PUBLIC CITIZEN HEALTH RESEARCH GROUP

Health Letter

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Health Policy Placebos

The following article "supporting single-payer national health insurance" by Drs. Stephanie Woolhandler and David Himmelstein, of Harvard Medical School and Cambridge City Hospital and founders of Physicians for a National Health Program, is reprinted with permission from the April 14, 2008, issue of The Nation. *This article is part of the* Health Letter*'s on-going effort to educate our readers on the national health care crisis and the need to move toward single-payer health insurance. This issue of the* Health Letter *contains another article on this topic, as have the February 2008 and March 2008 issues, to name a few. As the Woolhandler-Himmelstein article reflects, election-year debate will naturally include important issues like national health insurance. Public Citizen is a non-partisan organization, and it takes no position on the candidates in the upcoming elections or in any other election.*

We don't administer useless nostrums for curable cancer—even when effective treatment is arduous. Yet Hillary Clinton and Barack Obama prescribe the health policy equivalent of placebos. (John McCain suggests arsenic, but more about him another time.)

The Democratic contenders proffer a superficially plausible reform model that has a long record of failure. Their proposals trace back to Nixon's 1971 employer mandate scheme, concocted to woo moderate Republicans away from Ted Kennedy's single-payer plan. Like mandate reforms subsequently passed (and failed) in Massachusetts (1988), Oregon (1989) and Washington (1993), Clinton's and Obama's plans would couple subsidies for the poor with a requirement that large employers foot part of the bill for employee coverage. These earlier reforms also required the self-employed to buy coverage, an individual mandate that Clinton (like the 2006 Massachusetts reform) would expand to virtually all; Obama limits his mandate to children. In both versions, a federal agency would serve as insurance broker, selling a new public plan and a menu of private ones—reprising the format of Medicare's ongoing privatization, implemented through competition rigged to favor private plans [see Trudy Lieberman, "The Medicare Privatization Scam, *The Nation*" July 16/23, 2007].

The earlier state reforms foundered on the shoals of cost. As health spending soared, employers rebelled and legislators rescinded the mandates and subsidies. Massachusetts looks set to replay this experience; only 7 percent of those required to buy unsubsidized coverage have yet to sign up, while the state wrestles with massive cost overruns for subsidies.

Proposals that rely on private insurers can add coverage only by adding costs. Both Democrats promise savings from computerization, prevention and chronic disease-care management. Yet medical computing hasn't yielded savings, despite thirty years of rosy promises. As for prevention, a raft of studies show that it saves lives but not money. And the Medicare Health Support program recently abandoned its care management project because it yielded no savings. Both Democrats'

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proposals forgo the administrative savings possible under single-payer national health insurance (NHI) such as that proposed by the Conyers/Kucinich bill (HR 676) and by Ralph Nader. Bureaucracy consumes 31 percent of US health spending, versus 17 percent in Canada. The difference translates into $350 billion frittered away annually here, where a million healthcare workers, as well as hundreds of thousands in the insurance industry, spend their days on useless paperwork.

This waste is a natural byproduct of private insurance. Private plan overhead is eleven times that of Canada's NHI program. Each dollar spent on private premiums buys only 88 cents of care; the rest pays for insurers' marketing, underwriting, utilization reviewers and profits—and for the billions paid to their CEOs. Fragmented coverage also means duplication of claims-processing facilities and mountains of paperwork for doctors and hospitals, which must deal with multiple insurance products each with its own eligibility rules, co-payments, referral networks, etc.—tasks that are absent in Canada. Our multiplicity of insurers also precludes the payment to hospitals of a global, lump-sum budget. In Canada global budgets obviate the need for most hospital billing and much of the internal accounting needed to attribute costs to individual patients and payers.

Clinton's and Obama's plans also lack credible means to redirect the hundreds of billions now wasted on overtreatment. Hospitals, doctors and equipment firms profit from investments in expensive high-tech care, encouraging the overuse of interventions that help some patients but harm others—for example, spine surgery, cardiac stents and CAT scans (which often deliver radiation equivalent to 500 chest X-rays). Insurers limit their outlays through intrusive case-by-case reviews or by raising co-payments. But they have little interest in systemwide cost control, so their efforts have mainly shifted costs to patients or other payers—the economic equivalent of squeezing a balloon. In contrast, NHI would allow explicit public decision-making about today's capital investments that shape tomorrow's care, and straightforward mechanisms to limit profit.

"Each dollar spent on private premiums buys only 88 cents of care; the rest pays for insurers' marketing, underwriting, utilization reviewers and profits—and for the billions paid to their CEOs."

