**KEYNOTE ADDRESS**

**DELIVERED AT THE DEPARTMENT OF COMMUNICATION ARTS**
**VALDOSTA STATE UNIVERSITY**

# SYMPOSIUM ON SOCIO-CULTURAL ISSUES IN RURAL HEALTHCARE IN AMERICA

# THE PERSONAL EXPERIENCES OF A COUNTRY CARDIOLOGIST

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**SEPTEMBER 14, 2017, VALDOSTA**

Mr. Chairman, Dr. Tsikata, Distinguished Faculty, Ladies and Gentlemen.

It is a great honor to be invited to address this august gathering. I wish to thank all who made this possible.

I am a Cardiologist practicing in Jonesboro and Paragould, Arkansas, where I have had the privilege of treating an incredible population for whom medical care is most often few and far between. Arkansas is largely a rural state of many small and sparsely populated towns with healthcare facilities usually far removed geographically from many people. Many regions and counties in Arkansas are in fact designated as health professional shortage or medically underserved areas by the Health Resources and Services Administration (HRSA) of the U.S Department of Health and Human Services.

In my 4 years of medical practice in Arkansas, I have had the opportunity to observe the practice of medicine in a region different from where I trained with its attendant peculiarities and subtleties. My personal experiences informed by my background as an immigrant and a post-graduate trainee from the mid-Atlantic region had tuned my perceptual set or antenna to be able to perceive this differences with cognitive curiosity and interest.

I cannot presume to have a full grasp of all the intricacies of the culture and the healthcare system in the south in general or in Arkansas specifically to intellectually dissect and analyze it. My speech to you will touch on my personal experiences as a practicing cardiologist in Arkansas and my interaction with the healthcare system as well as with the culture and the people in a suburban and rural southern setting.

I shall begin by first giving some background information to provide the context within which to understand the points being raised.

**Prevalence of Poverty**

There is high unemployment and underemployment in Arkansas with low wages and high general poverty levels. According to data from the US census bureau, 2015 nationwide population survey, and the bureau of labor statistics, the median household income in Arkansas is $41,995, second from the rear and only higher than Mississippi, with an unemployment rate of 5.2%, the 24$^{th}$ highest in the country, and with the 4$^{th}$ highest poverty rate of 19.1%. Healthy lifestyle does not come cheap and is often outside the means of many. A complex interplay of factors undergirds the attainment of healthy living, prominent among which are life style choices and habits some of which are determined by poverty and general lack of financial resources to attain such healthy lifestyles. There is high rate of tobacco use, illicit drug use and unhealthy dietary patterns in this region.

**Cultural practices**

To understood a peoples' culture, you need to understand the food they eat. Cultural and social interactions are often organized around food and drinks. Dietary patterns in the south often involve fried foods, processed meats and sugar-laden drinks and foods. Eating habits have a suggested link to the geographical prevalence of cardiovascular disease in the south. In an article published in the journal Circulation by Shikany et al., titled, "Southern Dietary Pattern is Associated with Hazard of Acute Coronary Heart Disease in the Reasons for Geographic and Racial Differences in Stroke (REGARDS) Study", southern dietary pattern was associated with 56% higher risk for coronary heart disease. While soul food may be nutritious for the soul, serving to expedite the inevitable rendezvous with its maker, it may not be auspicious for the heart while on earth. The resulting high levels of cardiovascular disease gives relevance to and drives the demand for professionals like me with expertise in treating cardiovascular disease. The spectrum of cardiovascular disease is breathtaking and many times unrivalled in many other regions. I often remark that the experience one can accrue in a region like this in a few years is worth decades in other regions of this country.

**Cardiovascular Disease spectrum**

My practice area of Arkansas is firmly planted in the various infamous belts of diseases- the stroke, diabetes and obesity belts of America. There is a high burden of cardiovascular disease in the south in general. The Stroke belt runs through counties in Alabama, Arkansas, Georgia, Indiana, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Virginia.

The diabetes belt consists of 644 counties in 15 states, consisting of counties in Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, West Virginia, and the entire state of Mississippi. According to data from the Centers for Disease Control (CDC), 11.7% of people have diagnosed diabetes within the diabetes belt versus 8.5% outside of the belt.

