetts Eye and Ear Infirmary, Harvard Medical School, from 1981 to 1984.

Smith also has a master of science degree in epidemiology from the University of California at Los Angeles and a certificate in executive management from Anderson School of Management at UCLA. He earned a certificate in executive development from the University of Southern California in Los Angeles.

He served as dean of the School of Medicine and vice president for health sciences at Creighton in Omaha, Neb., for three years. He was the first African-American to hold such a position at Creighton.

### Harris chosen as chief resident of housestaff at Meharry

Barry L. Harris II, MD, currently serves as chief resident of all resident housestaff at Meharry Medical College in Nashville, Tenn.

There he is a third-year family practice resident and clinical instructor in the department of Family and Community Medicine.

He most recently received nomination and will be inducted into Alpha Omega Alpha honors medical society.

He currently is in his second year as postgraduate physician trustee to the Board of Trustees of the NMA as well as being section chair for the Resident's Section. Also, he serves the Student National Medical Association as a profes-

sional board member emeritus.



**Harris**

Spiritually, he serves as singles minister at the Schrader Lane Church of Christ in Nashville.

He has interests in health policy, health care administration and "prevention focused" healthcare delivery and intends

to incorporate this into his future practice.

## Members on the Move

### Vice speaker named chair of orthopaedic surgery

Cato T. Laurencin, MD, has been named the Lillian T. Pratt Professor and chairman of the Department of Orthopaedic Surgery at the University of Virginia. Laurencin, vice speaker of NMA's House of Delegates, also has been named one of only 15 University Professors at U.Va.

"In academic medicine the triple threat is a rare person who can do utterly outstanding patient care (and) state-of-the-art research in addition to extraordinary medical education for the physicians of tomorrow," said Arthur Garson Jr., MD, dean of the U.Va. School of Medicine. "Cato Laurencin is the rarest in that he is a quadruple threat, adding administrative and public service skills as well. We are highly fortunate to have him with us."

Laurencin was clinical professor and vice chairman of orthopaedic surgery at the Drexel University College of Medicine in Philadelphia and director of shoulder surgery at Hahnemann University Hospital. In addition he was the Helen I. Moorehead Distinguished Professor of Chemical Engineering at Drexel University, where he directed the Center for Advanced



**Laurencin**

Biomaterials and Tissue Engineering.

He earned his B.S.E. in chemical engineering from Princeton and his M.D. from Harvard Medical School.

Simultaneously he earned a Ph.D. in biochemical engineering and biotechnology from the Massachusetts Institute of Technology.

Board certified in orthopaedic surgery, Laurencin is a fellow of the American College of Surgeons and a fellow of the American Academy of Orthopaedic Surgeons.

He has lectured throughout the world in the areas of shoulder surgery and biomaterials science as an American British and Canadian Traveling Fellow, and has been an instructor in shoulder surgery at the American Academy of Orthopaedic Surgeons' Orthopaedic Learning Center.

Laurencin is a Fellow of the American Institute for Medical and Biological

Engineering, and has been named an international fellow in biomaterials science and engineering. He most recently received the William Grimes Award for Excellence in Chemical Engineering from the American Institute of Chemical Engineers and the Leadership in Technology Award from the New Millennium Foundation.

In addition to his duties with NMA, Laurencin is a member of the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) Council at N.I.H. He also has been named to the National Science Board of the Food and Drug Administration.

"It is my privilege to lead the Department of Orthopaedic Surgery at the University of Virginia," Laurencin said. "The department has a rich clinical and academic history while the University is clearly one of the outstanding centers of our country. I am particularly impressed by the vision of the leaders of this institution."

He will hold professorships in both biomedical engineering and chemical engineering.

### Heart Association elects Grant president

Augustus O. Grant, MD, Ph.D., will serve as the American Heart Association's national president for fiscal year 2003 beginning July 1.

Grant, co-director of the Heart Station at Duke University and professor of medicine at Duke University Medical Center in Durham, N.C., will be responsible for all medical, scientific and public health matters of the association.

He has had a long relationship with the American Heart Association. He received a Bay Area Heart Association research fellowship in 1974; a grant-in-aid; and an Established Investigator Award in 1984.

He has served on the Scientific Review Committee for the former North Carolina Affiliate. He chaired the Committee of Scientific Sessions Program and has been a member of the National Research Review Committee, chairing the physiology and pharmacology sections; Women and Minorities Committee; and the Science Advisory Coordinating Committee.

Grant has also served on the editorial boards of *Circulation: Journal of the American Heart Association* and *Circulation Research*.

Grant earned his M.B. and Ch.B degrees – the equivalent of an M.D. degree – from the University of Edinburgh in Scotland. He received a Ph.D. in pharmacology from the University of California in San Francisco.

He is a member of the American College of Cardiology, the North American Society of Pacing and Electrophysiology and a past president of the Association of Black Cardiologists.

### Caine, Satcher picked as new leaders of APHA

The American Public Health Association's Governing Council chose NMA member Virginia Caine, MD, as its next president.

A 10-year APHA member, Caine is an associate professor of medicine in the division of infectious diseases at Indiana University School of Medicine and is director of the Marion County Health Department in Indianapolis. A member of the APHA's Health Administration Section, Caine will take over as APHA president at the close of APHA's 131st Annual Meeting, which will be held Nov. 15-19 in San Francisco.

A longtime member of the NMA, Caine is a member of the NMA's Environmental Health and Bioterrorism Task Force.

The Governing Council also elected former U.S. Surgeon General David Satcher, MD, Ph.D, to be its vice president for the United States. He will serve a one-year term in office.

### Burroughs promoted to chief of medicine

Valentine J. Burroughs, MD, was appointed director and chief of medicine at North General Hospital in New York. He is chairman of NMA's Health Policy Committee and is a member of NMA's Board of Trustees.

He is a practicing, board-certified endocrinologist and internist who maintains a private practice in Manhattan. Burroughs has special expertise in managing health care delivery and wellness programs for minority communities in managed care and public health environments.