Without savings, the tax increases Obama and Clinton propose would be eaten up by subsidies for the uninsured, leaving nothing for the majority of Americans already covered but often unable to afford care. As we found in a 2005 study with Elizabeth Warren and Deborah Thorne, three-quarters of the 750,000 families driven to bankruptcy each year by illness or medical bills had coverage, though with unaffordable co-payments, deductibles and uncovered services. NHI would eliminate these gaps. Private insurers caused the healthcare crisis. Yet both Democratic contenders advocate reforms that would fortify private plans, making government their debt collector. Their proposals, while palatable to the health industry—which supplies the Democrats with huge donations as well as key officials (DNC credentials committee co-chair James Roosevelt moonlights as an insurance company CEO)—cannot cure our healthcare crisis.

Nonetheless, we're optimistic about the prognosis for healthcare reform. If you turn up the volume on C-SPAN you can hear the audience cheering whenever Clinton or Obama lets the words "single payer" slip out—a reflection of the fact that three-fifths of the general public, as well as the 124,000-member American College of Physicians, support NHI. As in the JFK era, a charismatic, if only tepidly liberal, candidate can help raise hopes and expectations, igniting a mass movement that pushes a progressive agenda further and faster than the candidate intends.

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THE PUBLIC CITIZEN HEALTH RESEARCH GROUP
Health Letter

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Physician Support for National Health Insurance on the Rise

A new study of U.S. physicians has found, contrary to previous opposition by doctors, that almost 60 percent of physicians support legislation to establish national health insurance.

In the United States, proposals for national health insurance have usually been opposed if not undermined by organized medicine. But that has not always been the case. In 1915, when the possibility of sickness insurance was first proposed by the American Association for Labor Legislation —a coalition of academicians, businessmen, and labor leaders— the American Medical Association supported the idea. But by 1917, following the Russian Revolution and the entry of the U.S. into World War I, this support had languished and most states lost interest in reforming the payment of care.

When the idea of national health insurance resurfaced during the first Franklin D. Roosevelt administration, the times seemed ripe for reform. Still, FDR felt that economic security was more important than health insurance, and used his political capital to press for the former. Although the Committee on the Costs of Medical Care had issued its report in 1932 supporting health reform and the American Federation of Labor pressed for universal health coverage, the virulent opposition of the AMA and the more subtle nudging of Dr. Harvey Cushing (an FDR in-law) led the President to skirt the issue. The Social Security Act therefore deliberately excluded health insurance.

In 1948 President Harry S Truman officially endorsed national health insurance. Again, the political climate did not favor his views. The combined effect of Cold War ideology and the witch hunts of Wisconsin senator Joseph McCarthy, who saw communists lurking everywhere, helped squash any possibility of reform. During this period, the AMA developed a powerful war chest that helped defeat 80 percent of pro-health insurance legislators in 1950.

The AMA was therefore armed and ready when a national health insurance plan for the elderly, Medicare, was proposed. While organized medicine recognized a need to cover the elderly and was not entirely opposed to the legislation, it was able to influence the agenda and protect fee-for-service. In the end, physicians ended up as winners, with more covered patients and a fee schedule that reflected their interests.

Sporadic attempts at major health reform during the Nixon years did not prosper, even though Senator Kennedy proposed a national health insurance plan with a single government payer as in Medicare. It was not until 1993 and 1994 and the first Clinton administration that national health insurance was once again under serious consideration. Although at first blush it seemed that the planets had aligned to support the enactment of a national health plan, any semblance of consensus quickly fell apart following a very cumbersome process. The deliberations were orchestrated by several health insurance companies, led by the First Lady, excluded Congress, and were perceived as secretive, all fatal flaws that jeopardized political success. The outcome was equally dysfunctional, producing an acronym-studded, complicated plan that defied sound bites and even reasonable political debate. In the end, the plan was torpedoed by the insurance companies, who launched a much more effective publicity campaign against the plan. The public understood the ads a lot better than they grasped the proposed reform, thereby assuring that national health insurance was a taboo subject for the remainder of the Clinton years.

It is against this backdrop that the current debate must be seen. As all presidential candidates once again approach the subject of health reform, they know that they must mobilize support beforehand if any proposal is likely to be approved. This time, not only is the medical profession failing to oppose national health insurance, but the majority is actually supporting a national health scheme. A national survey conducted by two faculty members of the Indiana University School of Medicine found that 59 percent of respondents supported legislation to establish national health insurance (28 percent "strongly" and 31 percent "generally"). The survey had a 51 percent response rate, but respondents did not differ significantly from non-respondents with respect to sex, age, type of doctoral degree, or specialty. Support for national health insurance varied by specialty. Psychiatrists were the most supportive, with 83 percent in favor. These were followed by pediatric subspecialists (71 percent), emergency medicine physicians (69 percent), general pediatricians (65 percent), general internists (64 percent), family physicians (60 percent) and general surgeons (55 percent). The only specialties in which less than half of those responding supported national health insurance were the surgical subspecialties, anesthesiology, and radiology.

