

The opinions expressed here are not necessarily the opinions of the National Medical Association.

Changing Mindsets for Changing Times

To the Editor,

I read with great interest the article by Dr. Bussey-Jones and colleagues which described the importance of cultural competence and the need to bridge conventional and alternative therapies¹. Adverse clinical outcomes may occur if physicians are deficient in such knowledge. Their deficiencies may contribute to the devastating ethnic and racial health disparities in this country.

Two additional points should be made on this topic. First, commercial health plans lack standards or requirements to provide for culturally and linguistically competent care. Secondly, there is no standardization in medical training to create culturally competent care providers². Thus, the question arises: if we are truly committed to eliminating racial and ethnic health disparities, where will the motivation come from to change the status quo?

The lack of language services affects access to health and preventive care services³ and results in greater emergency room use, impediment of patient provider communications, and an increase in the likelihood of non-compliance with care plans⁴. Culture strongly influences one's perception of disease, prevention, and behavior modification, thus the need for culturally and linguistically appropriate health

services becomes imperative.

To improve health delivery and narrow the gap in health disparities among racial and ethnic groups, the conventional medicocentric viewpoint must expand to include cultural competency at every level⁵. This requires a movement away from the historical, patriarchal western approach to practicing medicine. To make this a reality, we need national legislation, not just philosophical concepts. This is exemplified with pending legislation SB853 in California to mandate cultural and linguistic competency among health plans⁶. The American Association of Medical Colleges and all residency programs should require cultural competence as an essential component of medical education. Physician recertification should include some cultural-competency training.

The major demographic changes in the United States and enthusiasm for "alternative care" from the U.S. healthcare consumer require that we rethink the entire model of healthcare delivery^{7,8}. To improve cultural competence in the healthcare milieu, we need to expand our definition of care providers to include partnerships with traditional healers and other evidence-based complementary-care providers. Physicians serving the underserved should demand legislative directives for change. The NMA and historically black medical institutions have fulfilled a longstanding commitment to supply such physicians and should continue to lead the changing dynamics of the health delivery system.

Lisa Merritt, MD
Executive Director
Multicultural Health Institute
institute@merrittmd.com

References

1. Bussey-Jones J, Genao I. Impact of Culture on Health Care. *J Natl Med Assoc.* 2003;95:732-735.
2. Pena Dolhun E, Munoz C, Grumbach K. Cross-cultural education in U.S. medical schools: development of an assessment tool. *Acad Med.* 2003;78:615-622.
3. Betancourt JR, Green AR, Carrillo JE, et al. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and healthcare. *Public Health Rep.* 2003;118:293-302.
4. Betancourt JR. Cross-cultural medical education: conceptual approaches and frameworks for evaluation. *Acad Med.* 2003;560-569.
5. Misra-Hebert AD. Physician cultural competence cross-cultural communication improves care. *Cleve Clin J Med.* 2003;70:289,293,296-298.
6. Pending California State Senate Bill 853 (Escuita). Health Plans and Language Access.
7. Shine KI. Healthcare quality and how to achieve it. *Acad Med.* 2002;77:91-101.
8. Crampton P, Dowell A, Parkin C, et al. Combating effects of racism through a cultural immersion medical education program. *Acad Med.* 2003;78:595-598.

Paclitaxel Treatment Article Misleading

To the Editor,

We believe that the article by Kamineni and colleagues (October 10 issue)¹ gives misleading information concerning paclitaxel treatment. The article says that during paclitaxel treatment, sinus tachycardia was the most common arrhythmia which could be attributed to underlying comorbid conditions, such as dehydration, anemia, sepsis, and hypoxia. But the article title is structured as "Cardiotoxicities of

Paclitaxel in African Americans," so there is a discrepancy between the title and article information. Mentioned those EKG abnormality (sinus tachycardia, nonspecific T-wave changes, premature atrial contraction, premature ventricular contraction, atrial flutter, atrial fibrillation) may be associated with most cancers due to comorbid condition. In our opinion, those complications cannot be accepted specifically as cardiotoxicities of paclitaxel, as suggested by the title of the article.