**Burroughs**

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Send "Members on the Move" notices to:  
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 National Medical Association,  
 1012 Tenth St., NW,  
 Washington, D.C.  
 20001-4492.  
 Or e-mail them to  
 NMAnews  
 @NMAnet.org.

# Institutions on the Move



NMA President L. Natalie Carroll, MD, and Morehouse School of Medicine President James R. Gavin III, MD, attend the dedication of the new National Center for Primary Care at Morehouse in Atlanta.

## National Center for Primary Care opens at Morehouse

The United States leads the world in medical advances, which makes the health care gap between some segments of the population all the more glaring.

On Nov. 1, Morehouse School of Medicine celebrated the opening of the National Center for Primary Care (NCPC), the only center of its kind in the nation. The NCPC is focused on improving access to quality health care for minorities and the poor.

"In a nation as prosperous as ours, there must be a way to bridge the chasm that lies between minority and majority, rich and poor," said David Satcher, MD, Ph.D., director of the NCPC and former U.S. Surgeon General. "The National Center for Primary Care will be the place where we wrestle with issues such as preparing physicians to practice in underserved areas, and working to find the tools we need to ensure quality health care on the front lines of medicine."

Funded by a \$15 million grant from the U.S. Public Health Service's Office of Minority Health, the 105,000-square-foot NCPC is Morehouse's latest weapon in the fight to care for the medically underserved.

Through research, support, training and the generation of health policy, the National Center for Primary Care will lead the way toward a better understanding of disparities to speed the process of eliminating them.

The NCPC was awarded a five-year grant from the National Institutes of Health to serve as a center of excellence for health disparities research and programs. The center will be led Dr. Satcher serving as principal investigator and will involve several Morehouse departments and programs.

The National Center for Primary Care is on the campus of Morehouse School of Medicine, at 720 Westview Drive, S.W., Atlanta. For information, visit [www.msm.edu/ncpc/ncpc.htm](http://www.msm.edu/ncpc/ncpc.htm).

## NMA, Meharry working for increased seat belt use

Special to NMA News

The chief executive of the National Highway Traffic Safety Administration singled out Meharry Medical College for specific mention when he released data in Chicago from NHTSA's latest roadside survey disclosing a sharp increase in safety seat belt use among African Americans.

NHTSA Administrator Jeffrey W. Runge, MD, said his agency's latest survey shows African Americans currently use safety belts 77 percent of the time, due in part to efforts by Meharry Medical College, the Blue Ribbon Panel to Increase Seat Belt Use Among African Americans, and a number of African-American organizations that implemented the panel's recommendations.

"These numbers are the result of years of hard work by our traffic safety partners in the African-American community. This is extremely heartening, and will quickly result in fewer deaths and injuries to our citizens," Runge said.

### NMA & Traffic Safety

The collaboration established in 2000 between the NMA and the NHTSA continues to address traffic safety in the African-American community.

- ◆ More African Americans die and are severely injured in traffic crashes than any other racial group.
- ◆ Motor vehicle crashes are the leading cause of death for African Americans through the age of 14 years and the second leading cause of death for ages of 15 and 24 years.
- ◆ During 2000, seat belt use among African Americans was 5 percent lower than that of whites.
- ◆ 42 percent of minority children were at greater risk of air bag-related injuries from being placed in the front seat of vehicles with passenger-side air bags.

For additional Buckle Up! information, view [www.NMAnet.org](http://www.NMAnet.org).

## Howard plans African-American 'biobank'

By Jocelyn Kaiser  
*Science Magazine*

Hoping to jump-start an era of personalized medicine for black Americans, researchers at Howard University want to build the first large DNA and health database on people of African descent. The project aims to collect DNA samples from 25,000 volunteers over five years and use the data to probe how genetics and lifestyle factors contribute to common diseases.

Experts say biobanks will eventually help doctors tailor prescriptions to individuals and advise patients who are at elevated risk for certain diseases. But although biobanks are planned or under way in Europe and at some U.S. medical institutions, Howard's Genomic Research in the African Diaspora (GRAD) biobank would be the first to look specifically

at African Americans. "This is a new front in biomedical research that we must be involved in," says human geneticist Georgia Dunston of Howard University College of Medicine, who will direct the project.

Dunston expects the project to study diseases such as prostate cancer, type II diabetes, hypertension, obesity, and asthma. The university hopes to build the biobank by enrolling patients from studies funded by the government and industry sources. Randall Maxey, president-elect of the National Medical Association, thinks that having a historically black university head the project will change attitudes about clinical trials among African Americans, who have been wary of participating since they learned of the notorious Tuskegee syphilis studies that started in the 1930s. "I think the trust factor is going to go up," says Maxey.

## In Memorium

### ANGELA GAIL AYER, MD

Angela Gail Ayer, MD, died on Jan. 3 in St. Petersburg, Fla. She was 59.

She received the bachelor of arts degree from Fisk University in Nashville, Tenn., in 1966. In 1974, Ayer received her medical degree from Meharry Medical College. Her ophthalmology residency was completed at Homer G. Phillips Hospital in St. Louis.

Prior to entering medical school, Ayer worked for the Southern Education Foundation in Columbia, S.C.; and the National Urban League and the National Urban Coalition, both in Washington, D.C. After completing her medical training, Ayer returned to St. Petersburg to care for her ailing parents and assumed the position of chief of ophthalmology at the Bay Pines Veteran's Administration Medical Center.

She was a board member of the Pinellas County Medical Society, which admitted her father as one of the first four black physicians in 1967. Additionally, she was a fellow of the American Academy of Ophthalmology. She was a member of Alpha Omega Alpha Honor Medical Society, American Medical Association, American Society of Cataract and Regenerative Surgery, Southern Medical Association, Society of Military Ophthalmologists and the Tampa Bay

Ophthalmology Society.

Survivors include a sister, Janice Ayer Jackson; a brother, Orion Thomas Ayer Jr.; a niece; a nephew; an uncle; and several cousins.

### ARTHUR COLEMAN, MD

Arthur Coleman, MD, 82, who served as the president of the NMA in 1976, died Dec. 26 of lung cancer in San Francisco, Calif.