The current survey, which was published in the Annals of Internal Medicine, replicates a 2002 survey, when 49 percent of respondents supported the establishment of national health insurance. What, then, accounts for the rise in support? The survey does not provide any clues, but we can speculate on some of the reasons:

- There may be a difference in the physician pool, with new entrants to the medical profession being more accepting of change than those that have retired, who most likely entered the profession when solo practice and fee-for-service

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Public Citizen's Health Research Group Ranking of the Rate of State Medical Boards' Serious Disciplinary Actions, 2005-2007

Using data just released by the Federation of State Medical Boards (FSMB) on the disciplinary actions taken against doctors in 2007, we have calculated that there were 2,743 serious disciplinary actions (revocations, surrenders, suspensions and probation/ restrictions) taken by state medical boards in 2007, a sharp decrease in such actions from 2004, when the number peaked at 3,296. This marks the third consecutive year the number of these actions has decreased from the previous year. This means that there were 553 fewer serious disciplinary actions in 2007 than in 2004, even though there was a 6 percent increase in the number of physicians during that time. Calculating the rate of serious actions by dividing by the increasing numbers of physicians each year allows a calculation of the rate of serious actions per 1000 physicians over time.

As seen in the figure on page 5, the 2007 national disciplinary rate of 2.92 serious actions per 1000 physicians was also down for the third consecutive year compared with 3.18 in 2006 (3.62 in 2005 and 3.72 in 2004). This decrease in rate represents a 22 percent fall since 2004 and is the lowest rate since 2000.

The three-year average state disciplinary rates (2005-2007) ranged from 1.18 serious actions per 1,000 physicians (South Carolina) to 8.33 actions per 1,000 physicians (Alaska), a 7.1-fold difference between the best and worst state doctor disciplinary boards.

10 Worst States (those with the lowest three-year rate of serious disciplinary actions)

As can be seen in Table 1, the bottom 10 states, those with the lowest serious disciplinary action rates for 2005-2007, were, starting with the lowest: South Carolina (1.18 actions per 1,000 physicians); Minnesota (1.24); Mississippi (1.46); Wisconsin (1.63); South Dakota (1.95); Nevada (2.19); Connecticut (2.21).Washington (2.24); Maryland (2.26); and New Jersey(2.32).

Four of these 10 states, (Maryland, Minnesota, South Carolina, and Wisconsin) have been among the bottom 10 states for each of the last five three-year periods. In addition, Nevada, South Dakota and Washington have been in the bottom 10 states for each of the last three three-year cycles.

States with Largest Decreases from 2001 to 2007

Ten states have experienced at least a 10-place worsening in ranking between the 2001-3 ranking and the 2005-7 ranking: Alabama went from 13th to 34th; California from 22nd to 36th; Georgia from 15th to 33rd; Idaho from 14th to 25th; Massachusetts from 23rd to 35th; Mississippi from 20th to 49th; Nevada from 33rd to 46th; New Jersey from 24th to 42nd; North Dakota from 3rd to 13th; and South Dakota from 37th to 47th.

10 Best States (those with the highest three-year rates of serious disciplinary actions)

The top 10 states for 2004-6 are (in order from the top down): Alaska (8.33 serious actions per 1,000 physicians); Kentucky (6.55); Ohio (5.71); Arizona (5.37); Nebraska (5.19); Colorado (4.92); Wyoming (4.86); Vermont (4.83); Oklahoma (4.75); and Utah (4.72).

Seven of these 10 states, Alaska, Arizona, Colorado, Kentucky, Ohio, Oklahoma, and Wyoming have been ranked in the top ten for all five of the three-year average periods in this report.

States with Largest Improvement from 2001 to 2007

Ten states have experienced at least a 10-place improvement in ranking between the 2001-3 ranking and

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were the dominant modalities.

- Physicians are more aware of the 47 million Americans who lack health insurance, a fact that is widely publicized by the AMA, among others.
- National health insurance has become increasingly attractive at a time of dwindling employer-based coverage, lagging Medicaid fees, and ever more complicated reimbursement systems required by private insurers.
- Physicians are all too cognizant of the fact that international rankings show the United States to be #1 only in how much it spends, lagging in every other indicator of health service access and health status outcome.

While national health insurance is not synonymous with a single-payer system, it is but a short step for support for the former to result in advocacy for the latter since it is not possible to have national health insurance in this country and yet retain the wasteful private health insurance industry. U.S. physicians just need to recognize that the high administrative costs of current U.S. health care are neither in their own nor in their patients' interests. At present more than half of all Americans support a single –payer system in which all Americans would have their health expenses covered by a taxpayer-financed government plan. Given the present levels of discontent with how health services are delivered and paid, change is likely. As Arnold Relman has framed the choice, physicians will have to decide if they cast their lot with the multiple insurers to which they devote too much time and paperwork, or with their consciences, their patients, and the standards of their professional peers.

the 2005-7 ranking: Arkansas from 29th to 16th; Delaware from 50th to 29th; District of Columbia from 42nd to 22nd; Hawaii from 51st to 21st; Illinois from 35th to 12th; Maine from 34th to 24th; Nebraska from 28th to 5th; Rhode Island from 46th to 23rd; Tennessee from 44th to 28th and Vermont from 19th to 8th.