Dietary and lifestyle patterns are known to contribute to the high levels of cardiovascular disease in these regions.

**Health insurance coverage**

Many individuals prior to the enactment of the Affordable health care act(ACA) lacked medical insurance coverage and nowhere is this situation direr than in southern America. Arkansas is one of the states that expanded Medicaid and established state-based marketplace exchanges under the ACA. According to a 2014 Gallop poll, Arkansas and Kentucky saw the steepest reductions in uninsured rates among adult residents in the first year of the ACA coming into force in 2014. Arkansas alone saw a drop in its uninsured rate from 22.5% in 2013 to 11.4% in 2014. A large swathe of my patients is indigent and had no insurance coverage prior to the enactment of the ACA. With access to health care came a flood of patients with complex medical problems complicated by years of neglect and poor access to the healthcare system especially for preventative and ongoing care for chronic medical conditions. Even with medical

insurance, many of my patients struggle with out-of-pocket costs and costs of medications etc. I have on occasion seen some patients without charge in my office and still regularly supply many of my patients with free drug samples provided by pharmaceutical companies.

Interacting with pharmaceutical representatives and obtaining drug samples from drug companies had become frowned upon in many academic centers due to conflict-of-interest concerns. I came out of training with puritanical ideals of non-interaction with pharmaceutical representatives only to learn quickly that without free drug samples, many of my patients would not have access to medications due to high out-of-pocket costs.

**Accessibility to healthcare facilities**

Arkansas is made of many small sparsely populated towns with hospitals and physician clinics few and far between. It is typical for patients to drive long distances to attend clinic appointments and to access hospital facilities unlike in densely populated urban areas where there is close proximity of healthcare facilities to the patient population. There is a robust referral network with well-connected transfer systems that allow for seamless patient transfers to centers of excellence for the provision of higher care. It is a thing of beauty to watch the American healthcare system function at its best, working from the ground up that an expectant mother in labor from a town of 500 people can travel over 40 miles to a hospital with obstetric care, deliver a baby with congenital cardiac abnormality, have that baby air-lifted to a tertiary facility over 150 miles away with pediatric cardiologists, cardiovascular surgeons and other specialists in the ready and with prior knowledge of this neonate's medical history well before arrival. Or to see a patient in dire need of a left ventricular assist device being air-lifted to a facility several hundreds of miles away in a neighboring state and being wheeled immediately on touch-down to an operating room with staff waiting and in the ready for the patient.

**Religiosity and its intersection with healthcare delivery**

The south is the cross road where religion and healthcare intersect. The Bible belt runs through parts of the south, of which Arkansas is an important integral, to parts of the midsection of the United States. According to data from the Pew Research Center, 76% of Adults in the south identify as Christian, 34% of whom are Evangelical Protestants. 71% of Adults in the south believe in God with absolute certitude. It therefore comes as no surprise that religious beliefs factor heavily in the physician-patient relationship. Christianity is the dominant religion I have encountered in my interaction with patients. In my hospital in Paragould Arkansas, morning prayers are routinely said over the overhead speakers. When a prayer is being said hospital wide, staff whenever possible and patient alike will be seen to pause in their strides in reverence before resuming their respective activities after the prayer is done.

My first experience of direct religious influence in day-to-day healthcare delivery was in 2013 when I had just started work in Arkansas. I had a patient with irregular heart beat called atrial fibrillation whom I had decided to cardiovert with electrical shock. After explaining the process of cardioversion to obtain informed consent, the patient and boyfriend asked me if I believed in

God. I promptly responded in the affirmative and they proceeded to ask that we all hold hands including with my nurses with the boyfriend leading us in prayer. After the prayer was said I asked a nurse anesthetist to prep patient for sedation prior to cardioversion while I run off to take care of other patients. I was later called by the ER physician that the patient had spontaneously converted to normal rhythm. Prayer works, God has healed was the uniform refrain from the patient and family. Was the spontaneous conversion of heart rhythm an act of God or was it coincidental, a not uncommon occurrence in these situations? The answer to that question depends on your belief system. I give credit to my patient population for not blindly refusing orthodox medical care in hopes that their God miraculously cures all diseases. On the contrary, they accept conventional medicine but believe strongly that it is God who heals using health practitioners as conduits to channel his healing power.

