

Health Letter

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Unseen Payoffs and the Poverty of Prevention

If the automobile industry followed Washington's health care model, they'd be installing air bags only in cars that have already crashed.

— *AIDS Action Council, 2006*

Central to the debate on health reform is the role of prevention. Who could be against prevention? Prevention is seen as way to promote better outcomes, conserve scarce resources, and save money. This is part of popular lore, captured in sayings such as "A stitch in time saves nine" and "An ounce of prevention is worth a pound of cure." Still, what we as a nation spend on prevention varies widely from one state to another. Moreover, there may be too narrow a focus on the cost-saving aspects of prevention, thereby ignoring other more important effects of the preventive strategy, such as enhancing wellness and improving the quality of life.

A recent report, *Shortchanging America's Health 2008* by the Trust for America's Health, summarizes current data on federal public health dollars spent by each state and what each state contributes to prevention. The report found wide disparities in federal allocations by state and in the support that each of the principal agencies within the Department of Health and Human Services provides for health promotion and disease prevention.

The U.S. Center for Disease Control and Prevention (CDC) is the lead health care agency for disease and injury prevention. It therefore serves as a bellwether for the role

of prevention in overall spending. The agency suffered a 5 percent drop in funding between fiscal years 2006 and 2007, with cuts affecting a variety of preventive initiatives and state priorities. The breakdown of CDC dollars by state reveals that the agency spent an average of \$17.23 per capita in FY 2007. But some states fared a lot better than others, the difference varying more than fivefold when the state that received the most (Alaska, with \$69.76 per capita) is compared to that which received the least (Kansas, with \$13.61).

The differences in prevention dollars allocated by the Health Resources and Services Administration (HRSA) are even more dramatic, with a range that varies more than six fold from highest to lowest. Again, Alaska has the highest per capital total of HRSA funds, \$57.57, and

Kansas has the lowest, \$8.73. The national average is \$17.09, almost twice what Kansas gets.

The third major source of federal dollars is the Office of the Assistant Secretary for Preparedness and Response (ASPR). The bulk of the funds distributed by this office are funneled through the Hospital Preparedness Program agency and are aimed at increasing the states' ability to protect the civilian population from acts of bioterrorism and other public health threats. Here, the differences in state allocations per capita vary almost threefold. Although presumably based on "on the number of people in a state or on a need-based formula for priority programs," the funding appears to follow the "inverse care law" in

continued on page 2

CONTENTS

Just How Does the U.S. Health Care System Stack Up?

A critical look at the actual quality of health care in the U.S. 4

Recalls

June 16, 2008 - July 15, 2008

This month, Spiriva and fireworks are on the list 5

FDA Public Health Advisory

CT scans may cause malfunction of implanted medical devices 8

Mistakes Were Made: Disclosing Medical Errors

Why full disclosure of medical errors is encouraged..... 9

OUTRAGE OF THE MONTH

Botox, Mark Spitz, Nadia Comenici and Willie Nelson 12

from page 1

which those at highest risk get the least resources. How else to explain that Wyoming (with \$2.21 per capita) ranks #1 in funding while New York (with \$0.75) ranks last?

If some of these disparities in federal monies were offset by state funds, inter-state differences would be mitigated. But it is not possible to verify this: federal investments can be compared across states, but comparable investments in state funds cannot be ascertained: the data are collected and reported in ways that do not allow easy comparisons of one state's spending to another. In the absence of consistent definitions, state public health budgets have been divided by the respective state populations to obtain per capita figures on overall spending. This yields inter-state differences that are even more disparate than the federal allocations. While the national median is \$33.24, the states' per capita investment varies from \$152.66 (Hawaii) to \$3.46 (Nevada), a more than 44-fold difference. This reflects not only the different priorities and endowments of each state but also the volatility of state budgets, which often need to be balanced. Faced between curtailing entitlements and cutting public health programs, state officials usually opt for the latter.

The short-changing of prevention within a system that spends more per person than any other has led policy-makers to connect the two. Is lack of prevention fueling the US's greater expenditures on care? Could greater attention given to preventive medicine mean cheaper care? While it is tempting to make this link, some

economists say "not so fast."

Jonathan Gruber of MIT has stated that he does not know of "any evidence that preventive care actually saves money." This is because health promotion can be labor-intensive, especially if the goal is to get patients to change their behavior and convince recalcitrant patients to "get with the program." Moreover, some preventive strategies have blunderbuss or wide-

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net effects. As a result, much effort is spent on reaching those who would not be at risk in any case, and would therefore not have gotten sick. Put another way, while the costs are borne by everybody, the benefits accrue only to those who would have suffered the disease or injury. This lack of targeting adds costs to the system, even when it produces a healthier population as a whole.