Discussion

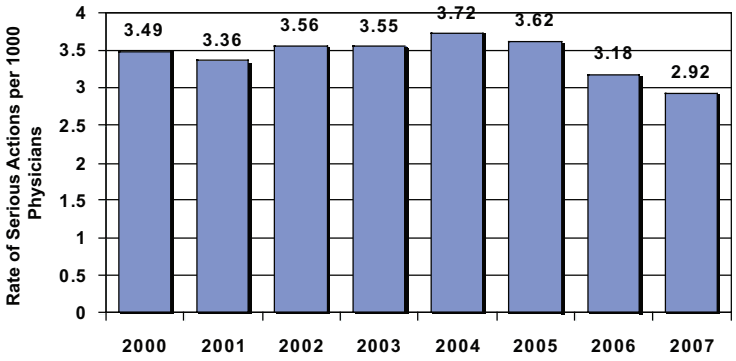
These data demonstrate a remarkable variability in the rates of serious disciplinary actions taken by the state boards. Only one of the nation's 15 most populous states, Ohio, is represented among those 10 states with the highest disciplinary rates. Absent any evidence that the prevalence of physicians deserving of discipline varies substantially from state to state, this variability must be considered the result of the boards' practices. Indeed, the ability of certain states to rapidly increase or decrease their rankings (even when these are calculated on the basis of three-year averages) can be due only to changes in practices at the board level; the prevalence of physicians eligible for discipline cannot change so rapidly.

Moreover, there is considerable evidence that most boards are under-disciplining physicians. For example, in a report on doctors disciplined for criminal activity that we published recently, 67 percent of insurance fraud convictions and 36 percent of convictions related to controlled substances were associated with only non-severe discipline by the board.

In this report, we have concentrated on the most serious disciplinary actions. Although the FSMB does report less severe actions such as fines and reprimands, it is not appropriate to give such actions equal weight as license revocations, for example. A state that embarks on a strategy of switching over time from revocations or probations to fines or reprimands for similar offenses should have a rate and a ranking that reflects this decision to discipline less severely.

A relatively recent trend has been for state boards to post the particulars

Rate of Serious Disciplinary Actions by State Medical Boards: 2000-2007



of disciplinary actions they have taken on the Internet. In October 2006, Public Citizen's Health Research Group published a report that ranked the states according to the quality of those postings (available online at http://www.citizen.org/publications/release.cfm?ID=7478).

The report showed variability in the quality of those Web sites akin to that reported for disciplinary rates in this report. There was no correlation between state ranking in the Web site report and state ranking in that year's disciplinary rate report (Spearman's rho = 0.0855; p=0.55). A good Web site is no substitute for a poor disciplinary rate (or vice versa); states should both appropriately discipline their physicians and convey that information to the public. However, no state ranked in the top 10 in both reports.

This report ranks the performance of medical boards by their disciplinary rates; it does not purport to assess the overall quality of medical care in a state or to assess the function of the boards in other respects. It cannot determine whether a board with, for example, a low disciplinary rate has been starved for resources by the state or whether the board itself has a tendency to mete out lower (or no) forms of discipline. From the patient's perspective, of course, this distinction is irrelevant.

What Makes a Difference?

Boards are likely to be able to do a better job in disciplining physicians if the following conditions are met:

- Adequate funding (all money from license fees going to fund board activities instead of going into the state treasury for general purposes)
- Adequate staffing
- Proactive investigations rather than only reacting to complaints
- The use of all available/reliable data from other sources such as Medicare and Medicaid sanctions, hospital sanctions, malpractice payouts, and the criminal justice system
- Excellent leadership
- Independence from state medical societies
- Independence from other parts of the state government so that the board has the ability to develop its own budgets and regulations
- A reasonable legal standard for disciplining doctors ("preponderance of the evidence" rather than "beyond a reasonable doubt" or "clear and convincing evidence").

Most states are not living up to their obligations to protect patients from doctors who are practicing medicine in a substandard manner. Serious attention must be given to finding out which of the above bulleted variables are deficient in each state. Action must then be taken, legislatively and through pressure on the medical boards themselves, to increase the amount of discipline and, thus, the amount of patient protection. Without adequate legislative oversight, many medical boards will continue to perform poorly.

