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James S. Jackson, Ph.D., was named Associate Dean of the University of Michigan's Rackham School of Graduate Studies in 1987. He has been at the University of Michigan since 1971 and is currently a Professor of Psychology, Research Scientist at the Institute for Social Research, and Faculty Associate at the Center for Afro-American and African Studies and the Gerontology Institute. In 1986-87 he was a National Research Council/Ford Foundation Senior Postdoctoral Fellow at the Groupe D'Études en Sciences Sociales, Paris, France. Dr. Jackson received his undergraduate degree in psychology from Michigan State University, his M.A. degree in psychology from the University of Toledo in 1970, and his Ph.D. in social psychology from Wayne State University in 1972. Since 1977 he has been the Director of the Program for Research on Black Americans of the Research Center for Group Dynamics, Institute for Social Research. He is currently a member of several scientific review panels, including the National Academy of Sciences Committee on the Status of Black Americans: 1940-1980, the National Cancer Institute's study on black/white cancer survival differences, the European Economic Community Study on Immigration and Racism, and chairs the Gerontological Society Task Force on Racial Minority Groups.

THE BLACK AMERICAN ELDERLY Research on Physical and Psychosocial Health

James S. Jackson, Ph.D.
Editor

Patricia Newton, M.D.
Adrian Ostfield, M.D.
Daniel Savage, M.D., Ph.D.
Edward L. Schneider, M.D.

Associate Editors



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2

The Role of Black Universities in Research on Aging Black Populations

David Satcher

We have recently realized that persons over the age of 65 are becoming an increasingly important segment, numerically and sociopolitically, of this society. It is generally agreed that, as a group, the elderly deserve the best that our society has to offer. Yet as a society we are very poorly prepared and perhaps poorly motivated to deal with the needs of the elderly. In fact, with all of our sophistication, we still have a poor understanding of those needs. Nowhere is this more evident than in the health care field.

We pride ourselves as a nation on having the most highly sophisticated health care system in the world. The strengths of that system, we claim, are its diversity, its specialization, and its technology. Yet when confronting the perspectives of the elderly and their needs, the weaknesses of our system become apparent: fragmentation, lack of coordination, and lack of integration. It is clear that if we are able to respond to the challenges the elderly present to our health delivery system, we will have much improved health care for everyone.

Inherent in these systemic problems facing health needs of the elderly are the biases of health care professionals that affect their experiences. Rarely are the elderly popular with young physicians looking to make exotic diagnoses. In that context, when I was in medical training the elderly were often referred to in very negative terms. In addition, because we often expected the elderly to be "naturally sick," we did not vigorously look for treatable causes.

THE NEED FOR DISCIPLINARY INTEGRATION

Aging research starts with the questions of what aging is and how we separate it from other life processes and pathology. What determines diversity in the qualities and characteristics that we associate with aging? How do we optimize the aging process for any individual or group, and how do we reduce pathology? How do we better organize services within the health care system to meet the needs of the elderly? Do we have the researchers to address these kinds of questions? Certainly we have outstanding biochemists, physiologists, immunologists, and pathologists. We have outstanding internists and practitioners of every specialty in clinical medicine. We have outstanding behavioral and social scientists. But what we do not have is the kind of integration and communication among these various specialties that allow us to answer questions we have posed, questions that can only be answered by an integrated effort with maximum communication among disciplines.

We lack horizontal integration of researchers and health care providers within our institutions and society. But even if we had this horizontal integration, how would we assess the time-related process of aging long enough to answer the basic questions? That requires vertical integration and communication even between the generations. It requires quality longitudinal research, and longitudinal research is all too rare at institutions in our country. It does not have the short-term payoff or gratification that has become so important in our society. It does not respond to the need to "publish or perish." And yet it is clear that longitudinal research is critical to progress in knowledge about aging. Thus in order to respond to the needs of the elderly in the health care system, I suggest the following changes:

1. More positive attitudes on the part of all concerned.
2. Better communication and integration of effort among biomedical scientists, behavioral scientists, and clinicians.
3. Increased longitudinal studies with vertical integration of research and services.
4. Extended coordination of services, including home care, ambulatory care, inpatient care, and long-term care.

AGING RESEARCH IN BLACK POPULATIONS

What about aging research in black populations? Are the issues different? Are the challenges different? Some data, of course, are very revealing. Blacks constitute approximately 15% of the population under the age of 15 in our country. Over the age of 65, blacks constitute about 8% of the population.

Those data are very telling. In life expectancies, blacks overall average about 5.6 years less than whites. What do these data say about aging in blacks? We really do not know. Only if the burden of environmental challenges and onslaughts were randomly distributed throughout society would these data tell us anything about aging in blacks. The Department of Health and Human Services Task Force on the Health Status of Blacks and Other Minorities made it quite clear that the burdens are not randomly distributed horizontally or vertically. Infant mortality is twice as common in blacks. Cardiovascular disease and cancer affect blacks at a much greater rate. In fact, prior to the age of 70, more than 42% of black deaths are excess deaths—deaths that would not have occurred if blacks had the same life expectancy, age- and sex-adjusted, as whites. In addition to cardiovascular disease and cancer, more common causes of deaths in blacks include homicide, accidents, and substance abuse. In fact, poverty is more common in blacks at every age. Many blacks today over the age of 65 have survived the same burdens that have led to the deaths of the bulk of their cohorts, but in many cases they bear the scars, including the poverty.

One goal of aging research must be to minimize the burdens and to maximize the outcome of the aging process for all people, including blacks. The black elderly are victims historically and currently are excessively burdened by poverty, crime, and discrimination based on race and age. Aging research on black Americans certainly deserves special consideration and priority.

In addition to the challenges facing aging research in general (including attitudes, lack of communication, integration and coordination of resources), we currently face several serious problems. There is a paucity of well-trained investigators with special interests in the problems of aging in blacks. Less than 3% of physicians, pharmacists, dentists, and other health care professionals in this country are black, while approximately 2% of all biomedical scientists are black.

Even for those blacks interested in research on aging in black populations there are serious barriers. These include (1) research experience and discipline; (2) peer support for starting research; (3) difficulty in obtaining the resources needed for research, including skills and negotiating the system; and (4) bias within the system of support at every level.

THE CHALLENGES FACING HISTORICALLY BLACK INSTITUTIONS

It is important to place in perspective the challenges facing historically black institutions. As a rule, these institutions were founded with a special commitment to provide unique opportunities for health-professional education

for minorities and the disadvantaged and access to health care for the underserved. For many years, these institutions stood virtually alone in providing access to health-professional education for blacks in this country. In fact, almost 90% of the black veterinarians today are alumni of the Tuskegee School of Veterinary Medicine. Seventy percent of the black pharmacists are graduates of the one of the four black schools of pharmacy, and more than 50% of the black physicians and dentists are graduates of Howard University or Meharry Medical College. One of the major challenges facing black institutions today is to continue our unique commitment to the underserved, since the needs of the underserved are still paramount in this country. There are three major areas of concern: (1) the health status of blacks and other minorities, (2) the underrepresentation of blacks and other minorities in the health professions and the biomedical sciences, and (3) the need to strengthen our institutions to respond to these challenges.

In order to deal with these concerns adequately, there are several themes that must be emphasized. First, we must underline the need to cultivate the relationship we have with the black community, including the black elderly, through our institutions and our alumni throughout the country. The access we have to the black community provides a special opportunity for us to contribute to problem solutions. We also need to increase our emphasis on research, even in the face of the demands for teaching and delivering health services with limited faculties and resources. We need to continue to improve the environment of our institutions, so that research can more easily flourish.

A good example of this environmental improvement is the Plan for Academic Renewal (PAR) at Meharry Medical College started in July 1982. This is both a financial and an academic plan. It is a plan to significantly strengthen our faculty, with special emphasis on research skills. It is a plan to develop centers of excellence for research in areas such as geriatrics, nutrition, and tropical diseases. It is a plan to provide more educational support in terms of student scholarships, as well as support for the library. It is a plan to revitalize our facilities. All of these efforts as they come about are strengthening our institution as one that contributes significantly to research in various areas. As a part of this effort we have also had to increase significantly the performance expectations of our faculty and students. In fact, there is an increasing demand for faculty to become more involved in research and for students to take advantage of opportunities to develop and prepare for research careers.