Coleman studied medicine at Howard Medical College. He served in an Air Force hospital from 1945 to 1948. He was the first black physician and one of the last privately practicing family doctors in San Francisco's Bayview-Hunters Point district.

Dr. Coleman started practicing medicine in 1948 in the neighborhood where the city's largest concentration of African Americans lives, according to the San Francisco Chronicle. Known as a health care and civil rights advocate, Dr. Coleman was celebrated with a community parade down Third Street on his 50th anniversary of practicing in San Francisco.

In the 1960s, Coleman helped the community apply for federal funds to create the Bayview Community Health Service, which became a model for low-income health services all over the country. He served on the San Francisco Port Commission through the 1980, when he helped

create the Bayview-Hunters Point Health and Environmental Resource Center.

Coleman is survived by his wife, Renee Coleman; daughters Pat Coleman and Ruth Coleman; son John Coleman; three granddaughters and a grandson; and former wife Ruth Coleman.

Memorials may be sent to: The Arthur H. Coleman Endowment Fund, c/o Friends and Foundation of San Francisco Public Library, 100 Larkin St., San Francisco, CA 94102; or to National Medical Fellowships, 564 Market St., Suite 209, San Francisco, CA 94104.

### JOHN BERRY JACKSON JR., MD

John Berry Jackson Jr., MD, a founding member of the Sinker Miller Medical Society, died Feb. 20 of heart failure at the University of California San Francisco Medical Center.

Memorials may be sent to Meharry Medical College, 1005 Dr. D.B. Todd Jr. Blvd., Nashville, TN 37208; or to St. Mary's College High School Scholarship Fund, 1294 Albina Ave., Peralta Park, Berkeley, CA 94706.

### MARVIN ALEXANDER JACKSON, MD

Marvin Alexander Jackson, MD, who taught more than 2,000 medical students in the

Department of Pathology at Howard University from 1957 to 2000, died March 18 in Martinsburg, W.Va. He was 76.

He earned a bachelor of science degree in 1947 from Morehouse College and his MD in 1951 from Meharry Medical College. He was a rotating intern at the U.S. Naval Hospital in Saint Albans, N.Y. from 1951 to 1952 before becoming a staff physician in pathology.

He did his residency in pathology at University Hospital, Ann Arbor, Mich., for three years before earning his M.A. in 1956. He also was a resident in Orthopedic Pathology at the Hospital for Joint Diseases, N.Y., from 1956 to 1957, when he became a professor at Howard.

He was the chairman of the Department of Pathology at Howard University from 1960 to 1982 and published more than 30 articles in numerous scholarly journals.

He is survived by his wife, Aeolian Mayo Jackson; daughters Leigh Alexandra Jackson and Dr. Brooke A. Jackson; sister Kathryn J. Gordon; a brother-in-law; a son-in-law; two grandsons; two nieces and several cousins.

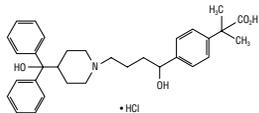
Memorials may be sent to: Morehouse College, In Memory of Marvin A. Jackson, Office of Alumni Relations, 830 Westview Drive, SW, Atlanta, GA 30314.

Prescribing Information as of January 2003

## ALLEGRA® (fexofenadine hydrochloride) Capsules and Tablets

### DESCRIPTION

Fexofenadine hydrochloride, the active ingredient of ALLEGRA, is a histamine H<sub>1</sub>-receptor antagonist with the chemical name (±)-4-[1-hydroxy-4-[4-(hydroxydiphenylmethyl)-1-piperidinyl]-butyl]-α, α-dimethyl benzeneacetic acid hydrochloride. It has the following chemical structure



The molecular weight is 538.13 and the empirical formula is C<sub>23</sub>H<sub>29</sub>NO<sub>4</sub>•HCl.

Fexofenadine hydrochloride is a white to off-white crystalline powder. It is freely soluble in methanol and ethanol, slightly soluble in chloroform and water, and insoluble in hexane. Fexofenadine hydrochloride is a racemate and exists as a zwitterion in aqueous media at physiological pH.

ALLEGRA is formulated as a capsule or tablet for oral administration. Each capsule contains 60 mg fexofenadine hydrochloride and the following excipients: croscarmellose sodium, gelatin, lactose, microcrystalline cellulose, and pregelatinized starch. The printed capsule shell is made from gelatin, iron oxide, silicon dioxide, sodium lauryl sulfate, titanium dioxide, and other ingredients.

Each tablet contains 30, 60, or 180 mg fexofenadine hydrochloride (depending on the dosage strength) and the following excipients: croscarmellose sodium, magnesium stearate, microcrystalline cellulose, and pregelatinized starch. The aqueous tablet film coating is made from hypromellose, iron oxide blends, polyethylene glycol, povidone, silicone dioxide, and titanium dioxide.

### CLINICAL PHARMACOLOGY

#### Mechanism of Action

Fexofenadine hydrochloride is an antihistamine with selective peripheral H<sub>1</sub>-receptor antagonist activity. Both enantiomers of fexofenadine hydrochloride displayed approximately equipotent antihistaminic effects. Fexofenadine inhibited histamine release from peritoneal mast cells in rats. In laboratory animals, no anticholinergic, alpha<sub>1</sub>-adrenergic or beta-adrenergic-receptor blocking effects were observed. No sedative or other central nervous system effects were observed. Radiolabeled tissue distribution studies in rats indicated that fexofenadine does not cross the blood-brain barrier.

#### Pharmacokinetics

##### Absorption:

Fexofenadine hydrochloride was rapidly absorbed following oral administration of a single dose of two 60 mg capsules to healthy male volunteers with a mean time to maximum plasma concentration occurring at 2.6 hours post-dose. After administration of a single 60 mg capsule to healthy subjects, the mean maximum plasma concentration was 131 ng/mL. Following single dose oral administrations of either the 60 and 180 mg tablet to healthy, adult male volunteers, mean maximum plasma concentrations were 142 and 494 ng/mL, respectively. The tablet formulations are bioequivalent to the capsule when administered at equal doses. Fexofenadine hydrochloride pharmacokinetics are linear for oral doses up to a total daily dose of 240 mg (120 mg twice daily).