Table 1: Ranking of Serious Doctor Disciplinary Action Rates by State Medical Licensing Boards, 2005-2007

Rank 2005-2007[1]	State	Number of Serious Actions, 2007	Number of Physicians, 2006[2,3]	Serious Actions per 1,000 Physicians, 2005 – 2007[4]
1	Alaska	19	1,832	8.33
2	Kentucky[5]	83	11,251	6.55
3	Ohio[5]	207	37,812	5.71
4	Arizona	81	15,127	5.37
5	Nebraska[5]	21	5,007	5.19
6	Colorado[5]	75	15,073	4.92
7	Wyoming[5]	3	1,206	4.86
8	Vermont	10	2,659	4.83
9	Oklahoma	22	7,111	4.75
10	Utah	32	6,093	4.72
11	Iowa[5]	29	7,528	4.55
12	Illinois[5]	170	41,581	4.52
13	North Dakota[5]	10	1,802	4.49
14	Louisiana[5]	46	12,755	4.35
15	North Carolina[5]	106	26,064	4.25
16	Arkansas[5]	17	6,696	3.98
17	Oregon[5]	40	12,267	3.91
18	West Virginia	11	4,710	3.87
19	New York[5]	279	87,497	3.73
20	Montana[5]	11	2,671	3.58
21	Hawaii[5]	14	4,779	3.55
22	District of Columbia[5]	23	5,087	3.37
23	Rhode Island[5]	18	4,569	3.29
24	Maine	13	4,197	3.24
25	Idaho[5]	8	3,149	3.13
26	New Hampshire[5]	10	4,289	3.12
27	Indiana[5]	46	16,014	3.12
28	Tennessee	43	17,791	2.99
29	Delaware[5]	10	2,638	2.94
30	Missouri[5]	40	17,447	2.92
31	Florida	158	53,566	2.89
32	Texas[5]	136	58,188	2.86
33	Georgia[5]	58	23,533	2.86
34	Alabama[5]	23	11,367	2.85
35	Massachusetts[5]	77	33,193	2.79
36	California	220	110,406	2.74
37	New Mexico	8	5,424	2.72
38	Pennsylvania	118	42,204	2.70
38	Virginia[5]	70	24,376	2.60
40	Michigan	69	27,877	2.48
41	Kansas[5]	15	7,725	2.33
42	New Jersey[5]	79	33,103	2.32
43	Maryland[5]	56	26,623	2.26
44	Washington	49	20,602	2.24
45	Connecticut[5]	27	14,895	2.21
46	Nevada	15	5,384	2.19
47	South Dakota[5]	7	2,072	1.95
48	Wisconsin[5]	28	16,837	1.63
49	Mississippi[5]	9	6,185	1.46
50	Minnesota[5]	15	17,186	1.24
51	South Carolina[5]	9	11,590	1.18
	National	**2,743**	**939,038**	**3.46**

1. Rank is calculated based upon an average of the disciplinary rates for 2005, 2006, and 2007. **2.** Includes osteopathic physicians for boards with jurisdiction over both physicians and osteopaths. **3.** In previous reports we used non-federal physicians, but in this report we used data for total physicians because the American Medical Association no longer provides physician data broken down by federal/non-federal status. **4.** Disciplinary rate for the period is calculated by averaging the disciplinary rates over the three-year period 2005-7. **5.** These states have a combined state medical and osteopathy board.

Product Recalls

March 14, 2008 -April 15, 2008

This chart includes recalls from the Food and Drug Administration (FDA) Enforcement Report for drugs and dietary supplements, and Consumer Product Safety Commission (CPSC) recalls of consumer products.

DRUGS AND 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. 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 Web site is www.fda.gov. Visit www.recalls.gov for information about FDA recalls and recalls issued by other government agencies.

Recalls and Field Corrections: Drugs – CLASS II

Indicates a problem that may cause temporary or reversible health effects; unlikely to cause serious injury or death

Name of Drug or Supplemenmt; Problem; Recall Information

Actavis brand Fentanyl Transdermal System, CII, 100 mcg/hr., Rx; Defective Delivery System; the patches may leak, resulting in the potential for overdosing. All lots; Actavis Elizabeth LLC.

Fentanyl Transdermal System, 75 mcg/h, Each transdermal system contains; 7.5 mg fentanyl and 0.3 mL alcohol USP, Rx Only, 28416 cartons; Superpotent; 6 month stability. Lot # 92461681; Watson Laboratories, Inc.

Actavis brand Fentanyl Transdermal System, CII, 50 mcg/hr., Rx; Defective Delivery System; the patches may leak, resulting in the potential for overdosing. All lots; Actavis Elizabeth LLC.

Actavis brand Fentanyl Transdermal System, CII, 75 mcg/hr., Rx; Defective Delivery System; the patches may leak, resulting in the potential for overdosing. All lots; Actavis Elizabeth LLC.

Caraco brand Metformin HCl tablets, USP, 1000 mg, in bottles of 100, 22,156 bottles; Tablet Weight: Some tablets may be undersized or oversized, which will result in the patient not receiving the expected dose. Lot #s 71810, 72015, 72017, 72022, 72080, 72082 and 72083; Caraco Pharmaceutical Laboratories, Ltd.

Durable Closure First Aid Antiseptic (Benzethonium Chloride 0.2%); Misbranded; active ingredients in the formulation of this OTC drug are labeled as inactive on the package labeling and drug is promoted for uses not described on package label. Lot # 749.011, exp. date 01/2009; Activ Group.