Another challenge to our institutions is to develop more cooperative efforts with majority institutions in research benefiting black populations. For example, in addition to sharing the Nashville-General Hospital, Meharry Medical College and Vanderbilt University have found new

ways to cooperate. It is now not unusual for members of our faculty and members of the Vanderbilt faculty to submit joint proposals; such as the Training Program in Tropical Diseases headed by Dr. George Hill at Meharry Medical College or the Alcoholism Control Project headed by Andy Spickard at Vanderbilt, a project involving several Meharry faculty members. Especially at our institution, we must maximize the role of teams in research internally and with consortia externally. It is important to our institutions that basic scientists, behavioral scientists, clinicians, and social scientists involved in applied community interventions collaborate to address problems facing the black elderly.

Our students have special needs. They need more information and greater understanding of the plight of the elderly. They need more appreciation for research on black aging populations, more role models in gerontology and geriatrics. Our students need more experience with good researchers and good clinicians. They need more opportunities to become involved with research on aging and comprehensive health care models in black populations.

SUMMARY

In summary, I make the following recommendations. First, it is clear that there needs to be greater concerted commitment to funding research on aging in this country, and especially aging in black populations. Second, there need to be more opportunities for horizontal and vertical integration in our approaches to research on aging, especially in black populations. More effort should be directed to initiating longitudinal research on aging, and those studies should be securely funded. The longitudinal research study of hypertension at Meharry is an excellent opportunity. I am very pleased that it is now supported by the National Institute on Aging.

Third, there needs to be more involvement of black scientists in aging research. Just as the black aging population carries heavy burdens from past experiences, blacks in research carry their own burdens. If we are serious about expediting research, we will make efforts to lighten those burdens as blacks attempt to become involved in research. Fourth, there needs to be more involvement of black institutions in aging research. This needs to be encouraged by the National Institute on Aging and other agencies within the National Institutes of Health. Just as the National Institutes of Health made special efforts in the late 1950s and early 1960s to enhance the research capabilities of institutions like Vanderbilt and the University of Virginia, efforts must now be made to enhance research opportunities and activities at historically black institutions.

And finally, there need to be special fellowships geared toward enhancing the opportunities for black students and black residents to become involved in research at the National Institute on Aging and other institutions throughout the country. While we face major challenges, we also have major opportunities to move forward in research on aging black populations.

PART II
Demography and
Epidemiology of
Older Black Adults

THE IMPLICATIONS OF SICKLE CELL TRAIT IN THE HOSPITAL POPULATION

David Satcher, M.D., Ph.D., Associate Director, (King-Drew Sickle Cell Center) Assistant Professor of Community Medicine (Charles R. Drew Postgraduate Medical School) and Florida Brown, Laboratory Technician (King-Drew Sickle Cell Center)

Controversial case reports involving illness in persons with sickle cell trait have raised disturbing questions. Studies presently in progress by the Veteran's Administration and other large agencies may yield some valuable answers. Our study grew out of the observation that the frequency of sickle cell trait was much higher in a hospital population than in the community surrounding the hospital. Efforts to explain this observation revealed some interesting and disturbing data.

In Los Angeles County, there has been widespread screening for sickle cell trait, sickle cell disease and related hemoglobinopathies. Most screening programs in Los Angeles County have revealed a prevalence of sickle cell trait which is consistent with other studies done throughout the country. In the King Hospital Service Area a review of some community screening programs conducted in 1973 and using cellulose acetate electrophoresis for initial screening showed that out of 10,970 persons tested, 1,010 or 9.4% were positive for sickle cell trait. This is not significantly different from other large screening programs conducted throughout the country. In May, 1973, we decided that we would use cellulose acetate electrophoresis for initial testing in all cases where hemoglobin testing was requested in the King Hospital. In January, 1974, we reviewed the results of in-hospital testing from May through December, 1973. We found that out of 1807 persons tested, 314 or 17.6% were diagnosed by cellulose acetate electrophoresis as sickle cell trait (AS). This frequency is significantly higher than that of the other screening programs of this community. Initial responses to this finding were mixed among the staff. One opinion was that this suggested that sickle cell trait was associated with some form of morbidity that made it more likely for a person with sickle cell trait to show up in the hospital population. Another opinion was that in the population of the King-Drew Service Area which is 85% Black and 13% Mexican-American, there is a higher prevalence of sickle cell trait and thus the community screening programs had failed to accurately detect sickle cell trait. Our own hypothesis was that we were not dealing with a random sample of the hospital population and that many persons were being tested who already knew they had sickle cell trait and that this knowledge and associated anxiety prompted their hospital visit.

To test the above hypotheses, we set out to answer the following questions: (1) where in the hospital were persons tested; (2) Why had the hemoglobin test been ordered; (3) How many persons with sickle cell trait already knew they had sickle cell trait before the hospital visit; (4) What problem had prompted the hospital visit; (5) What understanding did persons with trait have about sickle cell trait before and after the hospital visit.

In order to answer these questions, we randomly selected one hundred (100) persons with the diagnosis of hemoglobin AA and one hundred (100) with hemoglobin AS. We then prepared a questionnaire to determine prior knowledge of having sickle cell trait. We also

reviewed the charts to determine why the hemoglobin test was ordered and what the chief complaint and diagnosis were for the hospital visit. The first question as to where the testing was done yielded interesting results.

We first determined that eight hundred and seventy-five (875) or 49% of persons tested in King Hospital between May-December, 1977 were tested in the Department of Obstetrics and Gynecology. This was significant since this department has a policy of testing all of its patients by cellulose acetate electrophoresis on their initial visit. Of greater significance was the fact that in OB-GYN, only eighty-eight (88) or 10% of the persons tested had sickle cell trait (AS). This was consistent with the frequency of sickle cell trait in other screening programs in the King Hospital Service Area. However, this meant that the frequency of sickle cell trait in the other areas where the test had been ordered was greater than 20%. These other locations included the emergency ward and walk-in clinics and a few in-hospital ward locations.

Of the 100 charts which we reviewed to determine why the hemoglobin electrophoresis had been ordered, 48% of the persons who had sickle cell trait (AS) had given the physician a history of sickle cell disease or trait during the work-up. On the other hand, of the 100 charts of persons with AA hemoglobin, only 4% had given a history of sickle cell disease in themselves or their families. Likewise, when we talked by phone to persons with sickle cell trait, 27% said they knew they had sickle cell trait before they went to the hospital. Of the 100 persons with AA hemoglobin who were called, seven (7) knew their hemoglobin type before being tested at King Hospital.

The next question was "What prompted the hospital visit?" There were more than 10 different chief complaints. The most common complaints were pain and infections. However, the frequency of no single complaint was significantly different in the two populations except "hematuria." This complaint was four times more common in the sickle cell trait (AS) population than in the AA population. This difference is significant at the 0.1 level but not at the 0.05 level in this study.

The final question was an attempt to assess the understanding of persons about sickle cell trait. Of the one hundred (100) persons called who had sickle cell trait, only 35% understood the difference between sickle cell trait and sickle cell anemia.

This study supports the hypothesis that the significantly higher prevalence of sickle cell trait in our hospital population can be accounted for by the fact that we were testing many persons who had already been tested and knew their test results. The poor understanding which we found that they had about sickle cell trait could explain why they showed up in the emergency or walk-in clinic so frequently. Except for hematuria, there was nothing about their chief complaint or diagnosis which differed from that of persons with AA hemoglobin. A survey of laboratory tests including hemoglobin, urine specific gravity and pyuria revealed no significant difference in the two populations. The presence of elevated blood pressure at the initial hospital visit was significantly more

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prevalent among the AA population (24%) than the AS population (10%). This difference is significant at the 0.05 level but deserves further study.

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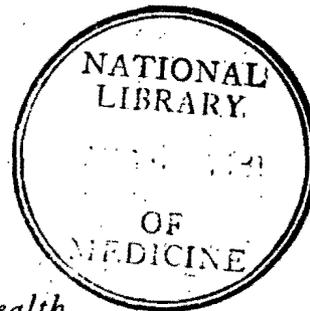
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BOOK REVIEWS

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Each chapter concludes with a brief discussion of the controversies regarding patient care that surround the field, and most of the chapters include an expression of the author's view of what the future may hold. It is fortunate that these efforts at prognostication are quite brief, since they add little.

The chapters are well referenced and include an index that is helpful. The use of boldface type to emphasize a critical issue in the text is employed throughout and is an effective device in focusing the reader's attention on important points.

