

A MINOR REDUCTION IN THE NUMBER OF CARDIOLOGISTS WILL MEAN A LARGE REDUCTION IN AN ALREADY INSUFFICIENT NUMBER OF AFRICAN-AMERICAN CARDIOLOGISTS

HON. KWEISI MFUME

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Wednesday, July 26, 1995

Mr. MFUME. Mr. Speaker, most authorities now agree that the current number of cardiologists practicing in the United States is more than sufficient to meet the anticipated demand for cardiovascular care.¹ However, even with this surplus, concerns persist with regard to the distribution of cardiologist over various practice roles (e.g., pediatric, clinical, interventional, research, etc.) and patient populations (e.g. identified by race, ethnicity, proximity to an urban center, etc.). The harm in maldistribution over practice roles is easier to identify than the harm in maldistribution over patient populations. Furthermore, the maldistribution itself is easier to quantify and remedy in the former case than in the latter. Yet, just as we appreciate the need to correct the imbalance of cardiologist², we must also recognize that the dearth of doctors in poor communities seriously affect the health status of African-Americans.

In *Adarand v. Pena*, 1995 U.S. Lexis 4037 (1995), the Supreme Court's most recent affirmative action ruling released on June 13, 1995, was a significant setback on the general issue of affirmative action, but it does not pose an insurmountable hurdle for federal programs such as those that would increase the number of Black cardiologists. *Adarand* held that affirmative action programs must meet a standard of "strict scrutiny" and must be "narrowly tailored." The Supreme Court was careful not to suggest that affirmative action programs were unconstitutional. While heightened standard requires more of a direct relationship between the programs administered and previous racial discrimination, the lack of Black cardiologists in the Medical profession and its subsequent impact on African-Americans communities should be sufficient to meet this burden.

African-Americans and the communities in which they live are typically underserved and the need for cardiovascular care greatly exceeds their proportion of the United States population. In fact, African-Americans have one of the highest rates of mortality from cardiovascular disease in the world. Significant intraracial, interracial, and ethnic differences in the incidence and management of cardiovascular disease have been repeatedly demonstrated. For instance, the prevalence of coronary heart disease, while similar for both African-American male and white men, is greater in African-American women than in white women.³ The prevalence, and severity of hypertension is substantially greater in African-Americans than in whites. Yet the causes of these disparities have never been sufficiently explained.

Because cardiovascular disease is the most common cause of death in African-Americans, it is a pressing issue in the African-American community. Although there has recently been

a steep nationwide decline in mortality from coronary heart disease and stroke, little of that much heralded improvement has trickled down to the African-American community. In fact, stroke mortality has increased in African-American men.

While there is a strong public consensus that social status and income are corrected with improved health and longevity, Dr. John Thomas of Meharry Medical College found that the mortality and morbidity of African-American physicians mimic that of high school dropouts. He reports a wide death gap between African-American and white physicians with white physicians living almost 10 years longer than African-American physicians.

Where African-Americans have benefitted from the decline in mortality, they have not done so in sufficient numbers to halt the widening of the gap between African-Americans and whites. If the mortality rate in African-Americans from all causes were reduced to that of white Americans, 60,000 fewer African-Americans would die each year⁴. Cardiovascular disease accounts for more than 40 percent of the excess deaths in African American women and more than 20 percent of the excess deaths in African American men.⁵

Despite their disproportionate demand for health services, African Americans as a group do not receive sufficient cardiovascular care. They make fewer office visits for coronary disease than their white counterparts and are less likely to be seen by cardiovascular disease specialists⁶. Even when cost or insurance coverage is not an issue, African Americans receive fewer interventions than White Americans.

The cardiovascular care that African Americans receive is insufficient for many reasons. African Americans communities tend to be poorer and underserved with regard to all services, medical services included. Perhaps, more importantly, many of the medical professionals who serve in such communities lack a meaningful understanding of the cultural factors which may distinguish their patients from the mainstream. Insight into a patient's routines, traditions, family structure, diet, stresses, and other factors which are largely culturally determined are key to developing a treatment plan that works for that patient. African-American patients may be wary of the medical establishment that has not responded appropriately to their needs. There are still physicians who have separate rooms for African American and White patients. This wariness may make them less likely to make routine nonemergency visits to the doctor, to follow a treatment plan, or to follow up with a specialist. This situation is of special concern in the field of cardiology because so much of cardiovascular health depends on early detection of "silent" signs, such as hypertension. Furthermore, patients with cardiovascular diseases are often called upon to endure the unpleasant or even painful side effects of medication or give up activities they enjoy in order to combat a health problem that is not causing them pain. So much of cardiovascular disease and its treatment seems counterintuitive that it has been the subject of a great deal of misinformation and home remedy. Crisis care of cardiovascular diseases is not a good option.

African American cardiologists are the best hope for allaying many of these insufficiencies. The key reason is that many more African American doctors than other doctors locate

their practices in socio-economically underserved areas⁷. A second reason which should not be overlooked is that African American cardiologists are more likely to have insight into the cultural differences in treating African Americans and are best situated to develop rapport with them. They are better able to instill confidence in their patients and thereby ensure their patients' compliance with treatment plans.