In addition, preventive efforts have the effect of adding years to life, thereby increasing the elderly population who is most likely to spend the most on health. Over the longer run, prevention may therefore result in higher overall expenditures. Researchers in the Netherlands recently published a study examining the impact of obesity and smoking on health expenses. The objective of the study was "to estimate the annual and lifetime medical costs attributable to obesity, to compare those to similar costs attributable to smoking, and to discuss the implications for prevention." The model used a cohort approach to allow for a lifetime perspective. Cost estimates included both those associated with obesity and smoking and those of other diseases that occur as life-years are gained.

The researchers found that, while obese people incurred the highest

costs until age 56, lifetime health expenses were highest among healthy living people (i.e., non-smokers with appropriate body-mass indexes) and lowest for smokers. Obese individuals held an intermediate position. The researchers therefore conclude that preventing obesity will not stem the tide of health care expenditures:

The underlying mechanism is that there is a substitution of inexpensive, lethal diseases towards less lethal, and therefore more costly, diseases. As smoking is in particular related to lethal (and relatively inexpensive) diseases, the ratio of cost savings from a reduced incidence of risk factor-related diseases to the medical costs in life-years gained is more favorable for obesity prevention than for smoking prevention.

What, then are we to make of these statements that cast doubt on the wisdom of prevention? Has prevention been oversold? Or are we missing something here? In order to make some sense of what seems to like contradictory evidence, we need to clarify what we know about prevention and its economic effects.

1. Many different activities fall under the rubric of "prevention."

Preventive measures include different interventions, with different purposes, scopes, actors, beneficiaries, and costs. One useful categorization is to classify them into three groups: health promotion, health protection, and disease prevention. Health promotion seeks to stimulate healthful behavior through information and education. Health protection is most often aimed at populations in general. It aims to reduce exposure to environmental threats and other health risks by legislation, regulatory controls, and interventions. Disease prevention targets specific conditions. It includes primary preventive activities (aimed at the risk factors or determinants of a specific disease, thereby trying to prevent the disease itself) as well as secondary preventive activities (aimed at preventing or mitigating the effects of a disease once it has been contracted). Of course, some

interventions may fall under more than one category. For example, use of safety goggles for certain occupational activities involves both health promotion and health protection.

2. Preventive strategies have different targets, and different degrees of efficacy. Because different types of activity have different scopes and strategies, they also vary in price tags and efficacy. Those that are aimed at very specific demographic groups or diseases tend to avoid the blunderbuss approach and are therefore cost-saving. Thus, for example, good preventive foot care for diabetics can prevent costly, potentially disabling amputations. Childhood immunizations also represent significant cost-savings over time.

3. Some strategies are cost-effective even when they are not cost-saving. Some preventive activities require an investment, but they are effective in terms of what they achieve. “Cost-effectiveness” compares expenditures (costs) in terms of outcomes. In the health field, outcomes are measured in terms of quality-adjusted life years (QALYs), which combines both quantity and quality in prolonged life. Different interventions can therefore be compared, allowing us to determine the relative efficacy of disparate strategies for a given investment. For most purposes, it therefore makes sense to use cost-effectiveness to establish prevention priorities.

The National Commission on Prevention Priorities, a blue-ribbon panel of experts in the field, have ranked some 25 evidence-based preventive interventions in terms of two major criteria: clinically preventable burden, which measures the health impact on the relevant population, and the cost-effectiveness of each service. The panel therefore gave each service a score for each criterion, then summed up the scores for a final number. Services therefore

were ranked between 2 (the lowest priority) to 10. Those with the top score of 10 were cost-saving; the scores for the rest reflect relative cost-effectiveness.

4. Prevention payoffs have a longer time horizon than most payers.

One major reason for the failure to invest in prevention is that most payers want a quick return on their investment, and this does not occur with most preventive strategies. Employers and insurers may therefore be reluctant to cover preventive services and have others reap the benefits of their efforts. Given the fact that people change jobs and therefore health coverage with some frequency, payers have few incentives to pay for services whose cost-saving potential is a long way off. Only when there is a longitudinal responsibility for the health of a population does it make sense to invest in prevention. It is therefore not surprising that national health programs are more likely to stress prevention than does the fragmented US health care system.

5. We need to make clear what we expect to achieve from specific preventive activities. The fact that some strategies are not money-savers does not mean that they are not worthwhile. Efforts to curtail smoking and promote healthier weights may very well be worth doing, but they need to be justified on grounds other than the reduction of health expenses or even cost-effectiveness. Both of these activities have societal benefits (e.g., reduction of second-hand smoke, greater productivity) that are not reflected in computations such as those conducted in the Netherlands study or in the rankings above. Ultimately, health promotion and disease prevention should be seen as intrinsically valuable and not merely as means towards fiscal ends.

