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Martin Luther King Jr. and health care

Reprint -By Jo Giles University of Nebraska Medical Center

Martin Luther King Jr. waves to the crowd in Washington, D.C., after delivering his "I Have a Dream" speech Aug. 28, 1963.

Even though he is most widely known for his impact on civil rights legislation, Dr. Martin Luther King Jr. shared his views on many social issues including health care. At the core of his philosophy ... how inequality and injustice affect all facets of public life.

In a 1966 speech, King said: "Of all the forms of inequality, injustice in health care is the most shocking and inhumane."

According to a 2002 report from the Institute of Medicine, when groups have equal access care and have the same education and income levels, gaps in health outcomes still exist between minorities and non-minorities.

Health care disparities are not just limited to race or ethnicity. Gender inequity, sexual orientation, geographic location and disability are historically linked to discrimination and exclusion.

Eliminating disparities in all of these areas would prevent about one million hospitaliza-tions each year, according to the Agency for Healthcare Research and Equality

This time of year, many like to imagine what King would say about current issues such as health care reform.

While he didn't leave any specif-ics, Dr. King's quote from his 1966 speech indicates that he certainly would encourage us to work to eliminate all health care disparities.

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NATIONAL DIABETES EDUCATION PROGRAM

A message from the National Diabetes Education Program, sponsored by the National Institutes of Health and the Centers for Disease Control and Prevention

Black men ignored by PSA screening recommendation

By Thomas A. Farrington

(Reprint-BlackNews.com) - There is a raging prostate cancer crisis in Black America where men are diagnosed with the disease at a rate 60 percent higher than all other men and die at a rate 140 percent higher.

This is the largest racial disparity for any type of major cancer in the United States. Even with these unbelievably gloomy statistics progress has been made over the past 20 years as the overall prostate cancer death rate for Black men and for all men has declined by approximately 40 percent.

Medical experts and the data collected over this period attribute this decline to an earlier detection and better treatment of the disease. The only test that is available today for early detection of prostate cancer is the PSA test.

The U. S. Preventive Services Task Force (USPSTF) issued the following draft recommendation on Oct. 7: "The USPSTF recommends against prostate-specific antigen (PSA) - based screening for prostate cancer. This is a grade D recommendation. This recommendation applies to men in the U.S. population who do not have symptoms that are highly suspicious for prostate cancer, regardless of age, race, or family history."

If this recommendation is allowed to drive public health policy, then the methods for detecting prostate cancer will be returned to those used prior to the PSA test. There is a history, and data, to know exactly what the outcomes will be; a majority of men will be diagnosed with metastatic incurable disease resulting in a higher death rate and increased suffering.

The harshest impact will be on Black men and other men at high risk for the disease. However, the USPSTF is basing its recommendation primarily on data that does not include a statistically significant number of Black men.

I am an 11-year prostate cancer survivor in good health today with no discernable side effects from my treatments. I have also witnessed the deaths of my father, both grandfathers and only brother-in-law from prostate cancer. I know the benefits of PSA testing and the horrible death that men experience from the disease. We cannot allow a public policy that would return us to the days of increased deaths and suffering - we have a better option.

I am asking that all of PHEN partners, survivor members and those that care about men's health to join me in taking action against the USPSTF recommendation. For the USPSTF to make a recommendation that ignores the very existence of the men most impacted by prostate cancer is an insult and irresponsible. Let your voice be heard on this issue. Thomas A. Farrington is founder and president of Prostate Health Education Network (PHEN).

Swimming lowers older adults' blood pressure

By Amy Norton

NEW YORK (Reuters Health) - Many older adults like to take a dip in a pool, and now a small study suggests it can be good for their blood pressure.

Researchers found that among 43 older men and women, those who started swimming a few times a week lowered their systolic blood pressure -- the "top" number in a blood pressure reading. On average, the swimmers started the study with a systolic blood pressure of 131 millimeters of mercury (mm Hg). Three months later, it was 122 mm Hg. Normal blood pressure is defined as an average reading no higher than 120/80 mm Hg. Readings of 140/90 or higher are considered high blood pressure, and anything in between is considered "pre-hypertension."

Swimming is often promoted as a good way for older people to exercise, since it's easy on the joints and it's not likely to cause overheating. And many follow that advice: after walking, swimming is the second-most popular form of exercise among the older set.