The book is adequately illustrated. The use of actual photographs of surgical fields, however, seldom contributes to one's knowledge of the subject, and this is particularly true when the photographs are presented in black and white. They are all the more redundant when accompanied by pen-and-ink drawings, as is frequently the case.

This book makes a contribution toward a better understanding of the current surgical therapy of common surgical problems and should be of interest to experienced surgeons as well as residents. The price may well deter those in the latter group from adding this book to their libraries.

JACK W. COLE, M.D.
Yale University
School of Medicine

New Haven, CT 06510

SYMPOSIUM ON PEDIATRIC PLASTIC SURGERY

Vol. 21. Edited by Desmond A. Kernahan and Hugh G. Thomson. 453 pp., illustrated. St. Louis, C.V. Mosby, 1982. \$79.50.

This book seems to have avoided most of the problems of multi-authored works. The editors have organized the material well. Most of the subjects are covered adequately, with inclusion of embryology when appropriate. The reader must bear in mind that usually only the author's favorite method is presented. A question-and-answer section appears at the end of each part of the book. In many cases the editor has tried to question controversial statements and to bring out different viewpoints. Although the question-and-answer format is informal, the content makes reading these sections worthwhile.

One might question why a whole book has been centered on pediatric plastic surgery. However, this is much more than plastic surgery in a younger age group; the problems confronted are entirely different from those in the adult and are usually related to congenital deformities. It is entirely appropriate for these problems to be handled in a separate presentation. Only in part four (Trauma) are there many parallels to the adult experience. Even here, methods of treatment can be quite different, taking into account the changes occurring with growth.

The most recent textbook covering the pediatric aspects of plastic surgery is more than 10 years old. This book covers all the important subjects in this field, from clefts to congenital hand deformities. There is also good coverage on craniofacial problems, and branchial-arch deformities, which brings the reader up to date on these changing fields. The book therefore fills a real need.

For the most part, the chapters are well written and well organized. I was particularly pleased with the coverage of congenital hand deformities. This subject is not always well understood or well handled, but in this work it is covered comprehensively and with clarity.

Any plastic surgeon who treats infants, children, or adolescents will want to own this book.

GEORGE H. GIFFORD, JR., M.D.
Children's Hospital Medical Center

Boston, MA 02115

UNDER THE INFLUENCE: A GUIDE TO THE MYTHS AND REALITIES OF ALCOHOLISM

By James R. Milam and Katherine Ketcham. 210 pp. Seattle, Madrona, 1981. \$12.95.

This book purports to be a guide to the myths and realities related to alcoholism. Its authors describe their primary purpose as provid-

ing a scientific explanation of alcoholism. They promise to do this by providing well-established "facts."

This endeavor fails because what they view as established facts are largely (at this juncture) attractive but unproved hypotheses or promising bits of scientific evidence — small pieces of a larger jigsaw puzzle that is far from complete. For example, the authors flatly assert that the cause of alcoholism is physiologically, not psychosocially based, that alcoholism is hereditary, and that addiction to alcohol is the result of genetically determined abnormalities in the metabolism of alcohol or acetaldehyde. Unfortunately, in trying to provide a definitive, but premature, explanation or "proof" of these contentions, they oversimplify the complex interaction of psychosocial and biologic factors that underly the disorder. They draw conclusions that may prove to be correct but are simply not supported by the available data.

This book is quite unsophisticated in its discussion of biologic processes and pathophysiologic mechanisms. The authors are guilty of several incorrect assertions, such as the statements that "all alcoholics develop malnutrition" and that "the great majority of alcoholics suffer from chronic low blood sugar." This book can in no way be considered a scholarly work.

Despite these drawbacks, it has some positive aspects. It is well written and readable. Relatively short, it can easily be read in one sitting. Given the inadequacies of its discussion of the causes of alcoholism, it is surprisingly good in its description of the development and progression of the various stages of the disease. The clinical description of alcoholism and its impact on the victim's life and family are well done. Any primary-care physician will benefit from the chapters dealing with these topics. The discussion of treatment is generally worthwhile, except that there is unsubstantiated emphasis on such nutritional approaches as hypoglycemic diets and lifelong vitamin and mineral supplements.

It seems, then, that although this book cannot be considered "must" reading for those already knowledgeable in the field of alcoholism, it contains some valuable sections, particularly for those seeking an introduction to the study of alcoholism and its clinical treatment.

TREVOR R. P. PRICE, M.D.
Dartmouth-Hitchcock
Mental Health Center

Hanover, NH 03755

ALCOHOL AND PUBLIC POLICY: BEYOND THE SHADOW OF PROHIBITION

Edited by Mark H. Moore and Dean R. Gerstein. 463 pp. Washington, D.C., National Academy Press, 1981. \$15.

This book is the report of a panel of the National Institute on Alcohol Abuse and Alcoholism, assembled to analyze alternative policies for the prevention of alcohol abuse and alcoholism. The first part of the report provides a historical, conceptual, and demographic background. The problem of alcohol abuse is portrayed in terms of health, economic, and social impact on drinkers, their intimates, and other associates. These effects are also viewed in the contexts of various drinking practices, including degrees of intoxication, frequency of intoxication, and cumulative consumption. When these drinking practices are paired with a recognition of the existing social and physical environment of drinkers, we get a clearer picture of the general level of risk. When alcohol abuse is given this kind of structure, it emerges as a problem that is broadly distributed over the population and not confined to the heaviest drinkers or to alcoholics. As a corollary, treatment has a very limited potential, and prevention is mandated.

With this conceptual background, the panel examines current approaches to prevention as they deal with the supply of alcohol, drinking practices, and the environment of those who drink.

The last part of the report presents evidence for and against three broad categories of alcohol-related prevention policies. Although it has been demonstrated that supplier-based preventive policies can work, they have not been applied on a systematic or consistent basis. Policies affecting drinking practices have also been shown to reduce alcohol-related problems, but cost effectiveness has not been exam-

ined. Attempts to alter the environment of the person who drinks have also been examined and applied to a limited extent. The authors recommend such an approach. The general conclusion is that the possibilities for successful preventive measures are certain to increase with experience.

The major strength of this report is its conceptual and scientific approach to the problem of alcohol abuse and the application of preventive policies from this broad-based perspective. The report deals very poorly with the alcohol problem relative to race, sex, and age. These variables would certainly be important for anyone developing preventive programs. The report also does not deal analytically with prevention of alcoholism; it implies that the behavioral approach suggested will result in a decrease in the occurrence of clinical alcoholism. Whereas this report should be an excellent reference for persons involved in health-services research, it has limited value for those involved with the care of patients. Since the treatment of alcoholism has received considerable attention in the past while prevention has received limited attention, this book is an important contribution to the literature on alcohol abuse and alcoholism.

DAVID SATCKER, M.D., Ph.D.
School of Medicine
at Morehouse College

Atlanta, GA 30314

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If the book to be reviewed is not listed in the Journal, we may require that you send it to us with your review, but it will of course be returned. The Journal reserves the right of final decision on publication.

BASIC SCIENCE

- Anatomy for Surgeons.** Vol. 3. *The Back and Limbs.* Third edition. By W. Henry Hollinshead. 878 pp., illustrated. Philadelphia, Harper and Row, 1982. \$72.
- Anthropometry of the Head and Face in Medicine.** By Leslie G. Farkas. 293 pp., illustrated. New York, Elsevier/North-Holland, 1981. \$59.50.
- The Assessment of Immunocompetence.** (Clinics in Immunology and Allergy, Vol. 1, No. 3.) Edited by A. D. B. Webster. 694 pp., illustrated. Philadelphia, W.B. Saunders, 1981. \$24.
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Guest Editorial

The Continuing Role for Black Medical Schools

DAVID SATCHER, M.D., PH.D.

Until 15 years ago the overwhelming majority of black physicians in the United States were educated at two medical schools: Howard University College of Medicine, a publicly supported institution in Washington, D.C.; and Meharry Medical College, a private institution in Nashville, Tennessee. As recently as the 1967-68 academic year, those two schools accounted for more than two-thirds of black first-year students enrolled in U.S. medical schools. In all other medical schools combined in that year, blacks accounted for less than one percent of the first-year enrollment.

This was soon to change dramatically. In 1968, the Association of American Medical Colleges called on medical schools to "admit increased numbers of students from geographical areas, economic backgrounds and ethnic groups that are now inadequately represented." Shortly thereafter, an AAMC task force investigating minority underrepresentation in medical schools recommended that by the 1975-76 academic year, 12 percent of all first-year medical students be black.

