

Health Letter

SIDNEY M. WOLFE, M.D., EDITOR

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Wrong Prescription

Bill Bradley's Health Plan is No Cure

The following article was reprinted from *The Progressive* magazine with their permission and was written by Drs. Ida Hellander and Steffie Woolhandler.

The rightward drift of the Democratic Party is nowhere more evident than in health care. In September, Bill Bradley, the former Democratic Senator from New Jersey and current Presidential candidate, declared his support for health reforms previously espoused by the ultraconservative Heritage Foundation. Bradley's plan is at its core profoundly reactionary, a vehicle for the Heritage Foundation's explicit agenda of "rolling back the welfare state."

Bradley's plan has already been endorsed by Chip Kahn, president of the powerful lobbying group the Health Insurance Association of America. And little wonder: Insurance companies and HMOs stand to gain billions of tax dollars from the Bradley plan, while Americans would still have no right to health care.

Bradley has impressed many with his ideas on race (and his jump shot). Yet his health proposal is so shameless in its \$200 billion transfer of tax dollars to the private insurance industry that it might have made Richard Nixon blush. At a time when the possibilities for progressive reform seem bright, why are Bradley's health care proposals so backward?

Meanwhile, Al Gore would not guarantee the right to health care either. Nor would he loosen the chokehold of the insurance industry over health policy. At most, he trumpets his support for the

Patient Bill of Rights, advocates putting additional money into the failed Children's Health Insurance Plan, and proposes a modest tax credit so that some in the 55 to 65 age group could buy into Medicare.

While national health insurance was espoused by Warren Beatty's fictional Senator Bulworth, not a single real-life candidate has the courage to advocate the non-profit national health insurance program America needs and Democrats supported from the New Deal era until the 1992 Clinton candidacy.

Bradley has compared his proposal for the 11.1 million uninsured children to the Medicare program for seniors. This is

nonsense. Medicare has guaranteed seniors basic health coverage for more than 30 years. Bradley's proposal is a mandate that parents buy their children private insurance. Admonishing parents to buy private coverage—even if such coverage were affordable and available (which it's not)—is a long way from guaranteeing kids coverage.

Bradley's plan relies on tax credits and a new federal bureaucracy to help poor families afford children's coverage. The subsidies would tempt employers to drop coverage of employees and their children but wouldn't be adequate to help many low- and middle-income fami-

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lies buy private coverage. This is exactly what happened with the federal Children's Health Insurance Plan, the most recent incremental effort to increase coverage. In 1998 alone, the number of uninsured children rose 330,000, following rises of 188,000 in 1997 and 755,000 in 1996.

Bradley also proposes privatizing Medicaid, the current government insurance program that covers some of the poor and the disabled, as well as nursing home costs for poor seniors. The \$193 billion in current Medicaid spending would go to private insurers. The nonelderly Medicaid recipients would get a voucher to purchase private coverage from plans participating in the Federal Employees Health Benefits program. Bradley would also offer tax credits to the uninsured to buy into that program.

As for the poor elderly who receive help from Medicaid with nursing home and long term care costs, Bradley would simply end 30 years of joint state and federal responsibility for their care and turn this over to the states completely (just in time for the boomers' retirement). Bradley would do the same for the disabled, risking the loss of the safety net for this vulnerable community.

With premiums rising at 8 percent per year, poor adults with Bradley's fixed tax subsidies or skimpy vouchers would be able to afford only the cheapest plans (mainly HMOs) in the Federal Employees Health Benefits Program, not the high-end coverage that members of Congress receive. Many millions of uninsured would continue to fall through the cracks. As with children, the tax subsidies for adults are inadequate to cover all the uninsured but might encourage employers to drop coverage to low-income workers.

For seniors, Bradley would create an optional prescription drug benefit to cover medication costs over \$500 annually. Seniors would have to sign up and pay an extra premium for this modest benefit. Bradley's tepid proposal barely scratches the surface of that problem.