Perphenazine Tablets, USP, 2 mg, Rx only, 100 tablets; Tablet separation; cracking and splitting of tablets. Lot # T002G07A; Vintage Pharmaceuticals LLC.
Perphenazine Tablets, USP, 4 mg, Rx only, 100 tablets; Tablet separation; cracking and splitting of tablets. Lot # T048F07A; Vintage Pharmaceuticals LLC.

Actavis brand Fentanyl Transdermal System, CII, 25 mcg/hr., Rx; Defective Delivery System; the patches may leak, resulting in the potential for overdosing. All lots; Actavis Elizabeth LLC.

Sore Relief First Aid Antiseptic (Benzethonium Chloride 0.2%) and Topical Analgesic (Lidocaine 2.0%), Misbranded; active ingredients in the formulation of this OTC drug are labeled as inactive on the package labeling and drug is promoted for uses not described on package label. Lot # 749.013, exp. date. 03/2008 and 749.015, exp. date. 04/2009; Activ Group.

Wellbutrin XL® (bupropion hydrochloride extended release tablets) 300 mg, 30 tablet bottles, Rx only, 24561 bottles; Presence of foreign material was found embedded within the tablets. Lot # P08A011, exp. date 05/2009; GlaxoSmithKline Inc.

CONSUMER PRODUCTS

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, call their hotline at (800) 638-2772. The CPSC web site is www.cpsc.gov. Visit www.recalls.gov for information about FDA recalls and recalls issued by other government agencies.

Name of Product; Problem; Recall Information

Boys' Hooded Sweatshirts. The Boys' Hooded Sweatshirts have a drawstring through hood which poses a strangulation hazard to children. In February 1996, CPSC issued guidelines to help prevent children from strangling or getting entangled on the neck and waist by drawstrings in upper garments, such as jackets and sweatshirts. Kidz World Inc., (212) 563-4949.

Candle Holders. The Holiday Times Candleholders could tip over, posing a fire hazard. Also, the glass holder could break, posing a laceration hazard to consumers. Wal-Mart Stores Inc., (800) 925-6278 or www.walmartstores.com.

Children's Book Board Sets. The cylinder on the toy concrete mixer and the tailgate on the toy dump truck of the Little Builder Children's Board Book Sets with Toys can detach, posing a choking hazard to young children. Dalmatian Press LLC, (866) 418-2572 or www.Dalmatianpress.com.

Children's Hooded Sweatshirts. The Hooded Youth Sweatshirts and Jackets have a drawstring through the hood, which can pose a strangulation hazard to children. In February 1996, CPSC issued guidelines to help prevent children from strangling or getting entangled on the neck and waist by drawstrings in upper garments, such as jackets and sweatshirts. Brents-Riordan Inc. LLC, (866) 835-6357 or www.brentsinc.com.

Children's Sunglasses. Surface paint in the orange lettering on the temples of the Children's Sunglasses contains excessive levels of lead, violating the federal lead paint standard. StyleMark Inc., (866) 928-1913 or www.stylemark.net.

Deck Cleaner. One of the components of the Cabot Composite Deck Cleaner can react with metal foil residue on the packaging, releasing heat and chlorine gas. This poses a fire and inhalation hazard to consumers. Cabot Stains, (877) 755-3336 or www.cabotstain.com/recall.

Easter Egg Containers. The paint on the Camouflage Eggs and Spinning Egg Top Toys contains excessive levels of lead, violating the federal lead paint standard. Hobby Lobby Stores Inc., (800) 326-7931 or www.HobbyLobby.com.

Electric Toasters. The Electric Toasters can turn on without bread in the slots and ignite items placed on top of it, posing a fire hazard. Salton Inc., (800) 233-9054 or www.esalton.com.

Electronic Spa Controls. The Serenity Spa Hot Tubs control can overheat, posing a fire hazard. Gecko Alliance, (800) 784 3256 or www.back-pak.com.

Fake Teeth. The gray surface paint on the Hillbilly Teeth contains excessive levels of lead, violating the federal lead paint standard. FUNTASTIC, (800) 434-5207 or www.funtastictoy.com.

Fire Alarm Control Panel. The sounder on the Gamewell-FCI 7100 Series Fire Alarm Control Panel's main circuit board can fail to alert when there is a malfunction. Gamewell-FCI, (800) 274-4324 or www.gamewell-fci.com.

Gas Water Heaters. The Natural and Propane Gas Water Heater's flue gas temperatures can exceed safe limits and produce excessive temperatures in the venting unit, posing a fire hazard. Also, the water heater's exhaust can leak into the surrounding room, posing a carbon monoxide hazard. A.O. Smith Water Products Co., (866) 880-4661 or www.hotwater.com.

Heating and Cooling Units. The serial plates on the Package Gas-Electric Heating and Cooling Units contain inaccurate information that could result in the use of undersized installation wiring, posing a fire hazard. Goodman Manufacturing Co. L.P., (800) 394-8084 or www.goodmanmfg.com.

Imaginarium Activity Centers. Small parts on the Imaginarium Multi-Sided Activity Centers and Jungle Activity Centers can detach, posing a choking hazard to young children. Toys "R" Us Inc., (800) 869-7787 or www.toysrus.com.