But there's been little research into the health benefits of swimming -- though a number of studies have suggested that it's as safe for older adults as walking and bicycling, said Hirofumi Tanaka, senior researcher on the new study. Published in the American Journal of Cardiology, the research appears to be the first to demonstrate that swimming can improve older adults' blood vessel function and curb their blood pressure. "Swimming is a very attractive form of exercise," Tanaka, a researcher at the University of Texas at Austin, told Reuters Health in an email. "It's easily accessible and inexpensive," Tanaka noted. "And because it does not involve bearing of body weight, due to the buoyancy of water, it is friendly to knee and ankle joints." The study included 43 adults, with an average age of 60, who had high blood pressure or pre-hypertension but were otherwise healthy. The researchers randomly assigned them to either have supervised swimming sessions or learn relaxation exercises. Over 12 weeks, the swimmers got in the pool three or four times a week, gradually working their way up to 45 minutes of swimming at a time. By the end of the study, the swimmers had shaved an average of nine points from their systolic blood pressure. In contrast, that number did not budge in the relaxation group.

The picture was similar when the researchers had the study participants wear portable monitors that tracked their blood pressure over 24 hours. On average, the swimming group had a 24-hour systolic blood pressure of 119 mm Hg -- down from 128 mm Hg at the study's start. Tanaka's team also used ultrasound tests to measure how well participants' blood vessels were dilating in response to blood flow. Again, they found improvements in the swimming group, but not in the relaxation group. The study was small, and it's not clear whether the blood pressure reduction lasts -- or whether it translates into a lower risk of heart attack or stroke down the line. But the results line up with what experts already recommend for older adults' heart health: get regular moderate exercise, along with a healthy diet.

Tanaka said that as long as an older adult has gotten the OK to exercise moderately, swimming should be a safe activity. But if you're sedentary, check with your doctor before becoming newly active. There was a time when swimming was considered potentially risky, Tanaka noted, because being in cold water "elicits cardiovascular changes." But most studies have indicated that bobbing in the waters of your local pool would be as safe as a walk around the neighborhood.

A Different Twist on "Having Heart": Increasing the "Public" in "Public Health

Ira F. Combs RN BS

The impact of heart disease among African-Americans has been so widely shared in the academic and grass roots communities that it is pretty much common knowledge at this point. From enhanced diet education to outreach programs such as those sponsored here at the Center for Reducing Health Disparities North Omaha office, the issue has been attacked from a number of angles and, despite this, the response of the community-at-large has been slow, at best.

By engaging in outreach in and around the North Omaha community, for example, the University of Nebraska Medical Center has been on the "community cutting edge" of providing information and assistance to a population that has been, for the most part, segregated. This social fact is important to consider because even when information is disseminated, access to care facilities and medical professionals has often been difficult, especially in a community where only 40% of residents own automobiles.

Heart health information is important, and getting the information out has not been a problem - until recently. There are a number of changes in our "target populations" that must be considered in order for the important work being done by the College of Public Health to reap optimum benefits. In a way, we must become heart-education specialists and social planners.

The social epidemiological approach has to be combined with the resources that we are providing to this community or it will wind up as just another well-intended program. There are factors that we, as public health professionals, have to deal with, factors that give "health" its proper priority and placement while realizing that the "public" component must take on a new flavor, especially with the changing demographics of not only this community, but the state, region and nation.