The Heritage Foundation must be flattered by Bradley's adoption of its ideas. For years, that foundation has pushed a similar plan for privatizing Medicare in an attempt to reduce public control while directing tax dollars to private insurers. Heritage scholars argue that consumers will choose the most

efficient private plans and that competition in the market will reduce costs.

However the evidence from seniors who have opted for HMOs is that private plans are actually more costly than traditional coverage. The U.S. General Accounting Office (GAO) found that Medicare lost \$1.3 billion in 1998 by enrolling seniors in HMOs.

In the past two years alone, Medicare HMOs have dumped 750,000 seniors who proved unprofitable. HMOs have recruited seniors by routinely misleading them about benefits. This year, Medicare HMOs are dramatically scaling back the prescription drug coverage that lured many seniors into HMOs in the first place. A four-year study of quality of care by John Ware, published in the October 2, 1996 issue of the *Journal of the American Medical Association*, found that seniors were more likely to decline in health under HMO care than in the traditional Medicare program. Yet instead of recognizing the failures of Medicare privatization, the Heritage Foundation and its allies in Congress push on.

While traditional Medicaid is a program of uneven quality, with large variations by state, the record of for-profit HMOs in treating Medicaid patients has clearly been worse. Florida officials banned 21 of the state's 29 Medicaid HMOs from expanding enrollment several years ago after systematic abuse of patients was uncovered not by state auditors but by courageous investigative reporters at a local newspaper. These HMOs used fraudulent marketing tactics (for instance, telling patients they would lose their Medicaid if they didn't enroll), delivered poor-quality care, disenrolled sick patients, and spent up to 70 percent of program costs on overhead and profits.

In Oregon, the percentage of poor women with inadequate prenatal care and the percentage of low-birthweight babies rose after Medicaid recipients were pushed into HMOs. A large experiment in which families were randomly assigned to HMOs found that low-income persons fared particularly poorly in the HMO setting.

A national health care system is financially viable. According to studies by both the GAO and the Congressional Budget Office, a single payer national health program would streamline health

care paperwork and, in doing so, save enough money to cover the 44.3 million uninsured. It would allow patients to choose their own physicians and hospitals, a right citizens of most industrialized countries take for granted.

Drug companies have the highest rate of profit of any industry, and the United States has the highest drug prices in the world. According to a study by Alan Sager and Deborah Socolar at Boston University, if the U.S. government used its bargaining clout to negotiate drug prices down to Canadian levels, the savings (about \$16.2 billion) would be sufficient to provide the 70 million Americans lacking drug coverage with necessary medications.

A recent *New York Times* article noted that the economy of Sweden is doing so well that the government is giving seniors the right to have a personal home care assistant. But when the U.S. economy does well, as it has since 1992, another 7 million people are thrown into the ranks of the uninsured.

No nation has ever achieved universal health care through the market. We and the 8,500 doctors at Physicians for a National Health Program believe that health care should not be a business but a human service that should be delivered through nonprofit national health insurance. The United States spends nearly twice as much on health care as any other industrialized country, including Sweden, and yet is the only one of these countries that does not guarantee universal coverage.

An editorial in the *Bangor Daily News* recently argued that "health care should be regarded as an essential part of an enlightened society" and that "health care ought to be viewed as a right of citizenship and not an obligation of business." Instead of tinkering with tax credits and HMOs, the candidates should be debating more fundamental questions.

Bill Bradley and Al Gore are pushing the corporate health agenda under the cover of liberal rhetoric. That's no way to get progressives' support.

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For-Profit Kidney Dialysis Centers Compromise Kidney Care

Treatment of end-stage renal disease (ESRD) is a big business in the United States—a \$15.6 billion industry, according to the U.S. Renal Data System. More than 200,000 patients undergo dialysis every year, 68 percent of them receiving their treatment in free-standing centers operated for profit and there is concern that imperatives resulting from the profit motive may be compromising care. Medicare reimbursement for dialysis has remained flat since 1973, which may drive for-profit providers to maintain income by cutting corners on treatment. And because long term dialysis represents a relatively constant source of income, whereas transplantation does not, for-profit providers have an incentive not to refer patients for transplantation surgery, despite the benefits a transplant offers the patient.