Locks. Red surface paint on the Lock and Leash™ Locks contains excessive levels of lead, violating the federal lead paint standard. Master Lock, (800) 464-2088 or www.masterlock.com.

Magnetic Action Figures. Small magnets inside the Magna-Man Magnetic Toy Figures can detach. Magnets found by young children can be swallowed or aspirated. If more than one magnet is swallowed, the magnets can attract each other and cause intestinal perforations or blockages, which can be fatal. MEGA Brands America Inc., (800) 779-7122 or www.megabrands.com.

Magnetic Dart Boards. Small magnets at the ends of the darts in the Fun 'N Games Magnetic Dart Boards can detach. Magnets found by young children can be swallowed or aspirated. If more than one magnet is swallowed, the magnets can attract each other and cause intestinal perforations or blockages, which can be fatal. Henry Gordy International Inc., (888) 790-2700.

Mounted Outdoor Light Fixtures. A weld that affixes a mounting bracket to the ceiling pan of the Progress Lighting Outdoor Ceiling Light Fixtures can fail, which can cause the fixture to fall and injure nearby persons. Progress Lighting, (866) 418-5543 or www.progresslighting.com.

Plush Insect Toys. The Cuddly Cousins Plush Insect Toys contain small parts, posing a choking hazard to small children. Dollar Tree Stores Inc., (800) 876-8077 or www.dollartree.com.

Plush Rocker Toys. The base of the Rock 'N Ride Plush Rocker Toys can become unstable and allow the rocker to tip forward or backward, posing a fall hazard to children. Tek Nek Toys Int'l L.P., (888) 686-2728 or www.teknektoys.com.

Plush Warming Polar Bears. The warming pouch inside the Cozy Warming Polar Bears can overheat and ignite when heated in a microwave oven, posing a fire and burn hazard to consumers. Avon Products Inc., (877) 217-0916 or www.avon.com.

Pre-School Magnetic Toys. Magnets in the small flexible parts of the animals, vehicles and building sets of Magtastik and Magnetix Jr. Pre-school Magnetic Toys can detach. Magnets found by young children can be swallowed or aspirated. If more than one magnet is swallowed, the magnets can attract each other and cause intestinal perforations or blockages, which can be fatal. MEGA Brands America Inc., (800) 779-7122 or www.megabrands.com.

Rhino Side-by-Side Vehicles. The brake caliper on the left front wheel of Model Year 2008 Rhino YXR450 and YXR700 Side-by-Side Vehicles could have been made incorrectly, resulting in brake fluid leaking. This can cause a loss of braking and control of the vehicle, posing a serious safety risk to the driver and passenger. Yamaha Motor Corporation U.S.A., (800) 962-7926 or www.yamaha-motor.com.

Ring Toss Game. The paint on the yellow peg of the Ring Toss Games contains excessive levels of lead, violating the federal lead paint standard. Educational Insights, (888) 591-9334 or www.educationalinsights.com.

Rug Warmers. The Comfortplus Under Area Rug Warmer's cord can come loose from the plug and cause sparks or flames, posing a fire hazard to consumers. WarmlyYours, (866) 369-0805 or www.WarmlyYours.com.

Seasonal Pens. The Flower Writers'; Christmas Writers'; Easter Writers'; and Spooky Writers' Seasonal Writing Pens' surface coating contains high levels of lead, violating the federal lead paint standard. Michaels Stores Inc., (800) 642-4235/ (800) MICHAELS or www.michaels.com.

Toy Helicopter Battery Chargers. The Lithium-polymer battery chargers and lithium-polymer batteries can ignite while charging, posing a fire hazard to consumers. Hobby-Lobby International Inc., (866) 933-5972 or www.hobby-lobby.com.

Toy Penguins. The head of the Toy Penguin Figures can detach, exposing connectors with sharp points, presenting a laceration hazard to consumers. Plan Toy Inc., (866) 517-7526 or www.plantoys.com.

Toy Puzzle Vehicle Sets. Surface paints on the puzzle pieces and components of the Toy Puzzle Vehicle Sets contain excessive levels of lead, violating the federal lead paint standard. Merchant Media Corp., (800) 367-9444 or www.qvc.com.

Toy Robots. Surface paints on the Interchange Robot Toys contain excessive levels of lead, violating the federal lead paint standard. OKK Trading Inc., (877) 655-8697/OKK-TOYS or www.okktrading.com.

Water Bottles. Surface paint on the Backyard and Beyond Metal Water Bottles contains excessive levels of lead, violating the federal lead paint standard. Downeast Concepts Inc., (800) 343-2424 or www.backyard-beyond.com.

Wire-Bound Journals. The paint on the metal spiral bindings of the Wire-O Bound Journals and Calendars contains excessive levels of lead, which violated the federal lead paint standard. Galison/Mudpuppy, (800) 670-7441 or www.galison.com.