First-year black enrollment did rise to 6.8 percent by the target year of 1975-76. Unfortunately, the percentage is no more than that today.

Despite the spurt in black enrollment in the early 1970s, overall progress has fallen far short of the AAMC goal, making the continuing need for predominantly black institutions obvious. Even today, four predominantly black medical schools (two other institutions have been added to Howard and Meharry—the Morehouse School of Medicine in Atlanta, and the Charles R. Drew Postgraduate Medical School in Los Angeles) account for close to one-fourth of the black enrollment in the nation's medical colleges.

Still, the situation of predominantly black medical schools is vastly different from what it was before majority institutions opened their doors to blacks and other underrepresented minorities. Today, minority schools are competing with all other medical schools for the most promising black students and faculty.

So, why should a student or faculty person who has the opportunity to go to an institution like Harvard, Stanford or Einstein come to Meharry? It is a question I am often asked,



Historically black institutions provide a great opportunity (for those) disturbed by significant inequalities in medical care.

whether I'm fundraising, recruiting or talking to potential students and their families. I first respond that this student or faculty person should feel no obligation based on his or her race or background to come to Meharry—or to go anywhere else for that matter. I emphasize that this person should examine his or her personal mission and needs as a basis for making that decision. But also I try to make the student or faculty person aware of several important points about Meharry Medical College.

First, Meharry has a unique tradition, reflected in the fact that we have educated 40 percent of all black physicians and dentists in this country and that 75 percent of our graduates practice in whole or in part in underserved communities. The historically black institutions provide a great opportunity for students and faculty whatever their race or background who are disturbed by significant inequalities in medical care in our nation—by the fact, for example, that some 30,000,000 people continue to lack access to basic medical care or that infant mortality is

twice as high among nonwhites as among whites. Not only do most Meharry graduates practice in medically underserved areas, but Meharry as an institution seeks to play a leading role in formulating innovative programs to bring care to the underserved.

Second, at Meharry this student or faculty person would interact with students and faculty persons whose backgrounds are unique; many of them are first generation high school or college graduates, many of them have struggled throughout their lives financially and academically and many of them have achieved for themselves a unique opportunity that would have been denied to them in the past.

Potential students and faculty should also know that the environment at Meharry is one of struggle—for equal opportunity for ourselves and others. It always has been and it perhaps always will be. Finally, that person should understand that Meharry Medical College is committed to excellence. We make no excuses for ourselves and we expect and accept nothing but the best from ourselves and others.

At Meharry, we are finding that we are able to compete successfully for top faculty, including more than a few who attended or taught at prestigious majority institutions. Certainly part of what attracts these new faculty members to Meharry is the prospect of providing academic leadership. But of equal importance, I believe, is the desire to join an institution committed to excellence in minority education and health care for the underserved. That desire was summed up well, I think, by Meharry's new chairman of medicine when asked about his move from the University of Pennsylvania School of Medicine—"I've achieved, but what have I given back to anybody?" is the way he put it.

I am convinced that the track record and commitment of institutions like Meharry in training doctors who provide care for those most in need of basic health services is what attracts the many dedicated and unusual young men and women, who by virtue of their achievement are offered unprecedented opportunities to attend majority schools. Many have chosen Meharry, including many white students (15 percent of Meharry's students are non-black), in the knowledge that unprecedented opportunities await them here as well.

Dr. Satcher is president of Meharry Medical College in Nashville, Tennessee.

Forum

Two Views on the Problem of Emerging Infectious Diseases

DAVID SATCHER AND ANTHONY S. FAUCI

Priorities in public health are constantly evolving. As the nation's prevention agency, the Centers for Disease Control and Prevention (CDC) must ensure that its prevention and control programs keep pace with the numerous and changing health problems that threaten all segments of our diverse society. To strategically address these public health issues, CDC has identified four priority areas: (i) strengthen core public health functions; (ii) develop, maintain, and enrich the capacity to respond to urgent threats to health; (iii) develop a nationwide prevention network and program; and (iv) promote women's health. Leading the list of urgent threats to health are new and emerging infections.

The spectrum of infectious disease is changing rapidly in conjunction with dramatic changes in our society and environment. Worldwide, population growth is explosive with expanding poverty and urban migration; international travel is increasing; and technology is rapidly changing—all of which affect our risk of infection with the countless microbial pathogens with which we share our environment. Despite historical predictions to the contrary, we

David Satcher is the director of CDC. Anthony S. Fauci is the director of NIAID.

remain vulnerable to a wide array of new and resurgent infectious diseases.

Our vulnerability to emerging infections was dramatically demonstrated in 1993. In that year alone, we witnessed the largest waterborne disease outbreak ever recognized in this country. The source was an urban municipal water supply contaminated with a *Cryptosporidium* sp.—an intestinal parasite that causes prolonged diarrheal illness in the immunocompetent and severe, often life-threatening, disease in the immunosuppressed. Also in 1993 the emerging bacterial pathogen *Escherichia coli* O157:H7 caused a multistate food-borne outbreak of hemorrhagic colitis and hemolytic uremic syndrome (HUS) with at least four HUS-associated deaths in infected children. Finally, a previously unknown hantavirus was identified as the etiologic agent of hantavirus pulmonary syndrome. This infection, which was linked to exposure to infected rodents, has primarily affected otherwise healthy young adults—mortality approaches 60%.



Satcher

Moreover, in recent years our antimicrobial drugs have become less effective against many infectious agents, and experts in infectious diseases are concerned about the possibility of a "postantibiotic era." In our communities, drug-resistant pneumococci are being recognized with increasing frequency and threaten our ability to adequately treat middle ear infections in children and community-acquired pneumonia in adults. In our hospitals, vancomycin-resistant enterococci have emerged, and concerns are increasing that the same resistance patterns may evolve in staphylococci.

Three recent reports by the Institute of Medicine document the urgent need to end years of complacency toward infectious diseases and to begin immediately with enhanced vigilance to address emerging infectious disease threats. To meet this urgent need, we must improve public health infrastructure at the local, state, and federal levels and adjust public health policy to foster a well-coordinated and systematic approach among clinical and public health professionals to prevent and control new and resurgent infectious diseases. Further, we must recognize that the health of the American people is inextricably linked to the health of people in other nations, infectious diseases can and do spread rapidly around the

globe, and global surveillance for emerging infections is vital to public health.

In partnership with local and state public health officials, other federal agencies, medical and public health professional associations, infectious disease experts from academia and clinical practice, and international and public service organizations, CDC has developed a plan that will help direct our efforts to safeguard this nation from the threat of emerging infectious diseases. This plan, "Addressing Emerging Infectious Disease Threats: A Prevention Strategy for the United States," is summarized elsewhere in this issue of *ASM News*.

The President's Health Security Act of 1993 addresses the need for universal health-care coverage as well as the need to enhance community-based public health strategies. As we proceed with health-care reform, priority must be given to strengthening partnerships among health-care providers, microbiologists, and public health professionals to detect and control emerging infectious diseases. As the nation's prevention agency, CDC looks forward to working with its many partners to address the challenges of emerging infectious disease threats.

David Satcher

New or emerging infectious diseases have had an extraordinary impact on society throughout history. In the Middle Ages, plague killed a quarter of Europe's population in 4 years. In this century, the influenza pandemic of 1918 claimed millions of lives worldwide. In the past two decades alone, we have seen the emergence of Legionnaires' disease, toxic shock syndrome, Lyme disease, Ebola fever, and human immunodeficiency virus-related disease, among others. Most recently we have witnessed the emergence of a hantavirus in the United States. Other infectious organisms, such as those that cause tuberculosis, malaria, and common bacterial infections, have developed drug re-

sistance, often making treatment difficult or impossible.

Factors such as rapid air travel between remote tropical areas and crowded commercial centers, increased mobility of formerly isolated populations, human settlement in formerly uninhabited tropical areas, changes in human behavior, and wars or natural disasters that disrupt diet and sanitation all increase opportunities for infectious diseases to spread more quickly—and to more individuals—than ever before. Clearly the threat from new or emerging microbes is real and potentially catastrophic.

A problem that is inherent in the establishment of a meaningful

commitment to resources for the support of basic biomedical research as a critical tool in our never-ending struggle



Fauci

against emerging infectious diseases is the difficulty in convincing the general public and their elected representatives that the threat is real. Our task is made more difficult because polio, typhoid fever, and diphtheria, among others—once major killers in this country—are now rare. Much of the general public assumes that infectious diseases are largely relics of the past. Furthermore, when we are immersed in public health crises that already exist, it is not easy to garner support for a future public health threat.