**Establishing a medical practice**

I shall turn my attention to the practice of medicine and my experiences which are in contradistinction to my previous experiences prior to moving to Arkansas. In small town Arkansas, I was told by hospital officials that a practitioner has to live in the small town, shop at neighborhood stores, attend local churches, football games, etc. to have his or her clientele feel them a part of their community. It is important that they see you as part of them for you to have a thriving and successful practice. Based on my previous experience, I found it hard to accept why I should be told where to live, where to worship, or shop. What should the patients care where I lived or what I did? The only concern should be the quality of care I provided. Relocating from Washington, DC and its suburbs to rural Arkansas was in and of itself a dramatic culture shock that further limitations were just going to be unsupportable. In order to establish a patient base and build referral networks you had to engage in outreach to community leaders, social groups and clubs as well as establish rapport with primary providers. These activities are usually in contrast with urban practices where referral networks are pre-existing and do not require much additional effort to sustain.

**Healthcare provider attitudes towards patients**

Healthcare provider life experiences and prejudices percolate into the physician-patient relationship. According to data from Medscape lifestyle report 2017, physicians admitted to having various forms of prejudices or biases including perceived patient low intelligence, low income status, lack of insurance coverage, heavier weight, race different from self, language differences, physical unattractiveness etc. 16% of surveyed physicians who admitted bias said it affected their treatment of patients.

In my experience, racial prejudices sometimes occur in the patient-physician interaction and could cut both ways. Anecdotally, I have met black patients who complain to me that it was

hard for them to find doctors to accept them into their practice unlike when they lived in urban areas. More often statements like, “we do not accept your insurance or we are not accepting new patients” is code or smokescreen for denial of service based on race or other prejudices like perceived drug-seeking behavior etc. My own wife and I were nearly turned away from an obstetrician’s office for perceived lack of insurance based on nothing other than racial prejudice but for a forceful intervention on my part. Again, my own wife had a hard time getting appointment to a primary care doctor’s office until she forcefully called them out for their biases. I personally experienced an emergency room physician in my own healthcare system asking me to step away from the door and put my hands by my side while talking to him, “put your hands by your side, the hand, the hand, I’m afraid you are going hit me,” because he projected violence unto my benign posturing and gesticulations. He remarked very much to my consternation that I should step away from the door so that I do not hit him with the door or to stop gesticulating as I could strike him with my hand.

On other occasions patients are refused office appointments based on perception of drug use based on their zip code. With the raging opioid crises ravaging rural America, with attendant Government crackdown on errant providers, coupled with the pure nuisance that drug-seeking patients pose to providers, it is easy for providers to be overly cautious in prescription of opioid medications and to take what can be considered as too broad and sweeping steps to exclude potential drug-seeking patients from their practice.

**Patient attitudes towards minority providers**

Many foreign physicians have expressed facing prejudicial treatments at the hands of their patients, colleagues and hospital management. My personal experience with patients as a black provider has been overwhelmingly positive. I often remark that my patient cohort in Arkansas is the best I have had in my medical career in the United States. They are profoundly respectful and appreciative of the quality service that I provide. I can literally do no wrong in their eyes.

I have had patients branded with white-supremacist tattoos who come and see me and keep returning time after time to my utter surprise. On one occasion, one of such patients gave me a bear hug on one of his follow-up visits saying to me, “you are my brother”. This was an epiphanic moment for me and hopefully for him. My view is most people with extremist and hateful views have not had much personal interaction with the people they hate. When given the opportunity to interact, they realize their common humanity, and how much like them they are with the same cares and worries that afflict all humans.

**Foreign doctors as an essential workforce in rural medicine**

25% of US physicians are foreign born. The United States medical schools are not producing enough medical doctors to meet the health coverage needs of this country. There is a projected

shortfall of 46,100 to 90,400 physicians by 2025 according to a report by the Association of American Medical Colleges. International Medical graduates are therefore relied upon to fill the shortage gap and nowhere are their services more needed than in rural America. International medical graduates serve as an essential workforce in medically underserved areas, locations where US physicians frequently are unwilling to practice. A Visa system called J1 ensures a constant stream of international medical physicians to underserved areas in exchange for these physicians remaining in the United States in lieu of returning to their home countries after post-graduate medical training. A study published in 2017 in the British Medical Journal (BMJ) comparing the quality of care delivered by general internists in US hospitals who graduated from foreign versus US medical schools found that for Medicare patients admitted to US hospitals, patients treated by international graduates had lower mortality than patients treated by US graduates.