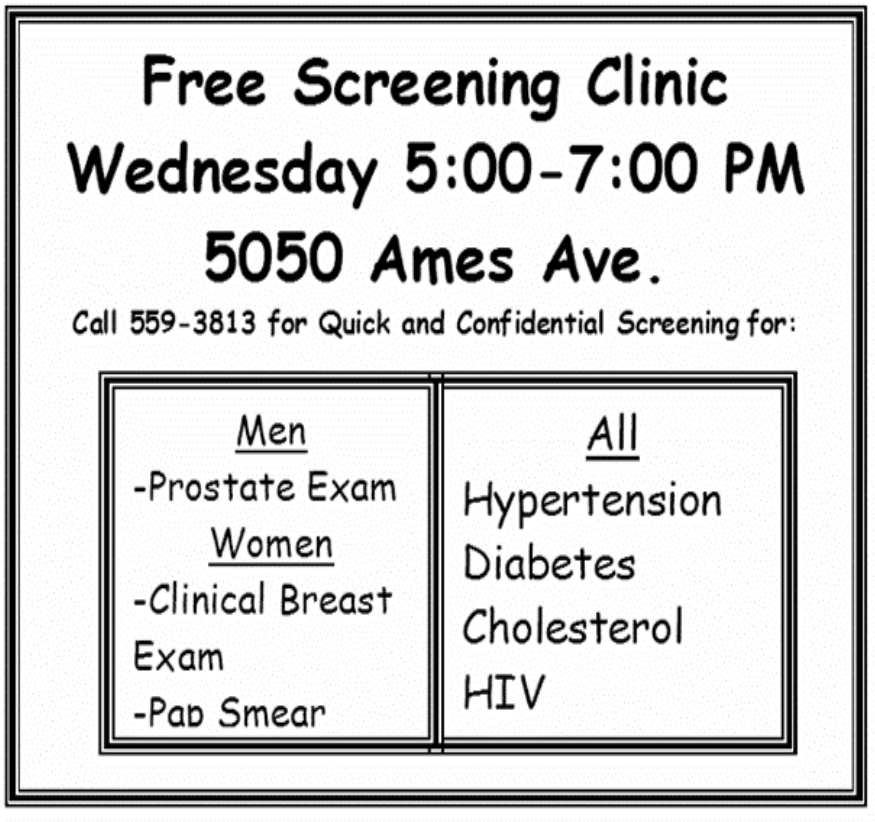
Outreach means doing more than providing information and access. In the latter instance, health care access has surely improved since the release of the Urban League of Nebraska's State of Black Omaha 1978 report some 34 years ago. In that document it was found that "there were no accessible health care providers within the black community." At that time there was little outreach and Creighton was not considered a part of an area that was bounded by Cuming on the south, Redick on the north, 52nd Street on the west and 16th Street on the east.

We have gotten better in terms of increasing access and outreach.

Today, African Americans are turning out in huge numbers to attend our information sessions, health fairs, workshops and conferences. Our public health program has offered free medical checkups and health information forums all over the traditional north and south side communities. With emphasis on lifestyle changes, diet and exercise, increasing numbers of Blacks and Latinos in Omaha are taking advantage of the information. But there is more work to be done because the population and its location, like the times, are "a'changin'." Even the Charles Drew Health Clinic is now on the southward fringe of north Omaha, and the "core" continues to shift.

Secondly, as "Public" public health professionals, our clearinghouses and information centers have to be stocked with as much demographic information as it is information on heart-related issues. I offer that we have to be on the cutting edge of urban planning and be in constant contact with developers and planners who are controlling the configuration of Omaha, in general, and of poor populations, in particular. We are not social engineers; but those who are must be informed by us, of the importance of health care provision and information; health care and education, as we view it, is a primary indicator of an area's (neighborhood, community) quality of life.

Third, we must begin training our incoming public health interns and professionals in grant writing and funding solicitation. The economy, like the demographics, is changing and in order for the information regarding "the heart" to get to the people who need it most, we must have the money and resources to expand even as the population does



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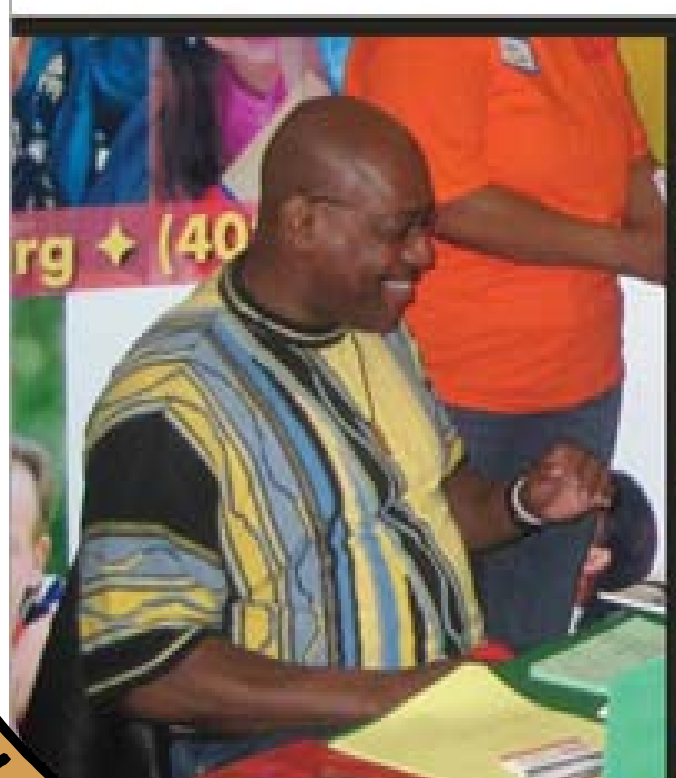

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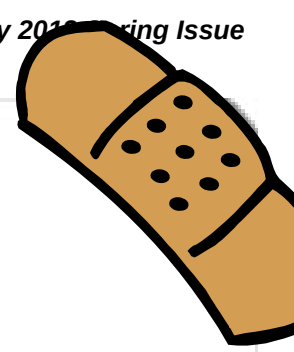

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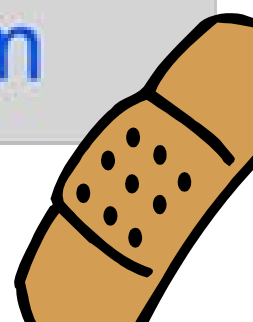

ryone can see me!