There are two main scientific, complementary approaches to the problem of identifying and responding to new and emerging microbes: surveillance and basic research. One example of surveillance would be sentinel outposts that examine serologies and evolving patterns of disease at the perimeter of tropical rain forests.

Basic biomedical research, the specific mission of the National

Institutes of Health (NIH), is the mainstay of the approach of the National Institute of Allergy and Infectious Diseases (NIAID) to emerging infectious diseases. There is no better argument for the continued support of basic biomedical research than the threat of new or emerging infectious diseases. The revolution in molecular biology spawned largely by basic research supported by NIH, the work on animal viruses such as the murine retroviruses, and the decades of research on the regulation of the immune system—among so many other endeavors—enabled the biomedical research community to be well positioned to meet the scientific challenges of the AIDS epidemic. Ongoing basic biomedical research prepares us to battle new or emerging microbes through improved diagnostic techniques, advanced molecular virology, better vaccine development, better adjuvants for vaccines, faster and more precise serological tests, improved monoclonal antibodies, and better ways to clone, sequence, and study viruses. Our ability as a nation to defend ourselves against new or emerging microbes is very closely related to the state of our basic biomedical research.

Infectious disease challenges of the future cannot be met without unwavering commitment to basic biomedical research. As part of this commitment, one goal of NIAID is to develop a research and training infrastructure aimed at building a critical mass of investigators with expertise in infectious diseases, field research, medical entomology, and epidemiology, as well as a scientific support structure capable of responding expeditiously to infectious disease emergencies.

Anthony S. Fauci

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Chapter 17

RESEARCH NEEDS FOR MINORITY POPULATIONS

DAVID SATCHER

Meharry Medical College, Nashville, TN

The intent of this paper is to address several questions regarding the research needs of minority populations. These questions include the definition of research, the need for minority involvement in research, the barriers to research by minorities and the specific areas of research needs for minorities today. There is a need for research on minority populations as well as minority professionals becoming more actively involved as researchers. Despite the intense desire of minorities for intervention relative to societal problems affecting us, without the appropriate attention to research study and activity solutions to the current problem will not be forthcoming.

BACKGROUND DISCUSSION

Because there are various definitions of research, a statement regarding what is meant by the term *research* is indicated. *Research* according to the author, is best defined as the process of searching for a specific answer to a specific question in a systematically organized, objective and reliable manner.

There are many kinds of research and many ways of approaching the answers to questions or the solutions to problems. One such approach is defined as *descriptive* which generally means that no manipulation of a sample of population is involved. In *descriptive* research, the investigator is content to thoroughly observe and describe the parameters of the prospective sample or population. This can be very valuable research and is often a prerequisite to other kinds of discrimination (Payton, 1979).

Another type of research is *analytical*. Here one starts with *descriptive* research but goes further with the sample or population and attempts to show relationships and/or associations of one factor to another. It is one thing, for example, to describe the percentage of people in a population who have high blood pressure and to define their age, sex and race, but it is another thing to show that if one is Black, the risk of having hypertension is significantly increased over one who is White. This demonstrates the move from *descriptive* research to *analytical* or correlational research.

Another kind of research is referred to as *experimental*. This, of course, includes both *descriptive* and *analytical* research. Here one attempts to intervene to impact upon the subjects under study and to show analytically that this inter-

vention does or does not influence the population under study in a specified way. Continuing with the example of hypertension, if a group of high-school students were divided into two equally matched groups and one group placed on a 5-gram sodium diet and the other group placed on a 10-gram sodium diet, then both groups followed over a period of years to assess the rate at which they developed high blood pressure, and these rates were compared, an experimental study would have occurred. Sometimes such studies occur naturally and information is gained without outside intervention.

Another way to classify research is by its purpose, and this is called by some people *levels of research*. The acquisition of knowledge for the sake of knowledge describes *basic research* or *pure research*. At the other extreme, applied research is concerned with the solution of immediate problems without regard for the basic reason or mechanism. Obviously, most research falls somewhere between these two extremes of *basic* and *applied* (Payton, 1979).

The author's career as a researcher began as a student in college working with a professor studying the effects of certain chemicals on the development of the notocord in the tadpole. At that time, no idea or concern for the application of this particular study was discussed. Later, as a candidate for the Ph.D. degree, the effects of X-radiation and I-131 on the chromosomes of small lymphocytes were studied. Again, the primary purpose was to observe the impact of X-radiation and I-131 upon the chromosomes of human or hamster lymphocytes (Satcher, 1970).

However, the author subsequently engaged in research that had almost an immediate application to patient care. For example, as the director of a sickle-cell research center in Los Angeles, California for 5 years, a major project involving the early diagnosis of sickle-cell disease was conducted. The outcome of this research had immediate implications for the diagnosis of patients with sickle-cell disease and the appropriate intervention (Satcher & Pope, 1978). Also, different approaches to the diagnosis and treatment of hypertension, including community outreach programs of education and health promotion were studied (Satcher & Ashley, 1974). Finally, a research project designed with the community as a laboratory to assess the Watts' community needs and expectations for a primary care center was conducted. Based on the results of this research, a residency program in family medicine and the family practice model unit were established in the middle of Watts. Today, this facility is still being utilized.

for the care of individuals and families and, for the training of residents (Satcher, Fink, & Kosecoff, 1980). At all of these different levels, from the notogord of the tadpole to the chromosomes of small lymphocytes to the door-to-door assessments of the needs of families in Watts, the projects have in common a question in search of an answer and a systematically organized objective approach with measures of validity and reliability that allow for the interpretation and utilization of the data.

THE NEED FOR MINORITY INVOLVEMENT IN RESEARCH

Several reasons are suggested as indications of the need for more minority involvement in research. First, minorities need to develop skills and capabilities for defining and answering questions reliably and objectively. Failure to develop such skills is both a lack of self-actualization and development. It also limits one's ability to contribute significantly to answering questions and solving problems in the world around him.

Second, there is a need for questions to be posed for research by minorities. A direct relationship exists between the questions that are selected as the subject of research and the background experience and needs of the researcher. Without the involvement of minorities in research, many important questions relating to the health and the securities of minorities will go unanswered.

Third, minorities need to be involved in research to improve the quality and objectivity of research. Objectivity in research is enhanced when it is spread among various groups with different perspectives. Subjectivity in the interpretation of data often stems from the limited perspective of the investigator. The community of researchers ideally should be an integrated one to assure the most objective approach to both the definition of questions and the approach to problems.

Fourth, minorities need research that is geared toward solving the unique problems of minorities. Although there are many ways to describe these problems, this paper approaches them from the health care and health professional education perspective.

As former Secretary Margaret Heckler of the Department of Health and Human Services emphasized in her introduction to the *Report of the Secretary's Task Force on Black and Minority Health* (Heckler, 1985), there continues to be a significant gap in the health status of Whites and nonWhites in this country. Among other things, she pointed to the significant gap in life expectancy which is 5-7 years greater for Whites as than for nonWhites in this country today. She also pointed out that each year there are 60,000 excess deaths among Blacks. Excess deaths are defined as deaths that would not occur if Blacks had the same age-adjusted death rates as Whites in this country. One of the areas where this gap in health status is reflected is infant mortality where the rate continues to be twice as great for Blacks as for Whites. It is also seen in the prevalence of hypertension that is approximately twice as great among Blacks as among Whites. The mortality rate from cancer of all kinds is 20-25% higher in Blacks than in Whites. These differences in the mortality

rates of various diseases are related to several factors that can be seen clearly in diseases such as hypertension in Blacks leading to strokes and heart failure. They are related to environmental factors, specifically socioeconomic differences in which Blacks tend to be poorer than Whites in this country. Certainly, a combination of genetic and environmental factors is critical to our understanding the difference in health status of Blacks and Whites.

Minorities also need to be involved in research in order to safeguard against bias and prejudice in the arena of research. Perhaps, the best example of the necessity of academic honesty in research was illustrated in the great debate relative to the role of heredity as a basis for differences in intelligence quota (IQ) tests. In the early 1970s there was widespread debate about differences in IQs between Blacks and Whites and the role of heredity (Jensen, 1968). It was claimed that the data existed to support those assertions in a series of articles in the *Harvard-Educational Review* magazine. Thorough review of these articles revealed that the data did not, in fact, support those conclusions (Golden & Bridger, 1969). This suggests that the background of the investigator can often influence the interpretation of data. Clearly, there is a need for minorities to be involved in all types of research at every level.