**Problems international medical graduates face in rural areas**

Most international medical graduates would rather live and practice in large cosmopolitan areas where they have interactions with immigrants of similar backgrounds and cultures. The reality is often that these international physicians are funneled to underserved areas by virtue of programs such as J1 waiver system. In rural areas, these physicians and their families tend to face racial and socio-cultural isolation. In these rural areas, the foreign physicians also tend to face the usual negative racial attitudes and prejudices that minorities and foreigners often face from being followed in department stores to our children being subjected to vile racial bullying in school at the hands of classmates of such tender ages that it is hard to fathom from whom or where they acquired such hatred. As Nelson Mandela said in his autobiography, Long walk to freedom, "No one is born hating another person because of the color of his skin or his background or his religion. People must learn to hate, and if they can learn to hate, they can be taught to love, for love comes more naturally to the human heart than its opposite."

In my personal experience, it is difficult to get people to perform repair works and other household maintenance in our house. This had led me to step up to the plate and perform some of these handyman jobs myself. From the foregoing, it is not difficult to figure out the reasons why foreign-born physicians fail to assimilate in the rural communities where they serve and end up leaving perpetuating the physician shortage problem in such areas.

**Limitations imposed on Foreign Medical Graduates (FMG) by visa status**

The commonest visa types on which foreign medical graduates practice are H1 and J1 visas. These visas are heavily regulated with many limitations such as restrictions to work for only a sponsoring employer. It is extremely onerous to change jobs on a J1 visa waiver program. Ordinarily, a J1 waiver candidate is not able to change jobs regardless of how unhappy they are except under extenuating circumstances, a term as nebulous and ill-defined as it is elastic. The spouses of foreign medical graduates who are often well educated and just as driven and ambitious as their better halves are not permitted under immigration law to hold a job while on dependent H4 visas. These extremely restrictive visa conditions often result in spousal frustrations and unhappiness which percolate into and sometimes destabilize marital relationships. Even though educational opportunities are available for spouses on H4 and J2 visas, in some states like Arkansas spouses do not qualify for in-state tuition at state colleges even when they have lived in the state long enough, own a home and have lived up to their fiscal obligations. My spouse who enrolled at Arkansas State University was ineligible for in-state or out-of-state tuition and had to pay as a foreign student which was decidedly more expensive, sometimes twice as expensive as in-state tuition. This in my view, is discrimination based on country of origin with the moral dichotomy of paying your share of taxes yet not being eligible for benefits that are enjoyed by those who contribute substantially less. It is to be noted that most states extend in-state tuition privileges to H1 immigrants and their H4 spouses who meet the qualification guidelines for in-state tuition.

**Employer attitudes towards immigrant health workers on visa**

Unfair immigration policies that tie H1 visa and J1 waiver employees to their specific employers empower unscrupulous employers to exploit their poor immigrant workers, leaving those employees with little option of changing jobs, as their immigration status is intricately tied to their employers. Physicians on J1 waiver are entangled in highly restrictive visa conditions that make it all but impossible to switch employers even in many cases of gross employer abuse. Mandatory liquidated-damages clauses in J1 waiver contracts requiring prohibitive amounts of money to be paid by immigrant physicians on severance of employment have become weaponized by employers as tools of forcible and coercive labor. Employers knowing fully well that the immigrant physicians have little option to escape, subject these workers to back-breaking workloads with unfair remuneration and frankly inhumane treatment with impunity. I have personally worked over and above my designated job-description, providing vital services to patients in need, in my job in Newport, Arkansas, without pay even though there was an undertaking to pay me for my moonlighting services. I had little recourse to claim my due compensation and the employer knowing well my limited options for recourse could not be

bothered. This government-enabled, employer perpetrated indentured servitude should have no place in a civilized society, certainly not in these modern times.

Thank you for this opportunity to speak to you and for your audience. It has been a real treat. I will draw my speech to a close at this point and invite questions.

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