Smoking related diseases are the number one cause of death in African-Americans

by Erin Marcus, MD

Lawrence Jones started smoking Kool Menthols when he was playing Rhythm and Blues in the ‘70s, as a way of fitting in with his band mates and the in crowd at the clubs where he played.

The band broke up after a few years, but the cigarettes remained. Instead of being a way to look sophisticated, smoking became a means for Jones to relax and, he says, to feel he was “in control of whatever the situation might be.”

And smoking remained a constant in his life through hardship, when his baby daughter died of a brain tumor, when his two marriages dissolved, and when he watched cancer slowly kill the woman he loved. He relied on cigarettes to get through the day, needing one before he brushed his teeth in the morning and another with his daily cup of coffee –- and says he was “difficult to get along with” when he couldn’t smoke. And even though he saw the Surgeon General’s warning about the health risks of cigarettes on the side of each pack, “people don’t pay that any attention,” he said recently. “I had a 10-month-old daughter die from cancer and she never smoked a cigarette in her life.”

Jones’ history -– of being drawn in by the seeming glamour of cigarettes as a youth and then becoming physically and mentally addicted to them as he grew older –- is similar to that of many smokers, and in particular African-American smokers, whom I’ve seen over the years as a primary care doctor. About one in four African-American men smoke, and smoking-related illnesses — including lung and throat cancer, heart disease and emphysema — are the number one cause of death in the African-American community, killing more than 47,000 black Americans each year. Tobacco companies continue to market menthol cigarettes heavily in the black community, through ads showing attractive young people and through sponsorship of concerts and other cultural events.

Happily, Jones’ story also demonstrates that even people who have smoked for decades can stop. At age 55, while sitting in a clinic examining room, he spotted a poster explaining how his health would improve after quitting. His doctor referred him to a weekly stop smoking class, and over the next four weeks, under the guidance of a counselor and with the support of a friend, he gradually tapered down his cigarettes from 14 a day to none. It now has been more than two months since his last cigarette, and, though he continues to rely on nicotine replacement patches, he is determined never to smoke again. “I don’t have any runs left,” he said. “I was sick and tired of being sick and tired.” “I have two beautiful grandkids that I’d like to see grow up,” he added. “I don’t want my family to have the pain and agony of seeing me deteriorate.”

Since quitting, he has noticed positive physical changes. He used to get winded walking a block; now he is able to walk several blocks without any problems. Smoking also used to dull his sense of smell and his ability to taste food; now, he says, he is regaining those senses and no longer has to smother his food with salt to give it taste –- “a gift,” he says, since salt worsens his high blood pressure. His family members tell him that his complexion looks much better. He has also saved money, and recently was able to buy an $80 pair of Stacy Adams shoes with the money he stashed in a jar whenever he got the urge to buy a pack of cigarettes.

Stopping a decades-long habit –- and breaking the physical and psychological addiction of tobacco –- was extremely tough for Jones, just as it is for most smokers. But he is optimistic that he will succeed.

Erin Marcus is an internal medicine physician and writes at New America Media.

THIS IS WHAT A HEART ATTACK FEELS LIKE TO A WOMAN.

(SHORTNESS OF BREATH)

Other Heart Attack Symptoms to Watch Out For:

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To learn more, visit WomensHealth.gov/HeartAttack

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Kids spend several hours a day playing video games and less than 15 minutes in P.E. Most can't do two push-ups. Many are obese, and nearly half exhibit risk factors of heart disease. The American Council on Exercise and major medical organizations consider this situation a national health risk. Continuing budget cutbacks have forced many schools to drop P.E.—in fact, 49 states no longer even require it daily.

You can help. Dust off that bike. Get out the skates. Swim with your kids. Play catch. Show them exercise is fun and promotes a long, healthy life. And call ACE. Find out more on how you can get these young engines fired up. Then maybe the video games will get dusty.