##### Distribution:

Fexofenadine hydrochloride is 60% to 70% bound to plasma proteins, primarily albumin and α<sub>1</sub>-acid glycoprotein.

##### Elimination:

The mean elimination half-life of fexofenadine was 14.4 hours following administration of 60 mg, twice daily, in normal volunteers. Human mass balance studies documented a recovery of approximately 80% and 11% of the [<sup>14</sup>C] fexofenadine hydrochloride dose in the feces and urine, respectively. Because the absolute bioavailability of fexofenadine hydrochloride has not been established, it is unknown if the fecal component represents unabsorbed drug or the result of biliary excretion.

##### Metabolism:

Approximately 5% of the total oral dose was metabolized.

##### Special Populations:

Special population pharmacokinetics (for geriatric subjects, renal and hepatic impairment), obtained after a single dose of 80 mg fexofenadine hydrochloride, were compared to those for normal subjects from a separate study of similar design. While subject weights were relatively uniform between studies, these adult special population patients were substantially older than the healthy, young volunteers. Thus, an age effect may be confounding the pharmacokinetic differences observed in some of the special populations.

**Seasonal allergic rhinitis (SAR) and chronic idiopathic urticaria (CIU) patients.** The pharmacokinetics of fexofenadine hydrochloride in seasonal allergic rhinitis and chronic idiopathic urticaria patients were similar to those in healthy subjects.

**Geriatric Subjects.** In older subjects (≥65 years old), peak plasma levels of fexofenadine were 99% greater than those observed in normal volunteers (<65 years old). Mean elimination half-lives were similar to those observed in normal volunteers.

**Pediatric Patients.** Cross study comparisons indicated that fexofenadine hydrochloride area under the curve (AUC) following oral administration of a 60 mg dose to 7-12 year old pediatric allergic rhinitis patients was 56% greater compared to healthy adult subjects given the same dose. Plasma exposure in pediatric patients given 30 mg fexofenadine hydrochloride is comparable to adults given 60 mg.

**Renal Impairment.** In patients with mild to moderate (creatinine clearance 41-80 mL/min) and severe (creatinine clearance 11-40 mL/min) renal impairment, peak plasma levels of fexofenadine were 87% and 111% greater, respectively, and mean elimination half-lives were 59% and 72% longer, respectively, than observed in normal volunteers. Peak plasma levels in patients on dialysis (creatinine clearance ≤10 mL/min) were 82% greater and half-life was 31% longer than observed in normal volunteers. Based on increases in bioavailability and half-life, a dose of 60 mg once daily is recommended as the starting dose in patients with decreased renal function. (See DOSAGE AND ADMINISTRATION).

**Hepatic Impairment.** The pharmacokinetics of fexofenadine hydrochloride in patients with hepatic disease did not differ substantially from that observed in healthy patients.

**Effect of Gender.** Across several trials, no clinically significant gender-related differences were observed in the pharmacokinetics of fexofenadine hydrochloride.

#### Pharmacodynamics

**Wheal and Flare.** Human histamine skin wheal and flare studies following single and twice daily doses of 20 and 40 mg fexofenadine hydrochloride demonstrated that the drug exhibits an antihistamine effect by 1 hour, achieves maximum effect at 2 to 3 hours, and an effect is still seen at 12 hours. There was no evidence of tolerance to these effects after 28 days of dosing.

Histamine skin wheal and flare studies in 7 to 12 year old patients showed that following a single dose of 30 or 60 mg, antihistamine effect was observed at 1 hour and reached a maximum by 3 hours. Greater than 49% inhibition of wheal area, and 74% inhibition of flare area were maintained for 8 hours following the 30 and 60 mg dose.

**Effects on QT<sub>c</sub>.** In dogs (30 mg/kg/orally twice a day), and in rabbits (10 mg/kg, infused intravenously over 1 hour) fexofenadine hydrochloride did not prolong QT<sub>c</sub>. In dogs, the plasma fexofenadine concentration was approximately 9 times the therapeutic plasma concentrations in adults receiving the maximum recommended daily oral dose. In rabbits, the plasma fexofenadine concentration was approximately 20 times the therapeutic plasma concentration in adults receiving the maximum recommended daily oral dose. No effect was observed on calcium channel current, delayed potassium channel current, or action potential duration in guinea pig myocytes, sodium current in rat neonatal myocytes, or on several

delayed rectifier potassium channels cloned from human heart at concentrations up to 1 x 10<sup>-5</sup> M of fexofenadine hydrochloride.

No statistically significant increase in mean QT<sub>c</sub> interval compared to placebo was observed in 714 seasonal allergic rhinitis patients given fexofenadine hydrochloride capsules in doses of 60 to 240 mg twice daily for two weeks. Pediatric patients from two placebo controlled trials (n=855) treated with up to 60 mg fexofenadine hydrochloride twice daily demonstrated no significant treatment or dose-related increases in QT<sub>c</sub>. In addition, no statistically significant increase in mean QT<sub>c</sub> interval compared to placebo was observed in 40 healthy volunteers given fexofenadine hydrochloride as an oral solution at doses up to 400 mg twice daily for 6 days, or in 231 healthy volunteers given fexofenadine hydrochloride 240 mg once daily for 1 year.

### Clinical Studies

#### Seasonal Allergic Rhinitis:

**Adults.** In three, 2-week, multicenter, randomized, double-blind, placebo-controlled trials in patients 12 to 68 years of age with seasonal allergic rhinitis (n=1634), fexofenadine hydrochloride 60 mg twice daily significantly reduced total symptom scores (the sum of the individual scores for sneezing, rhinorrhea, itchy nose/palate/throat, itchy/watery/red eyes) compared to placebo. Statistically significant reductions in symptom scores were observed following the first 60 mg dose, with the effect maintained throughout the 12-hour interval. In these studies, there was no additional reduction in total symptom scores with higher doses of fexofenadine hydrochloride up to 240 mg twice daily.