An increase in the number of African American cardiologists will increase their positive effect. African American patients have shown that they will go out of their way to receive care at the hands of African American practitioners, but all too often they do not have the choice. In most American cities with an African American population of at least 5%, patients do not have the option of receiving their care from an African American cardiologist. Consequently, 80% of the cardiovascular care that African Americans receive is provided by practitioners who are not African American.

There are very few African American cardiologists. African Americans make up 11.2% of the U.S. population, but less than 3% of the U.S. physicians. There are approximately 15,000 board-certified cardiologists in the United States,⁸ of whom less than 300 are African-American. A mere 1.5% of cardiologists in training are African-American.

The number of African American subspecialists is low for many of the same reasons that the number of Black professionals is generally low. The main reason is economics. As a group, African Americans have fewer financial resources than whites and so are less likely to have the luxury of pursuing subspecialty training. Their communities' need for their skills and their families' need for their earning power may push them into the work force earlier. By that reasoning, the proposed extension of training requirements from three to four years will weed out African American physicians even further from subspecialty training and Board certification.

Often white males benefit from the assumption that they are honest, competent, and possessed of a work ethic where their African American counterparts do not. Although this imbalance is largely due to an unwillingness on the part of Americans and the media to recognize these attributes where they are displayed by African Americans, there is also unmistakably a crisis in the African American community. Whatever the reason, unacceptable levels of violence, crime, drug abuse, welfare dependence, and other social ills pervade a segment of the African American community. The odor of bad apples tempt a segment of the population to throw up their hands at the whole barrel. African American professionals have paid dearly for this state of affairs. Every member of the Association of Black Cardiologists has a story to tell about the perseverance it took to overcome these presumptions.

A related reason for the low number of African American subspecialists is the self-perpetrating nature of prestige and connections. Only those who have the intangible benefits are in a position to acquire them. African Americans are less likely to have the benefit of role models and mentors to help them develop as black professionals and unlock career opportunities for them. The administrators who make the admissions and hiring decisions along a cardiologist's path to success remain

Footnotes at the end of article.

mostly white, which is perhaps not as important as the fact that they also remain mostly beholden to the status quo. For many of them, there is a network of relatives, family friends, colleagues, fraternity brothers, and club members to be considered for these choice slots before an opening is made available to a minority. Furthermore, even where the old boy network is not abused, many administrators consider it beyond the scope of their task to consider the populations their beneficiaries will serve. They have little reason to seek out or invest in a candidate who is not like them.

Furthermore, there are forces at work to make it more difficult to establish a health care practice. Cutbacks in government health funding and reimbursement levels threaten to destroy vital primary and specialty practices. Moreover, new emphasis on "managed" care is expected to reduce the demand for specialists in cardiology.⁹ As African Americans generally have practices with less than three partners, they are at greater risk under the new efficiency paradigm in health care delivery. In addition, African Americans, having only lately come into the subspecialties in significant numbers, may be more vulnerable to these forces than more established practices.

The number of cardiologists in this country has been determined by factors that have little to do with patient demands, primarily the labor needs of the hospital community. Unlike some areas of the private sector, opportunities for training and a career in a medical specialty are kept artificially finite, as the bands on the electromagnetic spectrum. Medical schools, residency programs, fellowships, hospitals, and medical boards are ordained to dole out ever-scarcer privileges.

The medical community must be free to compensate for the artificial scarcity. In order to ensure that underserved communities get the health care they need, we must bolster and protect the existing practices of primary and specialty care physicians in underserved communities and ensure that the number of African-American physicians continues to grow. We must protect and expand hard-won positions set aside for the medical training and career development of minorities, especially in the subspecialties.

We must be uncompromising in our condemnation in our condemnation of the violent, anti-social, anti-intellectual, or irresponsible forces in the African-American community while supporting the institutions that are working. Just as medicine has moved from crisis management toward prevention as the best approach to public health, we must put our resources into halting the cycles of poverty, crime, and isolation. The best law enforcement policy has always been a sense of community. The best welfare program has always been education. We must target promising African-American students early, motivate them to pursue medicine, and give them financial support and mentoring at every stage of the career path.

We must call on training and hiring institutions to take an active role in shaping the health care community in two key ways: First, to commit to compensating for the artificial barriers to African-Americans' success; second, to commit to "casting a wider net" in seeking out talented African-American. Over 50 percent of cardiology training programs have never admitted an African-American. If the United States to benefit from inclusion, it

must do more than fight discrimination. It must lean against the exclusionary tilt that exists in training program. We must come to see no minority participation in cardiology division as a sign that such an exclusionary tilt is at work and call on those institutions to pursue their commitments with more vigor.

African-American physicians are not supplicants at a rich man's door. Contrary to the beliefs of some, the choice is not between a highly qualified White candidate and a barely qualified African-American candidate. There is an ample cadre of talented African-American physicians yearning to be cardiologists.