A study published in the November 25, 1999, *New England Journal of Medicine* provides evidence that these concerns are justified. Researchers at Johns Hopkins and Harvard looked at differences in care between for-profit and not-for-profit facilities. They found that patients at for-profit facilities were 26 percent less likely to be placed on a waiting list for transplantation. Of even greater concern, they found that death rates were 20 percent higher among patients treated in for-profit facilities than among those treated in non-profits. To make the comparisons valid, the study population was adjusted for sociodemographic, clinical and other differences.

The authors wrote that “our results arouse concern about the current system of payment...that...does not provide incentives to maximize clinical outcomes.” They suggested that enhanced oversight or a new incentive system may be required to improve patient care, and noted that outcomes were improved in for-profit facilities when those facilities were located near competing not-for-profit facilities.

Another study published in the same

New England Journal issue, by John Z. Ayanian, MD, MPP, et al. looked at apparent racial inequities in transplantation. The researchers found that black ESRD patients were less likely to want transplants than white patients, and also less likely to be “very certain” about their decision not to pursue transplantation. However, after adjusting for the preferences and expectations, the data still showed large differences between blacks and whites in rates of referral for transplantation evaluations and in rates of placement on transplantation waiting lists within 18 months after beginning dialysis therapy. The differences also persisted after adjusting data for other variables including health status, type of dialysis facility, coexisting illnesses, socio-demographic characteristics and the cause of renal failure.

Ayanian et al. concluded that racial differences in preferences and expectations “explain only a small fraction of the substantial racial differences in access to transplantation.” Instead, the researchers suggested that “although few patients reported recent discrimination on the basis of their race, income, or sex...blacks may be more likely than whites to encounter problems in communicating with their physicians and may have less trust in the health care system.” The researchers recommended a number of ways to address the problems: 1) provide more systematic education about transplantation; 2) offer stronger encouragement to undergo transplantation and to consider potential living donors; and 3) monitor and inform doctors and medical groups about racial differences in referral rates among their own patients.

This latter research affirms the findings of a separate study published in the October 1, 1998 *Journal of the American Medical Association*, and reported in the November 1998 *Health Letter*. The earlier study indicated that blacks, women, and the poor are less likely to receive kidney transplants

than other Americans with similar transplantation needs. At each of the four stages of the transplantation process (being declared medically suitable, being willing to receive a transplant, undergoing a pre-transplantation workup, and actually receiving a replacement kidney) these groups were disadvantaged by less care. The genuine life-saving benefit of kidney transplants has been confirmed in new research published in the December 2, 1999, *New England Journal of Medicine*. More than simply reducing medical expenses and improving quality of life, the procedure appears to extend the lives of patients suffering from ESRD. This makes comprehensive, equitable treatment for the disease imperative.

An accompanying editorial put findings of the new research in broader perspective. Its author, Norman G. Levinsky, MD, of the Boston University Medical Center, wrote that “the increased mortality among patients treated at for-profit facilities...and the lower quality of care in such facilities, reported by other investigators, suggest that, faced with the same financial pressures, for-profit facilities respond differently from not-for-profit facilities—to the detriment of patient care.” Levinsky remarked that the documented racial disparities are “part of a general pattern in the United States, in which blacks have less access than whites to numerous effective clinical treatments....Such differences...are especially unconscionable in a program [the Medicare End Stage Renal Disease Program] paid for largely by the U.S. Government.”

Levinsky suggested that further research is needed to identify ways to overcome inequities in the ESRD Program, to determine whether inadequate Medicare reimbursement rates have led to erosion of care quality, and to review the practices of for-profit facilities and the kidney specialists treating patients with ESRD.

Point/Counterpoint

Is It Ethical to Pay Research Subjects Large Sums?

The following debate is reprinted from the November 15, 1999 issue of Physicians Weekly© with permission of American Passage Media.

No

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National Institutes of Health

Several moral concerns support limits on the amount of money that should be offered subjects.

One is "undue inducement," meaning that money may potentially cloud the judgment of individuals considering participation in research. As a result, several things could happen, all of which are negative.