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between protecting the public and avoiding any action that may seem punitive and discriminatory towards their colleagues, it is often the latter than wins out.

Following recommendations of the AMA, 47 states and the District of Columbia have active Physician Health Programs (PHPs) to assist those with substance abuse, mental illness, and disruptive or other inappropriate behavior. The only states without programs are Nebraska, North Dakota and Wisconsin. Last year, it was estimated that more than 9,000 physicians were being actively monitored by PHPs in the United States. While national data on outcomes are not available, some state-specific studies show that programs that treat and monitor impaired physicians have a recovery rate of over 70 percent.

A survey of the current PHPs reveals that they do not follow a standard template, but rather vary from one state to another. They therefore differ in structure, professions covered and in the issues they address.

The majority of programs (25/48) are run by the state medical association; another eight are operated by their respective state medical state boards. Some state PHPs operate as independent non-profit corporations, and at least one state (Michigan) contracts with a private entity to operate its PHP. Whatever their structure, more than three-fourths of all PHPs have a formal contractual relationship with their state medical board.

Most state programs cover a wide array of health professionals (e.g., physicians, dentists, nurses, podiatrists, pharmacists, etc.). Michigan and Virginia are particularly broad in terms of the professions they cover. Both include a wide variety of allied health professions within their purview. Nineteen states include "families of physicians" among those they serve. Interestingly, two states — Arizona and Wyoming— also cover attorneys; this suggests that their services are being marketed to other professions. Eleven states restrict their services to the medical profession (MDs, DOs, medical students, residents and physician assistants). These are Alaska, California, Connecticut, Georgia, Hawaii, Idaho, New York, Nevada, Oregon, South Dakota and Texas.

State programs also differ in terms of the conditions they monitor. Those with the broadest offerings address the needs of those diagnosed with substance abuse, alcoholism, mental illness, some physical conditions that reflect impairment, sexual misconduct and boundary issues, and behavioral problems. A breakdown of state PHPs by what they monitor reveals the following distribution:

- All 48 programs monitor chemical dependence. Indeed, five of the programs address this condition exclusively.
- A total of 41 programs also monitor mental health problems.
- 34 PHPs address issues of behavioral health.
- 27 programs monitor sexual misconduct and/or boundary violations.
- 25 programs address physical illnesses that may be causing impairment.

Other issues handled by PHPs include stress management, anger, disruptive behavior, and malpractice litigation. In addition, Florida addresses HIV monitoring, while Tennessee deals with overprescribing.

The differences among states reflect disparate perceived needs as well as varying capabilities. But because there is no reason to assume that physicians in given states are at particular risk or, conversely, exempt from impairment, one would expect greater uniformity in physician health programs. Differences in state programs are often justified as serving as policy laboratories, developing and testing strategies that work. But PHPs have now have been in existence for more than 30 years, and the stage of experimentation should now be over. By now, state programs should know what the "best practices" are in treating impaired physicians, and they should be sharing the knowledge gained to insure that problems are promptly identified and addressed.

"While there is no indication that the problem of physician impairment has worsened over time, greater concern over the high prevalence of medical errors, rising malpractice premiums and the trend toward group or institution-based care have all enhanced an awareness of the need for the medical profession to police itself."

OUTRAGE OF THE MONTH

"Physician, Heal Thyself" Not Always Simple

One issue is more whispered about than confronted in medical circles: that of impaired physicians. The American Medical Association (AMA) defines an "impaired physician" as one with "any physical, mental, or behavioral disorder that interferes with the ability to engage safely in professional activities." This includes but is not limited to psychiatric illness, alcoholism and drug dependency. Substance abuse accounts for approximately 75 to 80 percent of those affected. In the absence of hard data, experts estimate the percentage of impaired physicians at 10 to 15 percent of all working doctors.

While there is no indication that the problem of physician impairment has worsened over time, greater concern over the high prevalence of medical errors, rising malpractice premiums and the trend toward group or institution-based care have all enhanced an awareness of the need for the medical profession to police itself. The AMA's Code of Medical Ethics states that "physicians have an ethical obligation to report impaired, incompetent and unethical colleagues." But most physicians are not trained to detect and intervene in cases of colleagues with impaired judgment, and they are either uncertain about what to do or reluctant to take action. The result is that impaired physicians "suffer a disease of isolation and denial that is often fostered and enabled by silent colleagues." As a result, many impaired doctors are not identified until they have caused harm to themselves or their patients.

Part of the problem is that, in addressing impaired colleagues, the medical profession is torn by contradictory demands. On the one hand, it must protect the public from incompetence and adverse actions arising from physician impairment. But, because the profession regards addiction as a treatable illness rather than a moral failing, it must give physicians who suffer from substance abuse an opportunity to seek treatment. This means that all actions taken are confidential and non-punitive. And because treatment often includes bolstering those aspects of physicians' lives that provide stability and continuity, impaired physicians are most often allowed to practice while undergoing treatment for their addiction. In the conflict

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