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How to Kick the Salt Habit

Our bodies only need about 180 milligrams of sodium daily, but the average American consumes nearly 20 times that – about 3,400 milligrams. The U.S. Centers for Disease Control recommends that people with high blood pressure, everyone older than 40, and African Americans take in no more than 1,500 milligrams of sodium daily, or no more than 2/3 of a teaspoon of table salt. (For everyone else, they recommend limiting sodium to less than 2,300 milligrams daily).

These recommendations are tough to follow, especially since most packaged foods contain a lot of sodium – and most of us are used to eating lots of it beginning in childhood. But contrary to what many may think, low sodium foods can be tasty and inexpensive. Below are some tips to kick the salt habit.

1. Your taste buds will adapt to a low-sodium diet, even though it's tough at first. "When you first start making these changes, you find yourself looking up at the salt shaker when you're eating," Maybe putting the salt on the shelf out of view may help.

2. Avoid canned and other processed foods. Only a very small amount of the sodium we take in is from salt that we add at the table or in the kitchen; 80 percent is from processed food. The best way to follow a low-sodium diet is to buy fresh food and to cook it yourself. "The message people get is, don't salt your food, and that's the least important," . "It's not just the food, it's the processing." Even processed foods that don't taste salty, like bread and cottage cheese, have lots of sodium. We suggest a crock-pot for cooking if you don't have good access to a kitchen.

If you absolutely have to use canned vegetables, try to rinse them off with water.

3. Look at nutrition labels. The Food and Drug Administration has advice on how to read them.

Remember that the amount of sodium reported on the label is for a certain portion size, not for the entire can or box. The label for one popular brand of soup lists the sodium that's in just one cup – which is about half of what many people would consider a real serving.

Read labels on uncooked chicken, too, because many companies inject chicken with salt to plump it up and help preserve it.

4. If fresh fruits and vegetables aren't an option, consider frozen vegetables and fruits. Frozen vegetables in sauce and frozen dinners do have a lot of sodium, but plain frozen peas and carrots usually don't.

5. Don't believe it when a product says it's "low salt" or "low sodium."

6. Avoid restaurants, which really sneak in the salt. Sad to say, but none of the dieticians I spoke with could come up with any chain restaurants that serve low-sodium dishes. "We're living in a convenience society, and the convenience of someone else cooking for us or preparing our food is killing us," (If you aren't convinced, look at McDonald's nutrition facts.

7. Learn to cook with herbs and spices, and be willing to try new things. Chopped up garlic, lemon juice, and olive oil to season food. Maybe try adding a new fruit or vegetable every week.

8. If you have been eating a high-sodium diet for a long time, you may need to take it slow as you cut back. Maybe reducing your sodium intake by half for about a week or so, and then gradually taper it more over the course of a month.

9. Check out low-sodium recipes on the internet. Google "low sodium diets" you'll be surprised at the number of free diets and recipes you get.

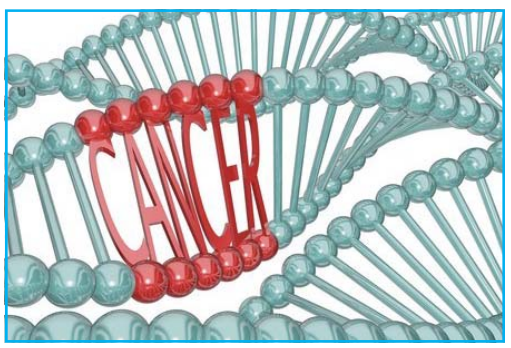
10. Try to find a buddy, or a support group at a local church or health center. "It's good to have someone to share it with," .

Cancer 101

(first part of a two part article)

What is cancer? Cancer is a group of many related diseases in which abnormal cells develop, divide uncontrollably and have the ability to infiltrate and destroy normal body tissue. Normally, cells grow and divide to produce more cells as they are needed to keep the body healthy. Sometimes, this orderly process goes wrong. New cells form when the body does not need them, and old cells do not die when they should. The extra cells form a mass of tissue called a growth or tumor. Not all tumors are cancerous; tumors can be benign or malignant.

Benign tumors are not cancer. They can often be removed and, in most cases, they do not come back. Cells in benign tumors do not spread to other parts of the body. Most importantly, benign tumors are rarely a threat to life. Malignant tumors are cancer. Cells in malignant tumors are abnormal and divide without control or order. Cancer cells invade and destroy the tissue around them. They can also break away from a malignant tumor and enter the bloodstream or lymphatic system. The lymphatic system carries lymph and white blood cells through lymphatic vessels (thin tubes) to all the tissues of the body. By moving through the bloodstream or lymphatic system, cancer can spread from the primary (original) cancer site to form new tumors in other organs. The spread of cancer is called metastasis.