Another example is the issue of recombinant DNA research and the fear that it created a significant risk for racial genocide. This debate goes back to the middle 1970s when many people were concerned that recombinant DNA research in the hands of the wrong people could reap great harm upon society, particularly those in positions of dependency (Anderson & Fletcher, 1980). The National Institutes of Health responded to this concern by attempting to assure that a significant number of minorities were placed on decision-making committees related to requests for research funds in order to assure proper monitoring of such research.

BARRIERS TO RESEARCH BY MINORITIES

Since it is clear that there is a need for both minority involvement in research and minority-oriented research, it is important to examine the present plight of minority researchers and to identify barriers that exist. There are both internal and external barriers which must be eliminated. Perhaps, the first and foremost internal barrier is that of low expectations. Too few minorities view themselves as being in a position to contribute to new knowledge as opposed to just reading and interpreting it. To a great extent, these attitudes can be influenced negatively or positively by the educational system. The second internal barrier is the lack of necessary discipline. The amount of discipline required to engage a basic research project is often quite great and requires significant patience. The magnitude of problems involved with such research coupled with the desire to become involved in applied solutions to problems represents a major challenge for minorities especially, but ultimately, for all investigators. The desire to implement solutions must be tempered with patience to answer basic questions.

There are also external barriers to minority involvement in

research. One of these barriers is the lack of appropriate relationships. The development of research skills and competence requires a relationship between students and teachers in which the teacher is willing to devote significant time and energy to the training and guidance of the developing research student. Such relationships are critical in order for young people to develop the skills and involvement in research at an appropriate time in their career development. Recognizing this problem, the National Institutes of Health has instituted several programs geared toward the development of these kinds of productive relationships. One such program is the Minority Biomedical Research Science (MBRS) program which is located at several institutions serving significant numbers of minority students. Another program, the Minority Access to Research Careers (MARC) is also an attempt to deal with this barrier.

Another external barrier is the lack of human and fiscal resources. Certainly, the single most important resource for research among minorities is trained personnel. Yet today in this country less than 2% of Ph.Ds in the basic biomedical sciences are awarded to Blacks (*Chronicle of Higher Education*, 1984). This constitutes a significant barrier, considering that almost 12% of the population is Black. Today, minority health professional schools and similar institutions in this country struggle to prepare more graduates for careers in research at various levels. Also under resources we must include access to funding. For example, The Association of Minority Health Professions Schools (AMHPS) has expressed a concern with regard to the 1982 study of funding by the National Institutes of Health, which revealed that less than one percent of the budget of NIH was awarded to all 103 historically Black colleges and universities combined. This is less than individual NIH grants to several institutions such as Johns Hopkins University and Harvard University (NIH, 1982). If these research barriers related to training, attitude and resources are to be eliminated, the efforts of many people must be involved.

SPECIFIC AREAS OF RESEARCH NEEDS FOR MINORITIES TODAY

Many areas of research needs exist relative to minorities today. For example, in the area of basic biomedical or basic biological research, genetic intervention is one that must involve minorities. The transformation and transfer of genes might well constitute the solution to problems such as sickle-cell disease within the next 5 to 10 years. Without the active involvement of minorities, this kind of research will continue to constitute an unnecessary threat. In the future there will be many other examples that will require minority involvement in basic biomedical research including a diagnosis and treatment of diseases such as Acquired Immune Deficiency Syndrome (AIDS).

In the area of clinical research there are many great needs in minority populations. The role of compliance in control of hypertension in Blacks and others is an area that will continue to need quality research. Additionally, the need for research in early diagnosis and treatment of various cancers in minorities is critical today if the increasing mortality rate from can-

cer of the lungs and other areas is to be stemmed (White et al., 1981).

There is, for example, the concern with the diagnosis of hearing-impairment and related problems in Blacks as compared to others. For many years, it was felt that the prevalence of deafness in Blacks was lower than in the rest of the population, but more recent data suggest that there might be a greater prevalence of deafness in Blacks that is sometimes associated with mental retardation. This association of deafness in mental retardation seems related to the fact that deafness in Blacks is more likely to be acquired deafness, associated with infections such as meningitis or with premature births. These same associations may well account for the increased prevalence of cognitive deficiencies associated with deafness in Blacks (Moore & Oden, 1977). This is obviously an area of many questions and problems that will require research for resolutions.

In the area of behavioral research, recent studies show that the problem of stuttering differs characteristically in Blacks as compared to others (Leith & Mims, 1975). These differences are believed to be deeply rooted in the sociological backgrounds of these two different populations. That factor alone is interesting, but of more interest is the implication that these different types of stuttering problems require different approaches to treatment in Blacks as compared to Whites. This represents an area of significant research in order to facilitate appropriate intervention.

Finally, there is an astounding need in the area of applied social research. For example, intervention is necessary to stem the tide of homicide in Black males. Intervention is essential for impact on the Black unemployment and teenage pregnancy problem (Gibbs, 1984). To adequately cope with the mortality rates from cancer, programs must be developed for health promotion and disease prevention that are effective among Blacks (Leffall, 1981). It is not certain that all necessary information on etiology and intervention is available. For example, what approaches to smoking cessation are most successful, and, how do they relate to age, sex, and socioeconomic status? What is the relationship between hypertension and social class, including the profession of parents? How should these factors influence an effort to reduce the prevalence of hypertension in Blacks? There is no end to the questions and problems regarding the health status of Blacks when compared to others in this country.

Certainly among native Americans, Hispanics, and others the same challenges abound. The absence of a data base for hypertension and other illnesses in native Americans is a continuing question. In all of these areas, the need for research among minorities and by minorities is critical. We must move to impact upon the existing barriers to progress in all areas of research by and involving minorities.

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GUEST EDITORIAL

THE CDC AND THE NMA PARTNERSHIPS TO CONTROL TOBACCO IN THE AFRICAN-AMERICAN COMMUNITY

David Satcher, MD, PhD, and Robert G. Robinson, MSW, DrPH

In less than a year, the National Medical Association (NMA) will celebrate its centennial anniversary, marking 100 years of professional service to the American people. This organization of African-American and other racial and ethnic physicians, and their families, has been a beacon of professional leadership for its members since 1895. Through its *Journal*, the NMA offers unwavering guidance in the application of medical science to promote and improve the health of America's African-American population. The legacy on which pioneering leaders founded the NMA almost 100 years ago is one in which its membership and the entire country can take extreme satisfaction. Yet, as we prepare for the turn of the century, we continue to encounter unacceptable disparities in the health of our most vulnerable populations. African Americans and other communities of color are disproportionately at risk with respect to health and social well being. It is incumbent on representative bodies such as the NMA to continue to help close the health-care gap. It is also critical that federal agencies such as the Centers for Disease Control and Prevention (CDC) form partnerships and assist in this mission.

Today, we are on the threshold of many new and exciting ventures in the area of public health, many of which target preventive aspects of health care. These public health ventures are especially critical for African Americans and others who suffer disproportionately from preventable disease, disability, and death. For too long, we have focused on disease, giving more attention

to treating and curing disease than to preventing poor health. Moreover, too many Americans are complacent about the risk factors that contribute to disease. In the case of the number one preventive risk factor—tobacco—this complacency is compounded by the addictive nature of the substance.

In July 1993, I assumed the directorship of two strategic agencies in the fight against disease—the CDC and the Agency for Toxic Substances Disease Registry. Both of these mission-driven agencies are committed to preventing disease. I have established five priorities that will help ensure our commitment to achieve this goal of prevention:

- continued support of state and local health departments,
- developing, maintaining, and improving capacity to respond to urgent threats to health,
- creating a nationwide prevention network and program,
- promoting women's health issues, and
- using cross-cutting approaches to developing new partnerships.