People might gloss over, misunderstand, or miscalculate the potential risks and benefits of participating in a study.

A large sum might influence individuals to hide information about their medical history. This jeopardizes not only their own safety but also the integrity of the data and risks the safety of future patients.

A large payment might induce people to participate in a study even if they really don't want to do so.

Large payments might also preferentially attract poorer subjects. The equitable distribution of the benefits and burdens of research is very important. We must ensure that certain groups or individuals are not asked to bear a disproportionate share of the burden. If money skews research participation toward the economically disadvantaged, the distribution of the burden would also be skewed.

Finally, many people are uncomfortable with the idea that someone might participate in research just for the money. Many feel strongly that the true nature of ethical research requires a person to at least understand that participating in research will benefit society.

Large amounts of money may obscure any consideration of other motives. People may not even begin to consider the altruistic aspects of being a research subject or understand the nature of the risks and benefits of the particular study in which they are enrolling.

Yes

Saul Levmore, J.D., Ph.D.
William B. Graham Professor of Law
The University of Chicago School of Law

We already allow the payments—the question is how high these payments should go.

Often, inconvenience and lost time, not risk, are recruitment barriers. Paying a few thousand dollars—if that's what it takes—to people who must endure confinement or side effects is better described as meeting a market clearing price, not unethical behavior.

The ethical rules in place remind researchers to take subjects' and society's needs into account. In many studies, researchers' interests are already well aligned with those of patients. If researchers overpay, potential subjects may withhold medical information to avoid exclusion from the study.

But scientists lose out if subjects suffer because of undisclosed factors in their medical histories. Research could be ruined. Therefore even the most selfish researcher has an incentive not to overpay.

The ideal of highly paid doctors, scientists, politicians, and hospital administrators declaring what is fair reimbursement can be offensively paternalistic. In fact, some subjects receive only the minimal payments that are currently deemed ethical for months of experiments. If we paid more attention to these people's sentiments, there might be a call to increase payments. Perhaps it should be unethical to underpay.

Existing rules about payments to human subjects are vague. The current conventions stem in part from uncertainty about what others will see as ethical and even legal.

There was once a convention of restrained payments to egg donors. But market forces shattered this, perhaps because those who seek fertility treatment are often affluent and politically astute. Payment norms in other areas of medicine may also change, especially if we talk openly about the issue.

◀ *Large amounts of money may obscure any consideration of other motives.*

If researchers overpay, potential subjects may withhold medical information to avoid exclusion from the study. ▶

Product Recalls

November 11—December 8, 1999

DRUGS & DIETARY SUPPLEMENTS

The recalls noted here reflect actions taken by a firm to remove a product from the market. Recalls may be conducted on a firm's own initiative, by FDA request, or by FDA order under statutory authority. A Class I recall is a situation in which there is a reasonable probability that the use of or exposure to the product will cause serious adverse health consequences or death. Class II recalls may cause temporary or medically reversible adverse health consequences. A Class III situation is not likely to cause adverse health effects. If you have any of the drugs noted here, label them *Do Not Use* and put them in a secure place until you can return them to the place of purchase for a full refund. You can also contact the manufacturer. If you want to report an adverse drug reaction to the FDA, call (800) FDA-1088. The FDA website is <http://www.fda.gov>.

Our listing of drug recalls this month includes Class I recalls of almost 2 million kits and injections for treating allergic reactions. The epinephrine in these injections and bee-sting allergy kits was found to be subpotent. This could pose a potential health hazard for those with known allergies because the epinephrine increases blood flow and helps restore breathing when used to treat acute asthma attacks or severe allergic reactions to insect stings or certain foods. Thus, serious adverse consequences or death could result from this defective product. All of these products were manufactured by Wyeth-Ayerst Laboratories, a division of American Home Products. The recall includes:

a) Ana-Kit Anaphylaxis Emergency Treatment Kit—consisting of one syringe (1.0 mL) containing two single doses (0.3 mL) of Epinephrine Injection USP, (1:1000) labeled in part Pkgd. and Dist. By: Bayer Corporation Pharmaceutical Division, Spokane, WA 99207, sold as individual kits or 6-packs. NDC 0026-9988-01 and 0026-9988-06