In one 2-week, multicenter, randomized, double-blind clinical trial in patients 12 to 65 years of age with seasonal allergic rhinitis (n=863), fexofenadine hydrochloride 180 mg once daily significantly reduced total symptom scores (the sum of the individual scores for sneezing, rhinorrhea, itchy nose/palate/throat, itchy/watery/red eyes) compared to placebo. Although the number of patients in some of the subgroups was small, there were no significant differences in the effect of fexofenadine hydrochloride across subgroups of patients defined by gender, age, and race. Onset of action for reduction in total symptom scores, excluding nasal congestion, was observed at 60 minutes compared to placebo following a single 60 mg fexofenadine hydrochloride dose administered to patients with seasonal allergic rhinitis who were exposed to ragweed pollen in an environmental exposure unit. In one clinical trial conducted with ALLEGRA 60 mg capsules, and in one clinical trial conducted with ALLEGRA-D extended release tablets, onset of action was seen within 1 to 3 hours.

**Pediatrics.** Two 2-week multicenter, randomized, placebo-controlled, double-blind trials in 877 pediatric patients 6 to 11 years of age with seasonal allergic rhinitis were conducted at doses of 15, 30, and 60 mg twice daily. In one of these two studies, conducted in 411 pediatric patients, all three doses of fexofenadine hydrochloride significantly reduced total symptom scores (the sum of the individual scores for sneezing, rhinorrhea, itchy nose/palate/throat, itchy/watery/red eyes) compared to placebo, however a dose response relationship was not seen. The 60 mg twice daily dose did not provide any additional benefit over the 30 mg twice daily dose. Furthermore, exposure in pediatric patients given 30 mg fexofenadine hydrochloride is comparable to adults given 60 mg (see CLINICAL PHARMACOLOGY).

#### Chronic Idiopathic Urticaria:

Two 4-week multicenter, randomized, double-blind, placebo-controlled clinical trials compared four different doses of fexofenadine hydrochloride tablet (20, 60, 120, and 240 mg twice daily) to placebo in patients aged 12 to 70 years with chronic idiopathic urticaria (n=726). Efficacy was demonstrated by a significant reduction in mean pruritus scores (MPS), mean number of wheals (MNW), and mean total symptom scores (MTSS, the sum of the MPS and MNW score). Although all four doses were significantly superior to placebo, symptom reduction was greater and efficacy was maintained over the entire 4-week treatment period with fexofenadine hydrochloride doses of ≥60 mg twice daily. However, no additional benefit of the 120 or 240 mg fexofenadine hydrochloride twice daily dose was seen over the 60 mg twice daily dose in reducing symptom scores. There were no significant differences in the effect of fexofenadine hydrochloride across subgroups of patients defined by gender, age, weight, and race.

### INDICATIONS AND USAGE

#### Seasonal Allergic Rhinitis

ALLEGRA is indicated for the relief of symptoms associated with seasonal allergic rhinitis in adults and children 6 years of age and older. Symptoms treated effectively were sneezing, rhinorrhea, itchy nose/palate/throat, itchy/watery/red eyes.

#### Chronic Idiopathic Urticaria

ALLEGRA is indicated for treatment of uncomplicated skin manifestations of chronic idiopathic urticaria in adults and children 6 years of age and older. It significantly reduces pruritus and the number of wheals.

### CONTRAINDICATIONS

ALLEGRA is contraindicated in patients with known hypersensitivity to any of its ingredients.

### PRECAUTIONS

#### Drug Interaction with Erythromycin and Ketoconazole

Fexofenadine hydrochloride has been shown to exhibit minimal (ca. 5%) metabolism. However, co-administration of fexofenadine hydrochloride with ketoconazole and erythromycin led to increased plasma levels of fexofenadine hydrochloride. Fexofenadine hydrochloride had no effect on the pharmacokinetics of erythromycin and ketoconazole. In two separate studies, fexofenadine hydrochloride 120 mg twice daily (two times the recommended twice daily dose) was co-administered with erythromycin 500 mg every 8 hours or ketoconazole 400 mg once daily under steady state conditions to normal, healthy volunteers (n=24, each study). No differences in adverse events or QT<sub>c</sub> interval were observed when patients were administered fexofenadine hydrochloride alone or in combination with erythromycin or ketoconazole. The findings of these studies are summarized in the following table:

**Effects on steady-state fexofenadine hydrochloride pharmacokinetics after 7 days of co-administration with fexofenadine hydrochloride 120 mg every 12 hours (two times the recommended twice daily dose) in normal volunteers (n=24)**

Concomitant Drug	C <sub>max,SS</sub> (Peak plasma concentration)	AUC <sub>(0-12h)</sub> (Extent of systemic exposure)
Erythromycin (500 mg every 8 hrs)	+82%	+109%
Ketoconazole (400 mg once daily)	+135%	+164%

The changes in plasma levels were within the range of plasma levels achieved in adequate and well-controlled clinical trials. The mechanism of these interactions has been evaluated in *in vitro*, *in situ*, and *in vivo* animal models. These studies indicate that ketoconazole or erythromycin co-administration enhances fexofenadine gastrointestinal absorption. *In vivo* animal studies also suggest that in addition to increasing absorption, ketoconazole decreases fexofenadine hydrochloride gastrointestinal secretion, while erythromycin may also decrease biliary excretion.

#### Drug Interactions with Antacids

Administration of 120 mg of fexofenadine hydrochloride (2 x 60 mg capsule) within 15 minutes of an aluminum and magnesium containing antacid (Maalox®) decreased fexofenadine AUC by 41% and C<sub>max</sub> by 43%. ALLEGRA should not be taken closely in time with aluminum and magnesium containing antacids.

#### Carcinogenesis, Mutagenesis, Impairment of Fertility

The carcinogenic potential and reproductive toxicity of fexofenadine hydrochloride were assessed using terfenadine studies with adequate fexofenadine hydrochloride exposure (based on plasma area under-the-concentration vs. time [AUC] values). No evidence of carcinogenicity was observed in an 18-month study in mice and in a 24-month study in rats at oral doses up to 150 mg/kg of terfenadine (which led to fexofenadine exposures that were respectively approximately 3 and 5 times the exposure from the maximum recom-

mended daily oral dose of fexofenadine hydrochloride in adults and children).

