lion at the last count, and 68 million in a decade, if my peers and I do nothing. The numbers are, to put it simply, unimaginable. And our silence has unfortunately been deafening. Meanwhile, today, millions of orphans roam the streets of African cities, abused and robbed of all hope.

I ask a universal physician query: what's my responsibility? Is a sick Africa my concern? My friend is a practical sort of man, given to action and less to abstract quandaries. He insists that we have a responsibility to the sick of the world, and Africa. And as long as we serve a greater good—greater than good incomes, good standard of living, and a great country—and as long as we aspire to the Hippocratic principles, we must think and act as if the world's ill are our patients also. To "above all, do no harm," doesn't translate to doing nothing.

My patient believes in personal advocacy and sacrifice, and shaming one's neighbor into action. He believes America, blessed with so much, can afford to share its largesse with the poor of Africa, who have nothing, and who expect nothing but death. He thinks the billions we recently lost in our markets would have been best used to buy cheaper antiretroviral drugs, to educate African masses and take care of AIDS orphans, so that tomorrow's Africa can have a semblance of a future.

It's too easy to pretend that the problem is too great and difficult for a single person to tackle. My friend, sick as he is, reminds me that the mere act of talking about poverty and AIDS is a first step. He reminds me that Mother Theresa, and Mahatma Gandhi before her, were individuals who moved oceans and continents.

"Y'all doctors can do a lot, alone and as a group to take care of Africa," he says. And I believe him. Now I have to convince all of my friends and my government to act.

Pius K. Kamau, MD
Attending Thoracic Surgeon
Medical Center of Aurora
Aurora, CO
Pkkamau@aol.com

Ethnic Differences in Incidence of Diseases and Response to Medicines

Dear Editor,

I enjoyed reading the recent article by Burroughs et al.[1] Besides the differences in response to medicines, there is also a fundamental ethnic/racial difference in the incidence and manifestations of various diseases and their responses to various therapeutic interventions. Among the examples are:

1. lower incidence of sudden cardiac deaths in arrhythmogenic right ventricular dysplasia in Chinese patients than in the Western population;[2]

2. higher frequency of diastolic than systolic heart failure in Chinese patients;[3]

3. higher incidence of cough in Chinese patients receiving ACE inhibitors for hypertension or heart failure;[4]

4. lower doses of warfarin required for anticoagulation in the Chinese patients;[5,6]

5. lower dose of heparin required during percutaneous coronary interventions in Asians than non-Asians;[7]

6. lower doses of nonsteroidal anti-inflammatory drugs required in Chinese than in Caucasian patients;[6]

7. lower doses of recombinant tissue plasminogen activator in producing infarct-artery patency among the Chinese patients with acute myocardial infarction;[8] and

8. the well-known fact that diuretics and calcium channel blockers are more effective than ß-blockers and ACE inhibitors in treating hypertension in black than the Caucasian patients, as pointed out by Burroughs et al.[1]

These ethnic differences, therefore, should always be taken into consideration in the management of patients with different ethnicity. In addition, because Chinese ethnicity is nowadays found in most parts of the world, such differences may also affect the outcomes of various international trials.[9,10]

Inclusion of various racial/

ethnic groups in clinical trials is a relatively recent area of clinical investigation. Because evolving concepts of efficacy of various cardiovascular drugs and other therapeutic interventions are based principally on results of multicenter studies around the world, it is important to recognize the heterogeneity of the various patient-groups. These differences should always be taken into consideration in order to provide meaningful information for the practicing physicians who deal with an increasingly nonhomogeneous population.[11,12]

Tsung O. Cheng, MD
Professor of Medicine
George Washington University
Medical Center
Washington, DC 20037

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Lack of Access to Good Healthcare & Obese African-American Women

Dear Editor,

I appreciate very much the opportunity to read your journal for the first time. I particularly found the President's Column: Leveling the Health Delivery Field *(J Natl Med Assoc.* 2002;94:1020-1024) of interest.

I founded S.O.S. (surviving our system of) HealthCare Inc. 13 years ago to address lack of access to good healthcare for those who fall through the safety net of our healthcare delivery system. After trying daily to find solutions for those who call, I know there are "vast inequities in the delivery of health services...blatant differences in the provision of healthcare in predominantly white communities versus non-white communities... (African American) more likely to receive the least desirable procedures (amputations, e.g.) and less likely the most sophisticated treatments," as the article notes. I also agree that providers have to "consider our own culpability in contributing to the glaring health disparities." I also strongly agree, "lines need to be redrawn so that patient care is separate and apart from the cost of medicine."

Very well said, Ms.President!

The second article about which I have comment is: An Assessment of Obesity Among African-Americans Women in an Inner City Primary Care Clinic: Obesity is prevalent in low-income African-American females by my observation in my rural southern county. If the truth were known, I suspect that more than 50% of this subpopulation has a higher average weight per height/body build than the norm for the females in American (this study showed 80%!). If this is true, we have identified a new norm regards weight rather than declaring greater than half the population overweight. Because of many causative factors we