b) Ana-Guard Epinephrine Injection USP (1:1000)—consisting of one syringe (1.0 mL) containing two single doses (0.3 mL) of Epinephrine Injection USP, (1:1000), labeled in part ANA-GUARD EPINEPHRINE INJECTION, USP (1:1000) ** Pkgd. and Dist. By: Bayer Corporation Pharmaceutical Division, Spokane, WA 99207 NDC 0026-9984-01 and 0026-9984-06

c) Epinephrine Injection, USP (1:1,000) Syringe—a refill item for the above two sold as 500 syringes/box under NDC# 0026-9982-01 each containing two single doses (0.3 mL) of Epinephrine Injection USP, (1:1000)

d) DERM/BURO INSECT STING KIT, Rx—consisting of one syringe (1.0 mL) containing two single doses (0.3 mL) of Epinephrine Injection USP, (1:1000), Pkgd. and Dist. by: Derm/Buro Inc., Deerfield, IL 60015

e) Epinephrine Injection, USP, 1:1000, Rx, in 1 mg/1 mL Tubex syringes, (25 gauge 5/8 inch needle) units of 10

All kits and syringes should be returned to the hospital, clinic or pharmacy where they were obtained. If you have any questions about the lot numbers and exact kits that are subject to this recall, check with your pharmacy. You can also find this information on the FDA website at <http://www.fda.gov/bbs/topics/ENFORCE/ENF00617.html>

Name of Drug or Supplement: Class of Recall: Problem

Albuterol—Warrick Pharmaceuticals brand, Inhalation Aerosol, 17 g, 200 metered inhalations, Rx for prevention and relief of bronchospasm; Class III; Insert mislabeling; insert incorrectly instructs user to only use with orange mouth piece, while product is accompanied by white mouthpiece, the correct color

Aldoril D50 Tablets, (Methyldopa (500mg)-Hydrochlorothiazide (50mg)), in 100 tablet bottles, Rx used to control hypertension; Class III; Dissolution failure for Hydrochlorothiazide

Anzemet Tablets (Dolasetron Mesylate), 100 mg, bottles of 5 tablets, Rx anti-nauseant and anti-emetic; Class III; Stability (6 month) test failure elevated degradation

Lot #: Quantity and Distribution: Manufacturer

Batch and EXP; 9-BBS-540 3/01, 9-BBS-548 through 9-BBS-556 EXP 4/01, 9-BBS-557 through 9-BBS-569 EXP 5/01, 9-BBS-570 EXP 5/01, 9-BBS-572 through 9-BBS-574 EXP 6/01, 9-BBS-811 EXP 2/01, 9-BBS-817 through 9-BBS-820 EXP 4/01; 5,187,724 units distributed nationwide and in Puerto Rico; Schering Laboratories, Inc., Kenilworth, New Jersey

Lot Numbers: B5511 EXP 1/00, D5714 EXP 4/00, D5719 EXP 4/00, E6156 EXP 4/00, E6172 EXP 2/00, H3896 EXP 4/00; 15,424 bottles distributed nationwide; Merck and Company, Inc., West Point, Pennsylvania

Lot Numbers: 3001616 EXP 2/01, 3003145 EXP 2/01, and 3003148 EXP 4/01; 10,329 bottles distributed in Ohio and Missouri; Hoechst Marion Roussel, Inc., Cincinnati, Ohio

DRUGS & DIETARY SUPPLEMENTS, cont.