What causes cancer? Cancer is caused by changes in genes that normally control the growth and death of cells. There are many factors that increase the chance of developing cancer, including lifestyle, environment, and genetic risk factors. There are also certain viruses that increase the risk of developing cancer. Certain lifestyle and environmental factors can change some normal genes into genes that allow the growth of cancer. Many gene changes that lead to cancer are the result of tobacco use, diet, obesity, lack of physical activity, exposure to ultraviolet (UV) radiation from the sun, or exposure to carcinogens (cancer-causing substances) in the workplace or in the environment. Viruses, such as the human papillomavirus (HPV), hepatitis B and C (HepB and HepC), and human immunodeficiency virus (HIV), increase the risk of some types of cancer. However, cancer itself is not contagious. A person cannot catch cancer from someone who has this disease. Changes, called alterations or mutations, in certain genes make some people more susceptible to developing some types of cancer such as breast, prostate and ovarian cancer. Some genetic alterations are inherited (from one or both parents). However, having an inherited gene alteration does not always mean that the person will develop cancer; it only means that the chance of getting cancer is increased. What does it mean when I am genetically at risk for developing cancer? Genetic risk factors can lead to development of hereditary forms of cancer. Inherited alterations in the genes called BRCA1 and BRCA2 (short for breast cancer 1 and breast cancer 2) are involved in many cases of hereditary breast and ovarian cancer. As with breast cancer, familial history is a major risk factor in prostate cancer. 5 to 10 percent of prostate cancer cases are believed to be due primarily to high-risk inherited genetic factors or prostate cancer susceptibility genes. A family history of a brother or father with prostate cancer increases the risk of prostate cancer by two- to three-fold, and the risk is inversely related to the age of the affected relative.

How does smoking relate to cancer? Tobacco smoke contains thousands of chemical agents, including over 60 substances that are known to cause cancer. Smoking harms nearly every major organ of the body. Cigarette smoking is directly responsible for approximately 30 percent of all cancer deaths annually in the United States and 87 percent of lung cancer deaths. Lung cancer is the leading cause of cancer death in both men and women. Smoking is also responsible for most cancers of the larynx, oral cavity and pharynx, esophagus, and bladder. In addition, it is a cause of kidney, pancreatic, cervical, and stomach cancers, as well as acute myeloid leukemia. Cigarette smoking also causes chronic diseases such as emphysema, chronic bronchitis, cardiovascular disease, stroke, and cataracts. Smoking during pregnancy can increase the risk of stillbirth, low birth weight, Sudden Infant Death Syndrome (SIDS), and other serious pregnancy complications (2). The health risks caused by cigarette smoking are not limited to smokers. Exposure to secondhand smoke, or environmental tobacco smoke (ETS), significantly increases the risk of lung cancer and heart disease in nonsmokers, as well as several respiratory illnesses in young children. Quitting smoking greatly reduces a person's risk of developing the diseases mentioned, and can limit adverse health effects on the developing child.

Am I at a higher risk for developing cancer because of race or ethnicity? Cancer affects people of all racial and ethnic groups. However, there are disparities between groups. African Americans are more likely to develop and die from cancer than any other racial and ethnic group. Additionally, certain racial/ethnic groups experience higher rates for specific cancers than other groups. Many of the differences in cancer incidence and mortality rates among racial and ethnic groups may be due to factors associated with social class rather than ethnicity. Socioeconomic status (SES) appears to play a major role in the differences in cancer incidence and mortality rates, risk factors, and screening prevalence among racial and ethnic minorities. Moreover, studies have found that SES, more than race, predicts the likelihood of a groups access to education, certain occupations, and health insurance, as well as income level and living conditions, all of which are associated with a persons chance of developing and surviving cancer.

Although many risk factors can be avoided, some, such as inherited conditions, are unavoidable. However, it is helpful to be aware of them. People who have an increased likelihood of developing cancer can help protect themselves by avoiding risk factors whenever possible and by getting regular checkups so that, if cancer develops, it is likely to be found and treated early. Next issue of NOAH will have information on how to prevent cancer and the signs and symptoms of possible cancer.

For information and question on

Breast Cancer call Jackie Hill 402-595-3807

Prostate Cancer Call Ira Combs 402-595-1458

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