*In vitro* (Bacterial Reverse Mutation, CHO/HGPRT Forward Mutation, and Rat Lymphocyte Chromosomal Aberration assays) and *in vivo* (Mouse Bone Marrow Micronucleus assay) tests, fexofenadine hydrochloride revealed no evidence of mutagenicity.

In rat fertility studies, dose-related reductions in implants and increases in postimplantation losses were observed at an oral dose of 150 mg/kg of terfenadine (which led to fexofenadine hydrochloride exposures that were approximately 3 times the exposure of the maximum recommended daily oral dose of fexofenadine hydrochloride in adults).

#### Pregnancy

**Teratogenic Effects: Category C.** There was no evidence of teratogenicity in rats or rabbits at oral doses of terfenadine up to 300 mg/kg (which led to fexofenadine exposures that were approximately 4 and 31 times, respectively, the exposure from the maximum recommended daily oral dose of fexofenadine in adults). There are no adequate and well controlled studies in pregnant women. Fexofenadine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nonteratogenic Effects.** Dose-related decreases in pup weight gain and survival were observed in rats exposed to an oral dose of 150 mg/kg of terfenadine (approximately 3 times the maximum recommended daily oral dose of fexofenadine hydrochloride in adults based on comparison of fexofenadine hydrochloride AUC).

#### Nursing Mothers

There are no adequate and well-controlled studies in women during lactation. Because many drugs are excreted in human milk, caution should be exercised when fexofenadine hydrochloride is administered to a nursing woman.

#### Pediatric Use

The recommended dose in patients 6 to 11 years of age is based on cross-study comparison of the pharmacokinetics of ALLEGRA in adults and pediatric patients and on the safety profile of fexofenadine hydrochloride in both adult and pediatric patients at doses equal to or higher than the recommended doses. The safety of ALLEGRA tablets at a dose of 30 mg twice daily has been demonstrated in 438 pediatric patients 6 to 11 years of age in two placebo-controlled 2-week seasonal allergic rhinitis trials. The safety of ALLEGRA for the treatment of chronic idiopathic urticaria in patients 6 to 11 years of age is based on cross-study comparison of the pharmacokinetics of ALLEGRA in adult and pediatric patients and on the safety profile of fexofenadine in both adult and pediatric patients at doses equal to or higher than the recommended dose. The effectiveness of ALLEGRA for the treatment of seasonal allergic rhinitis in patients 6 to 11 years of age was demonstrated in one trial (n=411) in which ALLEGRA tablets 30 mg twice daily significantly reduced total symptom scores compared to placebo, along with extrapolation of demonstrated efficacy in patients ages 12 years and above, and the pharmacokinetic comparisons in adults and children. The effectiveness of ALLEGRA for the treatment of chronic idiopathic urticaria in patients 6 to 11 years of age is based on an extrapolation of the demonstrated efficacy of ALLEGRA in adults with this condition and the likelihood that the disease course, pathophysiology and the drug's effect are substantially similar in children to that of adult patients.

The safety and effectiveness of ALLEGRA in pediatric patients under 6 years of age have not been established.

#### Geriatric Use

Clinical studies of ALLEGRA tablets and capsules did not include sufficient numbers of subjects aged 65 years and over to determine whether this population responds differently from younger patients. Other reported clinical experience has not identified differences in responses between the geriatric and younger patients. This drug is known to be substantially excreted by the kidney, and the risk of toxic reactions to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection, and may be useful to monitor renal function. (See CLINICAL PHARMACOLOGY).

### ADVERSE REACTIONS

#### Seasonal Allergic Rhinitis

**Adults.** In placebo-controlled seasonal allergic rhinitis clinical trials in patients 12 years of age and older, which included 2461 patients receiving fexofenadine hydrochloride capsules at doses of 20 mg to 240 mg twice daily, adverse events were similar in fexofenadine hydrochloride and placebo-treated patients. All adverse events that were reported by greater than 1% of patients who received the recommended daily dose of fexofenadine hydrochloride (60 mg capsules twice daily), and that were more common with fexofenadine hydrochloride than placebo, are listed in Table 1.

In a placebo-controlled clinical study in the United States, which included 570 patients aged 12 years and older receiving fexofenadine hydrochloride tablets at doses of 120 or 180 mg once daily, adverse events were similar in fexofenadine hydrochloride and placebo-treated patients. Table 1 also lists adverse experiences that were reported by greater than 2% of patients treated with fexofenadine hydrochloride tablets at doses of 180 mg once daily and that were more common with fexofenadine hydrochloride than placebo. The incidence of adverse events, including drowsiness, was not dose-related and was similar across subgroups defined by age, gender, and race.

**Table 1**  
**Adverse experiences in patients ages 12 years and older reported in placebo-controlled seasonal allergic rhinitis clinical trials in the United States**

Twice daily dosing with fexofenadine capsules at rates of greater than 1%	Fexofenadine 60 mg Twice Daily (n=679)	Placebo Twice Daily (n=671)
Viral Infection (cold, flu)	2.5%	1.5%
Nausea	1.6%	1.5%
Dysmenorrhea	1.5%	0.3%
Drowsiness	1.3%	0.9%
Dyspepsia	1.3%	0.6%
Fatigue	1.3%	0.9%

**Table 2**  
**Once daily dosing with fexofenadine hydrochloride tablets at rates of greater than 2%**

Adverse experience	Fexofenadine 180 mg once daily (n=283)	Placebo (n=293)
Headache	10.6%	7.5%
Upper Respiratory Tract Infection	3.2%	3.1%
Back Pain	2.8%	1.4%

The frequency and magnitude of laboratory abnormalities were similar in fexofenadine hydrochloride and placebo-treated patients. **Pediatric.** Table 2 lists adverse experiences in patients aged 6 to 11 years of age which were reported by greater than 2% of patients treated with fexofenadine hydrochloride tablets at a dose of 30 mg twice daily in placebo-controlled seasonal allergic rhinitis studies in the United States and Canada that were more common with fexofenadine hydrochloride than placebo.