Name of Drug or Supplement; Class of Recall; Problem

Country Health Formula #63 MSM Eye and Ear Drops, OTC, in 1 ounce bottles; Class II; Current good manufacturing practice deviations

Derma-Clear(tm), Skin Bleaching Treatment and Jeval A-Peel, Skin Bleaching Treatment, over-the-counter topical cream in 2 and 4 oz. plastic jars, (same ingredients, 2 trade names); Class II; New drug without new drug approval (contains more than 2% hydroquinone)

Duratuss G Tablets, (Guaifensin), 1200 mg, in 500 tablet bottles, Rx 12-hour sustained release expectorant; Class III; Dissolution failure

Hibostat Germicidal Hand Rinse, (Chlorhexidine gluconate), 0.5% w/w, OTC, used by health care professionals as a germicidal hand rinse; Class III; Alcohol low potency and specific gravity failure; rework without current good manufacturing practice control

Invigorate(tm) Liquid Drink in 32 fluid ounce plastic bottles. Label declares as an ingredient 2(3H) Furanone Di-hydro, also known as gammabutyrolactone (GBL), a supplement which stimulates the body's own ion of human growth hormone and as a sleep aid which "will induce deep invigorating sleep that will last 3-4 hours;" Class I; Unapproved new drug

Klonopin (brand of Clonazepam) Tablets, 0.5 mg, 1 mg, and 2 mg, distributed in bottles of 25 and 100 tablets; Class III; Impurity level exceeds specification

Koleprin DM Caplets, in 30 caplet bottles, OTC prompt release, cough and cold medication; Class III; Friability failure

Requip (Ropinirole Hydrochloride) 1 mg tablets, in bottles of 100, Rx for the treatment of Parkinson's disease; Class III; Tablets have been found to fade from green to yellow, making it difficult to distinguish between strengths or could cause the wrong product to be dispensed

Rocaltrol Capsules, (Calcitriol), 0.25 mcg, Rx, in 100 capsule bottles; Class II; Potential microbial contamination (*Bacillus cereus*/ *Methylobacterium* sp)

Lot #: Quantity and Distribution; Manufacturer

Lot Numbers: 433, 7538, 9463 and 9749; 541 containers distributed in Idaho; Cosmetic Specialty Labs, Inc., Lawton, Oklahoma. Recalled by BioMechanics, Aberdeen, Idaho

Lot & (Batch) Numbers: 90-0-5 (3728), 0-0-5 (3728), 1234567890-7 (4314), 234567890-7 (5109), 34567890-7 (5245), 4567890-7 (5461), 567890-7 (6197), 67890-7 (6242), 7890-7 (7237); 5,279 units distributed in Texas; Cosmetic Specialty Labs, Inc. (CSL), Lawton, Oklahoma

Lot Numbers: J980726A and J9800727A; unknown quantity distributed in Wisconsin; Mikart, Inc., Atlanta, Georgia

Lot #3152B EXP 4/01; 33,432 bottles distributed nationwide and in Saudi Arabia; Accupac, Inc., Mainland, Pennsylvania. Recalled by AstraZeneca, Wilmington, Delaware

All lots remaining on the market; Undetermined quantity distributed nationwide; Invigorate International, New York, New York. Recalled by Cabot Industries, LLC, West Babylon, New York

All lots, NDC 0004-0068-01, 0004-0068-50, 0004-0058-01, 0004-0058-50, 0004-0098-01 and 0004-0098-50; Approximately 48,706 bottles distributed nationwide; Roche Pharma, Inc., Humacao, Puerto Rico. Recalled by Roche Laboratories, Inc., Nutley, New Jersey

Lot #98603 EXP 2/01; 2,659 units distributed nationwide; SSS/Pfeiffer Pharmaceuticals, Inc., Atlanta, Georgia

Numerous lot numbers; 20,000 bottles distributed nationwide; SmithKline Beecham Pharmaceuticals, Crawley, West Sussex. Recalled by SmithKline Beecham Pharmaceuticals, Philadelphia, Pennsylvania

Lot #0419 EXP 10/31/00; 173 bottles distributed nationwide; Roche Laboratories, Inc., Nutley, New Jersey

M E D I C A L D E V I C E S

Device recalls are classified in a manner similar to drugs, Class I, II or III, depending on the seriousness of the risk presented by leaving the device on the market. Contact the company for more details. You can also call the FDA's Device Recall and Notification Office at (301) 443-4190. To report a problem with a device, call 1-800-FDA-1088. The FDA website is <http://www.fda.gov>.