We wonder whether the authors ruled out silent myocardial segmental/global dysfunction and performed echocardiographic analysis. If not performed, this could be a source of bias in evaluating the effect of the paclitaxel. We emphasize the importance of the echocardiographic information, especially in patients with nonspecific EKG. The risk factors able to potentiate cardiotoxicity must be analyzed before starting chemotherapy and follow-up by echocardiography, and/or isotope ejection fraction must be repeated before each course. Myocardial angiography or scintigraphy, which is easier to perform than myocardial biopsy and more sensitive and specific than echocardiography, seems to be the investigation of choice in a suspected patient. And ischemic analysis before and after treatment also should be performed in a patient with cardiac risk factors. Therefore, EKG abnormality of these patients cannot be attributed solely to the paclitaxel treatment.

Another problem is absence of continuous cardiac monitoring in their work. If we wish to seek arrhythmic effects of paclitaxel, continuous cardiac monitoring

becomes necessary for those patients. In our opinion, EKG checking gives only defective information during paclitaxel treatment. The monitoring of the patient before and during paclitaxel treatment may be crucial for discovering its arrhythmic potential.

Aggressive treatment modalities for patients with cancer are often associated with complications or side effects, frequently involving the cardiovascular system. Longer survival of cancer patients can lead to the development of related or unrelated cardiac problems. Ideal monitoring techniques, upon which efficient prophylaxis depends, are yet to be determined. Current prophylaxis relies upon early detection of systolic and/or diastolic dysfunction. Prophylaxis would be much more efficient if a biochemical marker of myocardial damage could be reliably used to stop further chemotherapy at the correct time before irreversible progressive macroscopic damage becomes evident upon imaging. Work is currently progressing to identify the role of markers, such as troponins and natriuretic peptides, in this regard².

Cardiac events may include mild blood pressure changes, thrombosis, electrocardiographic changes, arrhythmias, myocarditis, pericarditis, myocardial infarction, cardiomyopathy, and congestive heart failure. These may occur during or shortly after treatment; within days or weeks after treatment; or may not be apparent until months, and sometimes years, after completion of chemotherapy.

A number of risk factors may predispose a patient to cardiotoxicity.

These are: cumulative dose; total dose administered during a day or a course; rate of administration; schedule of administration; mediastinal radiation; age; female gender; concurrent administration of cardiotoxic agents; history of or pre-existing cardiovascular disorders; and electrolyte imbalances, such as hypokalemia and hypomagnesemia³. The potential for cardiotoxicity should be recognized before therapy is initiated.

Patients should be screened for risk factors, and an attempt to modify them should be made. Monitoring for cardiac events and their treatment will usually depend on the signs and symptoms anticipated and exhibited. Patients may be asymptomatic, with the only manifestation being electrocardiographic changes. Continuous cardiac monitoring, baseline and regular electrocardiographic and echocardiographic studies, radionuclide angiography, and measurement of serum electrolytes and cardiac enzymes may be considered in patients with risk factors or those with a history of cardiotoxicity. Treatment of most cardiac events induced by chemotherapy is symptomatic. Cardiotoxicity can be prevented by screening and modifying risk factors, aggressively monitoring for signs and symptoms as chemotherapy is administered, and continuing follow-up after completion of a course or the entire treatment. Prompt measures, such as discontinuation or modification of chemotherapy or use of appropriate drug therapy, should be initiated on the basis of changes in monitoring parameters before the patient exhibits signs and symptoms of car-

diotoxicity. It should be kept in mind that more and more oncologic patients are being cured from cancer; problems with long-term cytostatic cardiologic complications have triggered and needed intensive investigation. Long-lasting monitoring of cardiac status may help to identify those patients whose abnormalities have progressive character and who are at risk of fatal complications.