**Table 2**  
**Adverse experiences reported in placebo-controlled seasonal allergic rhinitis studies in pediatric patients ages 6 to 11 in the United States and Canada at rates of greater than 2%**

Adverse experience	Fexofenadine 30 mg twice daily (n=209)	Placebo (n=229)
Headache	7.2%	6.6%
Accidental Injury	2.9%	1.3%
Coughing	3.8%	1.3%
Fever	2.4%	0.9%
Pain	2.4%	0.4%
Otitis Media	2.4%	0.0%
Upper Respiratory Tract Infection	4.3%	1.7%

### Chronic Idiopathic Urticaria

Adverse events reported by patients 12 years of age and older in placebo-controlled chronic idiopathic urticaria studies were similar to those reported in placebo-controlled seasonal allergic rhinitis studies. In placebo-controlled chronic idiopathic urticaria clinical trials, which included 726 patients 12 years of age and older receiving fexofenadine hydrochloride tablets at doses of 20 to 240 mg twice daily, adverse events were similar in fexofenadine hydrochloride and placebo-treated patients. Table 3 lists adverse experiences in patients aged 12 years and older which were reported by greater than 2% of patients treated with fexofenadine hydrochloride 60 mg tablets twice daily in controlled clinical studies in the United States and Canada and that were more common with fexofenadine hydrochloride than placebo. The safety of fexofenadine hydrochloride in the treatment of chronic idiopathic urticaria in pediatric patients 6 to 11 years of age is based on the safety profile of fexofenadine hydrochloride in adults and adolescent patients at doses equal to or higher than the recommended dose (see Pediatric Use).

**Table 3**  
**Adverse experiences reported in patients 12 years and older in placebo-controlled chronic idiopathic urticaria studies in the United States and Canada at rates of greater than 2%**

Adverse experience	Fexofenadine 60 mg twice daily (n=186)	Placebo (n=178)
Back Pain	2.2%	1.1%
Sinusitis	2.2%	1.1%
Dizziness	2.2%	0.6%
Drowsiness	2.2%	0.0%

Events that have been reported during controlled clinical trials involving seasonal allergic rhinitis and chronic idiopathic urticaria patients with incidences less than 1% and similar to placebo and have been rarely reported during postmarketing surveillance include: insomnia, nervousness, and sleep disorders or parosmia. In rare cases, rash, urticaria, pruritus and hypersensitivity reactions with manifestations such as angioedema, chest tightness, dyspnea, flushing and systemic anaphylaxis have been reported.

### OVERDOSAGE

Reports of fexofenadine hydrochloride overdose have been infrequent and contain limited information. However, dizziness, drowsiness, and dry mouth have been reported. Single doses of fexofenadine hydrochloride up to 800 mg (six normal volunteers at this dose level), and doses up to 690 mg twice daily for 1 month (three normal volunteers at this dose level) or 240 mg once daily for 1 year (234 normal volunteers at this dose level) were administered without the development of clinically significant adverse events as compared to placebo.

In the event of overdose, consider standard measures to remove any unabsorbed drug. Symptomatic and supportive treatment is recommended.

Hemodialysis did not effectively remove fexofenadine hydrochloride from blood (1.7% removed) following terfenadine administration. No deaths occurred at oral doses of fexofenadine hydrochloride up to 5000 mg/kg in mice (110 times the maximum recommended daily oral dose in adults and 200 times the maximum recommended daily oral dose in children based on mg/m<sup>2</sup>) and up to 5000 mg/kg in rats (230 times the maximum recommended daily oral dose in adults and 400 times the maximum recommended daily oral dose in children based on mg/m<sup>2</sup>). Additionally, no clinical signs of toxicity or gross pathological findings were observed. In dogs, no evidence of toxicity was observed at oral doses up to 2000 mg/kg (300 times the maximum recommended daily oral dose in adults and 530 times the maximum recommended daily oral dose in children based on mg/m<sup>2</sup>).

### DOSAGE AND ADMINISTRATION

#### Seasonal Allergic Rhinitis

**Adults and Children 12 Years and Older.** The recommended dose of ALLEGRA is 60 mg twice daily, or 180 mg once daily. A dose of 60 mg once daily is recommended as the starting dose in patients with decreased renal function (see CLINICAL PHARMACOLOGY).

**Children 6 to 11 Years.** The recommended dose of ALLEGRA is 30 mg twice daily. A dose of 30 mg once daily is recommended as the starting dose in pediatric patients with decreased renal function (see CLINICAL PHARMACOLOGY).

#### Chronic Idiopathic Urticaria

**Adults and Children 12 Years and Older.** The recommended dose of ALLEGRA is 60 mg twice daily. A dose of 60 mg once daily is recommended as the starting dose in patients with decreased renal function (see CLINICAL PHARMACOLOGY).

**Children 6 to 11 Years.** The recommended dose of ALLEGRA is 30 mg twice daily. A dose of 30 mg once daily is recommended as the starting dose in pediatric patients with decreased renal function (see CLINICAL PHARMACOLOGY).

### HOW SUPPLIED

ALLEGRA 60 mg capsules are available in: high-density polyethylene (HDPE) bottles of 60 (NDC 0088-1102-41); HDPE bottles of 100 (NDC 0088-1102-47); HDPE bottles of 500 (NDC 0088-1102-55); and aluminum-foil blister packs of 100 (NDC 0088-1102-49).

ALLEGRA capsules have a white opaque cap and a pink opaque body. The capsules are imprinted in black ink, with "ALLEGRA" on the cap and "60 mg" on the body.

ALLEGRA 30 mg tablets are available in: high-density polyethylene (HDPE) bottles of 100 (NDC 0088-1106-47) with a polypropylene screw cap containing a pulp/wax liner with heat-sealed foil inner seal and HDPE bottles of 500 (NDC 0088-1106-55) with a polypropylene screw cap containing a pulp/wax liner with heat-sealed foil inner seal.