Each of these initiatives has overriding significance for the number one preventable cause of death in America today: tobacco use. The Surgeon General has called tobacco—which causes more than 400 000 deaths annually—the nation's most serious public health threat.¹

Unfortunately, disproportionate rates of the disease and death caused by tobacco use occur in the African-American community, which has the highest rates of tobacco-related cardiovascular and cancer incidence, rates that translate into approximately 45 000 annual tobacco-related deaths.² From 1950 through 1990, the rate of increase in lung cancer mortality was

From the Centers for Disease Control and Prevention. Requests for reprints should be addressed to Robert G. Robinson, MSW, DrPH, CDC, Office on Smoking and Health, 4770 Buford Hwy, NE, Atlanta, GA 30341.

higher for African-American men than for white men. Indeed, lung cancer mortality for African-American men increased nearly sevenfold during this period. Lung cancer mortality for African-American men surpassed that for white men in 1963 and was directly attributable to greater increases in smoking rates for African-American men than those increases for white men. Disturbingly, among African-American women, lung cancer surpassed breast cancer as the leading cancer-related cause of death in 1990.³

Currently, an estimated 46 million adult Americans smoke cigarettes, of which about 6 million are African Americans.⁴ The good news is that smoking rates among African-American youth are significantly lower than smoking rates among white youth. African-American youth, aged 12 to 17 years, have a prevalence of 3.2% compared with 11.6% for white youth⁵; moreover, only 4.4% of African-American high school seniors smoke, but 22.9% of their white counterparts smoke (Institute for Social Research, University of Michigan. Unpublished data. 1993).

Yet, the situation for adults, particularly African-American men, remains critical. Between 1990 and 1991, after two decades of decline, smoking prevalence among African Americans actually increased from 26% to 29% (CDC. Unpublished data. 1994). This increase is unconscionable and unacceptable. With the availability of such a vast body of scientific evidence attesting to the risks associated with smoking, how can we explain an increase in prevalence? One can point to a variety of explanations, not the least of which is the insidious advertising and promotional campaigns targeting African-American and other vulnerable communities, the difficulties faced by African-American smokers who wish to quit, and the effective penetration of the African-American community by the tobacco industry resulting from industry support of community-based programs, organizations, and elected officials.⁶

In 1991, the tobacco industry spent more than \$4.6 billion advertising tobacco products, making tobacco one of the most heavily advertised products in America.⁷ Significant expenditures find their way into the African-American community, through either billboard and print advertising or promotional campaigns. The latter is especially revealing because the tobacco industry has engaged in a dramatic shift in advertising expenditures from traditional mass media advertising that is required by law to carry rotational health warning labels, to nonmedia advertising and promotion that in some cases do not require federally mandated health warnings. Such promotional expenditures represented

more than three out of every four advertising dollars spent by the cigarette industry in 1991.⁷ In addition, there are four to five times more billboards in African-American communities than in white communities, and the majority of these contain tobacco- and alcohol-related images.⁸ The tobacco industry states that smoking is a matter of free choice. However, when communities are inundated with images over which they have no control, this is hardly a matter of free choice.

Research shows that African Americans are highly motivated to quit smoking, they make more serious attempts to quit than white smokers, and they are strongly concerned about the social and health consequences of smoking.⁹ Why then are African-American adults still smoking in such large numbers?

One reason may be related to the fact that physicians are less likely to counsel African Americans than white smokers to quit smoking. Reports from national surveys indicate that 34.4% of adult African-American smokers—compared with 38.2% of white smokers—who visited a physician or other health-care professional in the previous year received advice to quit.¹⁰ The importance of physician advice to clients has been an established fact for some time, particularly if more than brief counseling is involved.¹¹ Relatedly, multiple studies have shown that a brief intervention by health-care providers during routine office visits coupled with an office system that promotes cessation advice can result in chemically validated 1-year cessation rates of up to 15% of all smokers in the practice.¹² However, research also indicates that culturally relevant counseling protocols may be needed for the African-American smoker. African-American smokers who quit are significantly more likely to relapse than their white counterparts.⁹

The tobacco industry's support of the African-American community has been strategic and deliberate. This fact is especially evident by the high numbers of African Americans who work in tobacco-related industries. African-American tobacco farmers, for example, have been a significant proportion of this segment of the working force, even though in recent decades their decline has been disproportionately higher than the decline in white tobacco growers. African Americans also have had significant representation in tobacco industry blue- and white-collar jobs, particularly in managerial positions. Indeed, the tobacco industry's record in employing African-Americans is considerably more positive compared with other business sectors.⁶

Similarly, the tobacco industry has provided finan-

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cial support to an array of community interests, including sponsoring educational and cultural events, supporting elected officials, and funding multiple civic and social organizations. Such support has provided inroads for higher levels of tobacco advertising, particularly of brands high in tar and nicotine, in African-American media and communities. In addition, community leaders have been silent regarding the harmful effects of tobacco use, a silence that has only begun to be broken over the past 5 years. Thus, the tobacco industry has encouraged African-American communities with dollars for their silence, while targeting them with cigarette brands that contain the most lethal doses of addiction and death.⁶

The importance of community leader involvement in countering this influence was evidenced in Philadelphia in 1990.⁶ African Americans were instrumental in organizing one of the most successful coalitions in history to force the removal of a new cigarette (Uptown) developed especially for them. The Philadelphia-based Coalition Against Uptown cigarettes succeeded in getting the R.J. Reynolds Company to remove a high-tar, high-nicotine menthol cigarette from the market. This campaign proved the epitome of successful community organization. A combination of African-American-led tobacco control activism; media advocacy about tobacco-related health problems called on all members of an ethnic community to take control of which products are allowed entry into their community; and the coordinated efforts of diverse agencies encompassing health, research, church, and civic interests forced R.J. Reynolds to remove this cigarette from production. Other communities also have rallied around the elimination of tobacco marketing. Detroit and Baltimore are both noted for their efforts to restrict cigarette advertising on billboards.

The CDC currently is supporting several initiatives to improve the capacity of African-American physicians and leaders to promote tobacco prevention and control and to become advocates for decreased dependency on the tobacco industry. The Association of Schools of Public Health is developing physician-based protocols for smoking cessation intervention among African-American clients that use the *Pathways to Freedom* program. Similar initiatives are planned for the Hispanic community. The CDC is collaborating with the American Lung Association in its work with African-American Clergy and the American Cancer Society in its initiative to disseminate the *Pathways to Freedom* program in 15 states. Support also is being provided to African-American, Native-American, Hispanic, and

Asian tobacco control advocates to assess their respective communities' infrastructure related to tobacco control and to report the results of their assessments at the next World Conference on Tobacco and Health. Legends, a 1993 public service campaign targeting the African-American community, was developed and implemented by the CDC's Office on Smoking and Health, with the active partnership of the NMA. The next Surgeon General's Report on tobacco and health will focus on the implications of tobacco use among communities of color. The CDC, in funding 33 states to build their capacity in tobacco control, strongly emphasizes the need for diversity and for including traditionally underrepresented communities in tobacco control coalitions. Finally, the CDC is hoping to support an initiative that will target national organizations whose primary constituencies are communities of color, youth, women, and blue-collar or agricultural workers to broaden the base of the tobacco control movement and strengthen the forces of those committed to a tobacco-free society.

As a public health agency, however, the CDC cannot operate in a vacuum. All of these issues are interrelated to the community and its leaders and their capacity to identify and mobilize around issues that affect the well being of the community. The NMA is ideally situated to provide significant tobacco control leadership for the African-American community and strengthen its partnership with CDC. This partnership can help remove the barriers to counseling clients about the deleterious health effects of tobacco use and provide quit-smoking advice. Most important, the NMA can call on African-American leaders and organizations to develop a strategy to free themselves from dependency on the tobacco industry.

The challenges to the CDC and the NMA are immense. More research on tobacco use among youth and communities of color will bolster our understanding. More progress to control the ability of vendors to sell cigarettes illegally to youth will help deter smoking. Increased tobacco excise taxes, a critical element to support health-care reform, will result in more attempts by adults to quit smoking. We must be ready to help the smoker succeed.

In addition, policy initiatives of particular relevance to the African-American community need development and support. Such initiatives include regulating tobacco advertising and promotion and developing strategies to help replace financial support from the tobacco industry for community-based programs. The most positive trend is that communities of color continue to mobilize

to increase their voice and capacity for acting to promote and protect the health of their citizens. As a proven leader in health-care reform and health promotion, the NMA can play a key role in intensifying these efforts. We are a long way from achieving a smoke-free society, but through partnerships our journey is made easier.

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Black-White Differences in Mortality in Idiopathic Dilated Cardiomyopathy: The Washington, DC Dilated Cardiomyopathy Study

Steven S. Coughlin, PhD, John S. Gottdiener, MD, Kenneth L. Baughman, MD, Alan Wasserman, MD, Eric S. Marx, MTS, Mariella C. Tefft, RN, MS, and Bernard J. Gersh, MB, ChB, DPhil

Poorer survival among blacks may be caused by a greater severity of disease at the time of diagnosis or by racial differences in cardiac care, comorbid conditions, or biologic factors affecting survival.