Name of Device; Class of Recall; Problem

Proclear Compatibles Daily Wear Contact Lens; Class II; Leaking blister seal of contact lens packaging compromised sterility

Lot #: Quantity and Distribution; Manufacturer

416 lots of lenses each identified with a 10 digit reference number; 119,028 lenses distributed nationwide; Biocompatibles Eyecare, Inc., Norfolk, Virginia

C O N S U M E R P R O D U C T S

Contact the Consumer Product Safety Commission (CPSC) for specific instructions or return the item to the place of purchase for a refund. For additional information from the Consumer Product Safety Commission (CPSC), call their hotline at 1-800-638-2772. The CPSC website is <http://www.cpsc.gov>.

<i>Name of Product; Problem</i>	<i>Lot #: Quantity and Distribution; Manufacturer</i>
Aquarium Lights; Sharp edges on lights could cut insulation on the wiring. If wires become exposed, can cause shocks, electrocution and fire risk	All 36-inch SHOlights that hold two bulbs, and all SHOlights lights manufactured in July 1999 or earlier; 23,400 sold nationwide from August 1998 through July 1999; Perfecto Manufacturing Inc., Noblesville, Indiana (800) 241-7485
Boys Jackets; 7-inch drawstrings at the bottom of the jackets. Children could be dragged if the drawstrings catch in a vehicle's door, and suffer injury or death	USA Olympic brand; 20,000 J.C. Penney Co. Inc., Plano, Texas (888) 333-6063 www.jcpenney.com
Bunk Beds; Top bunk does not have guardrails on both sides. A child could fall or become entrapped between the wall and the mattress	Sold under the model names Prestige, Spindle, and Cottage, made of Northern White Ash with natural, cherry, honey or golden finishes; 2,800 sold at furniture and specialty bedroom stores throughout New England from May 1995 through February 1998; Northern Bedroom's Inc., Oxford, Maine (888) 800-7708
Camp Mess Kits; Sauce pan handle does not lock into place and fry pan handle can bend during use, spilling hot foods or liquids onto consumers and causing serious burns	Texsport label, 5-Piece kit; 146,000 sold at camping, mass merchandise and army surplus stores nationwide and in Puerto Rico from May 1994 through September 1999; Southern Exchange Co. Inc., Houston, Texas (800) 231-1402
Children's Pajamas; The pajama sets fail to meet federal children's sleepwear flammability standards	Style numbers 353558, 353554, 733002, 733032, 466291 and 67060. The style numbers are located on labels sewn into the side seams or collar of the garment; 231,000 sold at GapKids, babyGap, Gap Outlet and Old Navy stores nationwide from August through December 1999; Gap Inc., San Francisco, California (800) GAPSTYLE or (800) OLD NAVY www.gap.com or www.oldnavy.com .
Electrical Voltage and Continuity Testers; Batteries in tester could fail to maintain proper contact due to corrosion within the battery compartment, causing device to lose power posing risk of shock, electrocution, and thermal burns	Model T-2 hand-held with serial number lower than 74165430; 58,000 sold nationwide from December 1997 through September 1999; Fluke Corp., Everett, Washington (800) 753-8646 www.fluke.com/whatsnew/Notices/notices_99-10-01.asp
Mountain Bikes; Defective handle bar stems which do not tighten sufficiently to lock onto bicycles which can cause front wheel not to turn properly, resulting in serious injuries to the rider from falls	Magna "Great Divide," 21-speed mountain bikes (24-inch size for girls and boys, 26-inch size for women and men). The words "Great Divide" are located on the cross-tubes of these bicycles and the word "KALLOY" is located on the handlebar stems; 3,000 sold at Fred Meyer Stores in Alaska, Arizona, Idaho, Oregon, Utah and Washington from December 1998 through August 18, 1999; Dynacraft Industries Inc., San Rafael, California (800) 551-0032
Sewing Machines; When removing the sewing machines power cord from the power transformer on the sewing machine, loose pins from the power transformer could remain in the cord, posing a risk of electric shock	Husqvarna Viking model #1+ Serial Number Range between 10000001 and 19999991, Serial Number Range between 20000009 and 29999999, Serial Number Range between 33600003 and 33699993, Serial Number Range between 50000002 and 59999992; 1,100 sold nationwide from January 1998 through September 1998; Viking Sewing Machines Inc., Cleveland, Ohio (800) 446-2333
Trampoline Safety Net Enclosures; straps on the bottom of the net can break. Children can fall out under the net and off the trampoline and be injured	Look for black buckles and black or red extension straps on the yellow straps; 2,300 sold at Costco, BJ's, Academy and Bradlees stores nationwide from February to July 1999 for about \$150 to \$230; JumpSportInc., of Saratoga, California (888) 567-5867
Underwater Strobes; If strobe becomes flooded, gas build-up can cause battery cap to forcefully eject off of the strobe or cause front section to violently separate from the back section	Models YS-50, YS-60 and YS-120 with serial numbers beginning with 96 or 94; 7,000 sold nationwide from February 1988 through March 1999; Sea & Sea Underwater Photography (U.S.A.) Inc., Carlsbad, California (800) 732-7977