ALLEGRA 60 mg tablets are available in: HDPE bottles of 100 (NDC 0088-1107-47) with a polypropylene screw cap containing a pulp/wax liner with heat-sealed foil inner seal; HDPE bottles of 500 (NDC 0088-1107-55) with a polypropylene screw cap containing a pulp/wax liner with heat-sealed foil inner seal; and aluminum foil-backed clear blister packs of 100 (NDC 0088-1107-49).

ALLEGRA 180 mg tablets are available in: HDPE bottles of 100 (NDC 0088-1109-47) with a polypropylene screw cap containing a pulp/wax liner with heat-sealed foil inner seal; and HDPE bottles of 500 (NDC 0088-1109-55) with a polypropylene screw cap containing a pulp/wax liner with heat-sealed foil inner seal.

ALLEGRA tablets are coated with a peach colored film coating. Tablets have the following unique identifiers: 30 mg tablets have 03 on one side and either 0088 or scripted E on the other; 60 mg tablets have 06 on one side and either 0088 or scripted E on the other; and 180 mg tablets have 018 on one side and either 0088 or scripted E on the other. Store ALLEGRA capsules and tablets at controlled room temperature 20-25°C (68-77°F). (See USP Controlled Room Temperature). Foil-backed blister packs containing ALLEGRA capsules and all tablet packaging should be protected from excessive moisture.

### Rx only

Prescribing Information as of January 2003

Aventis Pharmaceuticals Inc.  
Kansas City, MO 64137 USA

US Patents 4,254,129; 5,375,693; 5,578,610  
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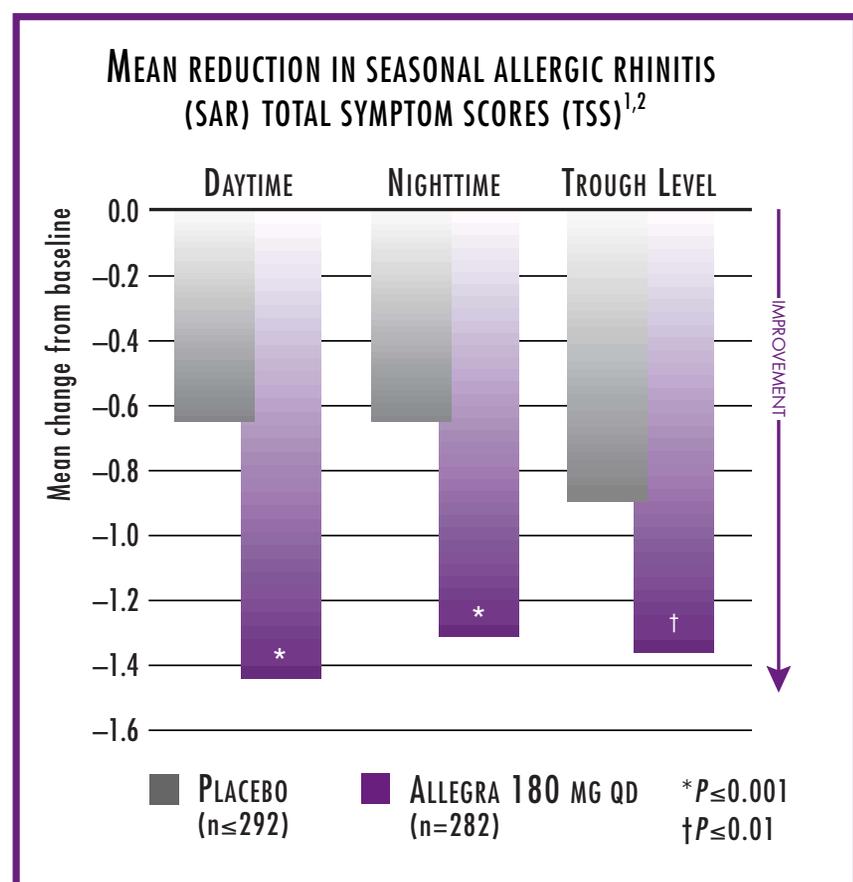
Aventis Pharmaceuticals  
Bridgewater, NJ 08807

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# SWITCH TO ALLEGRA® FOR PRESCRIPTION POWER.

SWITCH TO ALLEGRA FOR POWERFUL, 24-HOUR RELIEF<sup>1</sup>



2-week, placebo-controlled, randomized study of SAR patients (N=861). Trough level (8 AM instantaneous TSS—primary endpoint), daytime (8 PM reflective TSS), and nighttime (8 AM reflective TSS) scores were individually calculated as the sum of individual symptoms (sneezing; rhinorrhea; itchy nose/palate/throat; itchy, watery, red eyes) and ranged from 0 to 16. Baseline scores for placebo and Allegra, respectively, were: daytime 7.3, 7.3; nighttime 7.6, 7.6; trough level 7.6, 7.7. Study also included an unapproved dose of 120 mg qd (n=287).

†Administered as 240 mg bid for 14 days (n=144). There is no evidence that doses higher than those recommended are more effective.

§Clarinex and Claritin are nonsedating at the recommended qd doses of 5 mg and 10 mg, respectively.

||With Allegra 60 mg.

- **Powerful, 24-hour relief** of seasonal allergic rhinitis even at trough, with Allegra 180 mg qd<sup>1</sup>
- The **only 2nd-generation antihistamine that is nonsedating** at more than twice the recommended qd dose<sup>3,6,†§</sup>
- **Nonimpairing** while driving<sup>7||</sup>
- The most commonly reported adverse events with Allegra 180 mg and placebo in seasonal allergic rhinitis patients 12 and older are headache (10.6% vs 7.5%), upper respiratory tract infection (3.2% vs 3.1%), and back pain (2.8% vs 1.4%)
- The most commonly reported adverse events with Allegra 60 mg bid and placebo in seasonal allergic rhinitis patients 12 and older are viral infection (cold, flu) (2.5% vs 1.5%), nausea (1.6% vs 1.5%), and dysmenorrhea (1.5% vs 0.3%)

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