Comparison of Employees' White Blood Cell Counts in a Petrochemical Plant by Worksite and Race

Cora L.E. Christian, MD, MPH, Bonnie Werley, RN, MS, Angela Smith, RN, Nerissa Chin, RN, and Dan Garde

The results confirmed a substantial difference in white blood cell counts between blacks and whites but no significant difference between Quality Control Lab employees, plant employees, or the general US male population.

The Relationship Between Violent Trauma and Nonemployment in Washington, DC

Arthur H. Yancey, II, MD, MPH, Karen S. Gabel-Hughes, MHA, Sandra Ezell, MD, and David L. Zalkind, PhD

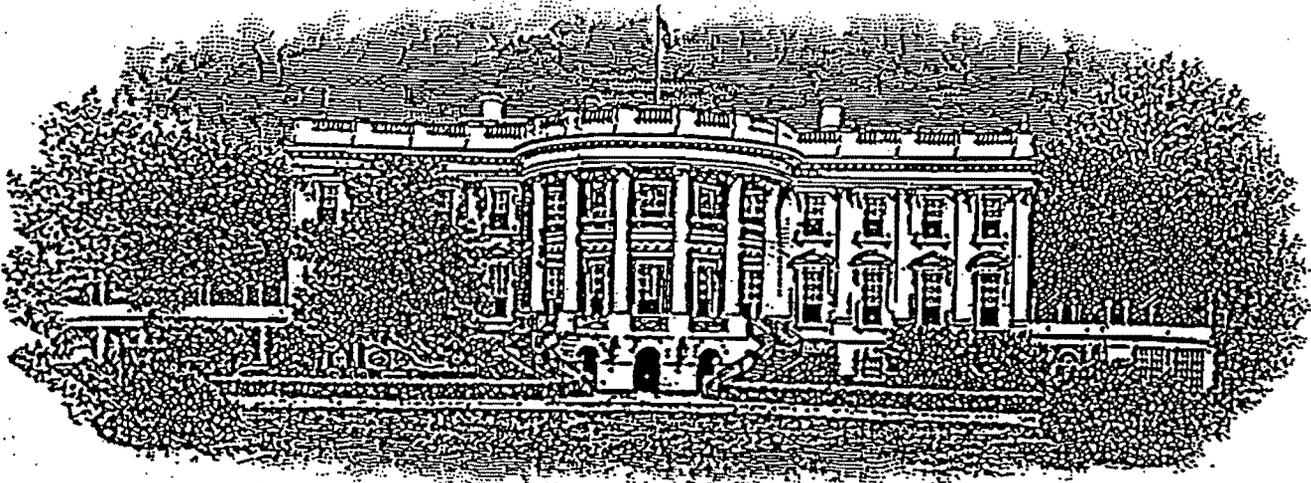
The purpose of this study was to determine the association of violent trauma with nonemployment status of victims, and whether victims' acquaintance with their assailants in violent activity is associated with a higher nonemployment rate than that of victims unfamiliar with assailants.

Common Emergencies in Cancer Medicine: Infectious and Treatment-Related

Charles R. Thomas, Jr, MD, Keith J. Stelzer, MD, PhD, Wui-jin Koh, MD, Lauren V. Wood, MD, and Ritwick Panicker, MD

The use of high-dose cytotoxic agents and the instillation of indwelling central venous catheters have altered the spectrum of infectious etiologies seen in clinical practice. And while most side effects of chemotherapy and radiotherapy are not considered life-threatening emergencies, they can be fatal if not recognized early and treated promptly.

THE WHITE HOUSE



Christopher C. Jennings
Deputy Assistant to the President for Health Policy
216 Old Executive Office Building
Washington, DC 20502
phone: (202) 456-5560
fax: (202) 456-5557

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MEMORANDUM

TO: Peter Erichsen
FR: Chris Jennings
RE: David Satcher articles
DATE: Tuesday, May 14, 1997

The articles that I have starred are the publications I think we should review, as we discussed. The articles that are checked have been successfully located. Any help you can give us with articles that are circled would be greatly appreciated. We will get back to you on any articles in which we believe has potential problems. Or on any articles we subsequently review (after we receive from you) that raises similar concerns.

Satcher Publication List

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- Satcher, D. "50 Years of History Guide CDC's Future" - U.S. Medicine, Vol. 33(1-2), pp. 20-21, January 1997.
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* Satcher, D. "An Assessment of Knowledge and Attitudes in the Black Community: Prenatal Diagnosis." In Proceedings of the National Conference on Prenatal Diagnosis, Los Angeles, California, 1979.

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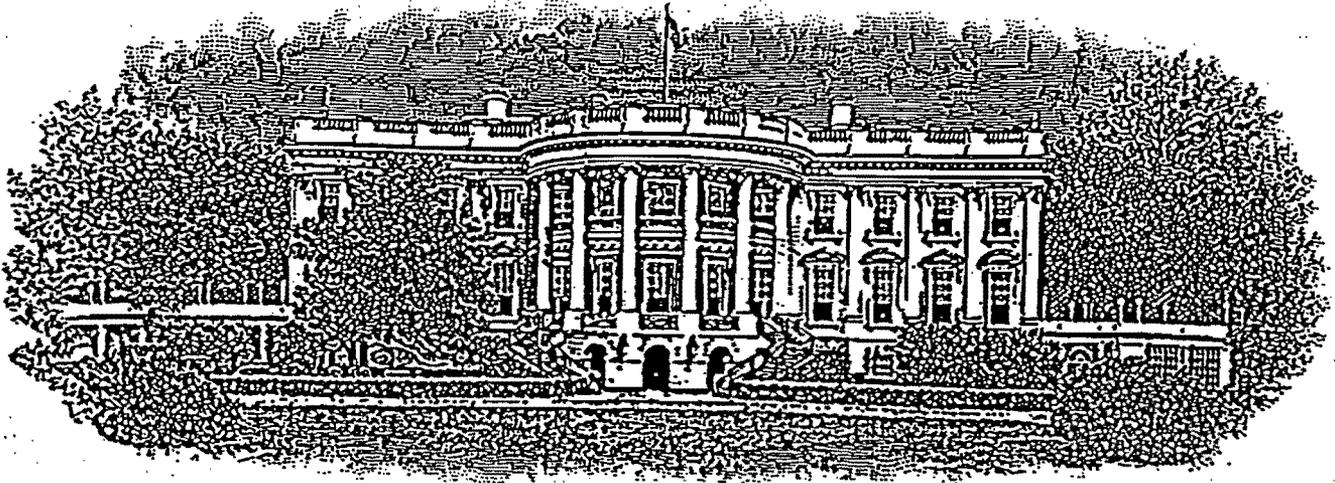
2/13/97

MEMORANDUM

TO: Peter Erichsen
FR: Chris Jennings
RE: David Satcher articles
DATE: Tuesday, May 14, 1997

The articles that I have starred are the publications I think we should review, as we discussed. The articles that are checked have been successfully located. Any help you can give us with articles that are circled would be greatly appreciated. We will get back to you on any articles in which we believe has potential problems. Or on any articles we subsequently review (after we receive from you) that raises similar concerns.

THE WHITE HOUSE



Christopher C. Jennings
Deputy Assistant to the President for Health Policy
216 Old Executive Office Building
Washington, DC 20502
phone: (202) 456-5560
fax: (202) 456-5557

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Comments: Thanks for your help. Please call
me with any questions - Sarah Brandi

456-5585

57000 Karen Kaufmann

Satcher Publication List

David

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PUBLICATIONS

- ✓ Satcher, D. "50 Years of History Guide CDC's Future" - U.S. Medicine, Vol. 33(1-2), pp. 20-21, January 1997.
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- ✓ Satcher, D. "Remarks on Prevention" International Society on Hypertension in Blacks (ISHIB) - Fall 1996 Newsletter.
- ✓ Satcher, D. "Glimpses Into the 21st Century" U.S. Medicine - August 1996. NEOB
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✓ Satcher, D., "Protecting the Next Generation: Prevention for the Poor," Proceedings of the 30th Annual Meeting of the Society of Prospective Medicine, Atlanta, Georgia, March 17-19, 1994. Society of Prospective Medicine, Publishers, Indianapolis, IN.

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