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Mistakes Kept Secret

She filed suit against the surgeon and hospital. They denied the charges. Her lawyer says most cases are settled and kept secret. "The medical profession seems to like to keep the errors that are made a secret to maintain the faith in the profession," said attorney Andrew Meyer.

That's why consumer advocates say the report's call for mandatory reporting of medical errors will likely face stiff resistance from doctors and hospitals.

But the Institute of Medicine says it is important not to blame individual doctors and hospital workers for errors, but to set up systems that stop mistakes from occurring in the first place.

One of the best systems is Brigham and Women's Hospital in Boston. There, all doctors enter their orders in a computer. This prevents mistakes caused by doctors' bad handwriting—like one that a jury found actually led to a patient's death in Texas.

Hospital Errors Leave Dozens Dead

But the computer does much more, including checking the doctor's order automatically against the patient's history. The report said systems like Brigham and Women's are necessary to help create a new culture of safety. Cases like Larviere's show it is long overdue.

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Study Shows Widespread Medical Errors

The following is reprinted from a report done by NBC Nightly News, with Bob Bazell reporting, on November 29, 1999.

Nov. 29—In a blistering report released Monday, a prestigious medical group said America's entire health care system needs "dramatic changes" to cut the enormous number of deaths and injuries from medical errors.

The group said hospitals should report mistakes to the federal government—not keep them secret as they often do now.

"For too long medical errors in hospitals and elsewhere have been buried and it is long overdue that they need to be reported to public agencies," said Dr. Sid Wolfe of Public Citizen, a consumer watchdog group.

Experts say between 44,000 and 98,000 Americans die from mistakes every year

in hospitals alone. That makes hospital errors the eighth leading cause of death—actually ahead of traffic accidents, breast cancer and AIDS. The report from the Institute of Medicine, a division of the National Academy of Sciences, said the numbers could be cut sharply. It sets as

"a minimum goal a 50 percent reduction in errors over five years."

Leading Causes of Death

According to the Institute of Medicine's figures, medical mistakes could rank eighth among the nation's leading causes of death. Other studies double that estimate, placing it above accidents as a killer of Americans.

Errors like the one that happened to Kim Larviere. Last year she entered the hospital for simple, routine surgery to remove varicose veins from her leg. But she says the surgeon mistakenly cut a key artery. Now she is severely disabled with a portion of one foot amputated. "Before it happened, I was a very independent woman. I did everything. I came and went as I pleased," said Larviere.

CAUSES	DEATHS (1997)
1. Heart disease	726,974
2. Cancer	539,577
3. Stroke	159,791
4. Chronic obstructive pulmonary (lung) disease	109,029
5. Accidents	95,644
6. Pneumonia & the flu	86,449
7. Diabetes	62,636
8. Medical mistakes	44,000
9. Suicide	30,535
10. Kidney-related disorders	25,331

National Vital Statistics Reports and the Institute of Medicine

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