Finally, it is well known that negative emotions, such as depression and anxiety, have been reported to contribute to the development of coronary heart disease⁴. And we emphasize the importance of assessing the negative emotions in relation

to cardiac complications in patient with malignancies.

*Vedat Davutoglu, MD
Serdar Soydinc, MD
Gaziantep University
School of Medicine
Sahinbey Medical Centre
Department of Cardiology
Gune Kent mah.
500 Evler sitesi. 7. Blok No:10
Gaziantep, Turkey
vedatdavutoglu@hotmail.com*

References

1. Kamineni P, Prakasa K, Hasan SP, et al. Cardiotoxicities of Paclitaxel in African Americans. *J Natl Med Assoc.* 2003;95:977-981.
2. Gharib MI, Burnett AK. Chemotherapy-induced cardiotoxicity: current practice and prospects of prophylaxis. *Eur J Heart Fail.* 2002;4:235-242.

3. Von Hoff DD, Rozenzweig M, Piccart M. The cardiotoxicity of anticancer agents. *Semin Oncol.* 1982;9:23-33.

4. Barefoot JC, Schroll M. Symptoms of depression, acute myocardial infarction, and total mortality in a community sample. *Circulation.* 1996;93:1976-1980.

We Welcome Your Comments

The *Journal of the National Medical Association* welcomes your Letters to the Editor about articles that appear in the JNMA or issues relevant to minority healthcare.

Address correspondence to ktaylor@nmanet.org.

C A R E E R O P P O R T U N I T I E S



**HOWARD
UNIVERSITY**

**Senior Vice President for Health Sciences
Howard University • Washington, D.C.**

Howard University is seeking qualified candidates for the position of Senior Vice President for Health Sciences.

Howard University is a private, nonsectarian, co-educational institution and is accredited by the Middle States Association's Commission on Higher Education. Howard University is a Doctoral/Research University—Extensive, the only Historically Black College or University with that Carnegie classification.

The Senior Vice President will lead the academic, research and clinical care activities of Howard University's Health Sciences Center, which includes the College of Medicine; College of Dentistry; College of Pharmacy, Nursing and Allied Health Sciences; Howard University Hospital; the Faculty Practice Plan; the Louis Stokes Health Sciences Library; and the Student Health Center. The Senior Vice President will also have responsibility for strategic and capital planning, new health sciences acquisitions, all satellite facilities and graduate medical education.

The successful candidate will possess an M.D., D.D.S., or other earned Doctoral degree in a health science discipline, and have substantial leadership and management experience in complex academic or health service environments.

Please send, in confidence, personal expressions of interest, nominations and credential letters of application that discuss relevant experiences and accomplishments, along with a curriculum vitae electronically (preferred) or by certified mail to:

LaSalle D. Leffall, M.D., Chair
Senior Vice President for Health Sciences Search
Howard University • c/o Howard Jessamy
4550 Montgomery Ave, Suite 615N
Bethesda, Maryland 20814 • (howardj@wittkiewer.com)
Telephone: 301.654.5070

Witt/Kieffer



**EMORY
UNIVERSITY**
ATLANTA, GA

DEPARTMENT OF EMERGENCY MEDICINE

Our academic department continues to grow. Therefore, we are seeking full-time academic emergency physicians in both research and clinician-educator tracks. Emory offers a dynamic and professional environment with special strengths in patient care, teaching, community service, EMS, toxicology, clinical research, laboratory research, and public health. We offer excellent salary and benefits. Applicants must be residency trained and/or board certified in EM. Emory is an equal opportunity, affirmative action employer. Women and minorities are encouraged to apply. For further information visit our web site at <http://www.emory.edu/em> or contact:

Arthur Kellermann, MD, MPH, Professor and Chair
Department of Emergency Medicine
1365 Clifton Rd., Suite B-6200
Atlanta, GA 30322
Phone: (404)778-2600 Fax: (404)778-2630
Email: Paula Bokros - pbokros@emory.edu

Emory is an equal opportunity/affirmative action employer