While there is no shortage of cardiologists in general, the disproportionate number of Black cardiologists will only be enhanced if programs which increase the number of minority cardiologists are abolished. If the Adarand case is used as fuel to feed fires of negative legislative action, it will re-enforce the stereotypes America needs to eliminate in order to move forward as a nation. A precise reading of Adarand verifies that under certain circumstances, the use of race or ethnicity as a decisional factor can be legally sustained. The extremely high mortality and morbidity rates of African-American more than establish the need for increased Black Cardiologists. Affirmative action programs can assist in reaching this goal.

FOOTNOTES

¹19th Bethesda Conference: Trends in the practice of cardiology: Implications for manpower. *J. Am. Coll. Cardiol.* 1988; 12(3):822-836

²Last year the 25th Bethesda Conference of the American College of Cardiology pronounced that cardiac surgeons are in adequate supply, and that there is even an overabundance of invasive cardiologists. The college recommended that the number of trainees in adult cardiology be decreased. But in the same report, the ACC found that more pediatric cardiologists are needed if the underserved are to be brought into the mainstream of cardiac care. 25th Bethesda Conference: Future personnel needs for cardiovascular health care. *J. Am. Coll. Cardiol.* 1994;24(2):275-328.

³Report of the Secretary's Task Force on Black and Minority Health. Margaret Heckler (secretary): U.S. Dept. of Health and Human Services, 1985.

⁴*Ibid.*

⁵*Ibid.*

⁶*Ibid.*

⁷Council on Graduate Medical Education Third Report. Improving access to health care through physician work force reform; directions for the 21st century. Washington, DC: U.S. Dept. Health and Human Services, October 1992.

⁸In 1992, there were 13,611 board-certified cardiologists in the United States.

⁹25th Bethesda Conference: Future personnel needs for cardiovascular health care. *J. Am. Coll. Cardiol.* 1994; 24 (2): 275-38.

KOREAN WAR VETERANS' MEMORIAL

HON. SAM GEJDENSON

OF CONNECTICUT

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 27, 1995

Mr. GEJDENSON. Mr. Speaker, I rise today in honor of the dedication of the Korean War Veterans' Memorial. The Korean war lasted 3 years, but our memories of those men and women who gave their lives and livelihoods while fighting in Korea will last forever. The Korean War Veterans' Memorial aptly provides this recognition. This tribute to the brave men and women who fought in Korea more than 40 years ago is long overdue, and I am pleased that after nearly a decade of work, the memorial will finally be unveiled today.

The memorial is also a good opportunity to improve citizen awareness of the sacrifices

made, and the service given, by our veterans in defense of our Constitution and the liberties it guarantees. All too often, we take our freedoms for granted. These precious freedoms were defended by those who sacrificed their lives in times of war. They are preserved by those who exercise their rights in defense of peace.

Today, there are more living American veterans than at any point in history. They are among the reasons that the United States is the mightiest, wealthiest, most secure Nation on the Earth today. They are the reason the United States has been, and will continue to be, the bastion of support and solace for those in a world still searching for freedom and human rights.

As a Member of Congress, I am pleased to be in a position to honor our veterans. They willingly went to war to defend our freedoms and the American dream we all strive to achieve. In this time of restricted budgets and divisive rhetoric, we must pause to recall the commitment given to use by those veterans and we must honor the commitments we have made to them.

TRIBUTE TO MAJ. GEN. JOE M. BALLARD

HON. IKE SKELTON

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 27, 1995

Mr. SKELTON. Mr. Speaker, today I pay tribute to, an outstanding Army officer: Maj. Gen. Joe M. Ballard. Major General Ballard most recently distinguished himself through exceptionally meritorious service, as commander, U.S. Army Engineer Center and Fort Leonard Wood. As a result of his outstanding leadership and keen vision Fort Leonard Wood has been established as an expanding TRADOC center for excellence. He masterfully employed information-age technology, concepts and doctrine to launch the engineer regiment toward Force XXI, thereby posturing the Engineer Center to lead the Army into the 21st century.

General Ballard established Fort Leonard Wood as a force projection platform by exceeding Army and FORSCOM readiness goals within Fort Leonard Wood's tactical units and deploying combat-ready units to Haiti, Cuba, Korea, Honduras, and Panama for operations other than war.

During a period of rapidly changing force structures and declining resources, General Ballard built Fort Leonard Wood into the model of fiscal stewardship, establishing a "Total Quality" standard for TRADOC installations. Indicative of General Ballard's pursuit of excellence, Fort Leonard Wood was selected as TRADOC's "best large installation" during the 1994 "Army Communities of Excellence" competition. The resounding success of his "U-DO-IT" self-help dormitory modernization project drew such widespread praise that it was featured in Soldier magazine, the NCO Journal, and Army Times. He also saved \$1.6 million per year by converting the directorate of logistics from contract to in-house operation.

When faced with a \$10 million budget reduction in fiscal year 1995, General Ballard took the lead among TRADOC installation