Of the 25 interventions considered, the following 11 received the highest scores:

Clinical Preventive Services/Targets	Total score
Discuss daily aspirin use — men 40+, women 50+	10
Childhood immunizations	10
Smoking cessation advice and help to quit — adults	10
Alcohol screening and brief counseling — adults	9
Colorectal cancer screening — adults 50+	8
Hypertension screening and treatment — adults 18+	8
Influenza immunization — adults 50+	8
Vision screening — adults 65+	8
Cervical cancer screening — women	7
Cholesterol screening and treatment — men 35+, women 45+	7
Pneumococcal immunizations — adults 65+	7

Just How Does the U.S. Health Care System Stack Up?

We Americans live in a nation where the medical-care system is second to none in the world, unless you count maybe 25 or 30 little scuzzball countries... that we could vaporize in seconds if we felt like it.
— *David Barry*

Senator John McCain has joined President Bush in declaring that we have “the best system in the world.” A recent survey found that this view is shared by 45 percent of the population and fully 68 percent of those who identify themselves as Republicans. But any mention of “the best” begs the old Borscht Belt question of “Compared to what?”

The fact is that, by practically any measuring stick — other than how much money it spends — the U.S. is lagging compared not only to most major industrialized countries, but also to some developing countries. Different organizations and researchers have devised a variety of ways to measure how the U.S. is faring vis-à-vis the rest of the world. These provide a sobering and humbling appraisal of health care expenditures and what they buy us.

There are three usual ways to measure health services. We can look at structure, the ingredients that go into providing care; at process, the way services are linked to ensure access and accountability; and at outcome, or health status, most often summarized as the five D’s: disease, death, disability, discomfort, and dissatisfaction.

Structure

Because structure refers to the country’s medical endowment in terms of personnel and facilities, at first glance the U.S. would seem to rank high in terms of its health labor force and clinic and hospital infrastructure. Still, the US does not have more resources available than the average for the countries in the Organization for Economic Cooperation and Development. In 2004, the U.S. had

2.4 practicing physicians per 1000 population, while the average for OECD countries was 3.0. Moreover, and most importantly, the country is in the midst of a contracting supply of primary care specialists, and that is expected to worsen in the next decade.

In the absence of a point of entry such as a primary care physician and a source of continuing care, many Americans lack a medical “home.” The result is fragmented care, uneven responsibility, and higher expenses, all of which affect the process of obtaining services. Not surprisingly, a cross-national study of seven developed countries found that U.S. respondents reported the highest overall medical error rate of those studied.

Process

The process also leaves a lot of people out, with almost 50 million uninsured and an equally large number having skimpy or inadequate coverage. This means that approximately 100 million people, one-third of the U.S. population, is uninsured or underinsured. And even those “covered” with Medicaid and Medicare cannot count on complete coverage, having to deal with gaps, co-pays and “doughnut holes” that act as barriers to health care. Those without coverage tend to receive fewer preventive services, get late or no care, lack continuity in the treatment they receive, and have worst outcomes.

Outcome

It is therefore not surprising that the U.S. has worst indicators of health status than many other countries that have fewer resources to spend on medical care. A study published earlier this year ranking 19 industrialized nations in terms of preventable deaths found that U.S. was the worst. The top three ranking countries were France, Japan and Australia. While France had 64.8

deaths deemed preventable for every 100,000 inhabitants, the U.S. had 109.7 deaths. If the U.S. could reduce these “excess deaths” to the average of that of the three top-performing countries, there would have been 101,000 fewer deaths per year by the end of the study period.

Public Opinion

Even when patients are unaware of data such as discussed above, they manifest their dissatisfaction with the system. One 2007 study surveyed 12,000 adults in Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom and the United States. This found that adults in the US reported high rates of coordination problems and billing hassles. Moreover, one-third of U.S. respondents said that the health system needed to be rebuilt completely, the highest rate of any of the seven countries.

The Best Health Care System?

What then do politicians mean when they say the U.S. has the best health care system in the world? They are probably referring to the abundance of resources (however poorly distributed) and the intensity and variety of technology (however ineffectively or unnecessarily used). While the U.S. is a significant leader in medical research, medical education, and in the application of new methods of diagnosis and treatment, the benefits of these accrue primarily to selected medical enclaves: those who are better educated, live in metropolitan areas, and have generous insurance coverage.

Product Recalls

June 16, 2008 - July 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 I

Indicates a problem that may cause serious injury or death

Name of Drug or Supplement; Problem; Recall Information

Aspire Lite, Female Sexual Enhancer, Liquid Capsule Technology, proprietary blend of herbal ingredients, 718mg, single blister packs or 3 and 12 count bottles, 1,008,737 Capsules; Unapproved New Drug: product found to contain Aildenafil in and Dimethyl sildenafil thione (sulfoildenafil) analogs of Sildenafil, an FDA-approved drug used as treatment for male Erectile Dysfunction (ED). Lot #: 082907, 092607B, 112007, 121907, 011708A; Palo Alto Laboratories Inc.

proved New Drug: product found to contain Aildenafil in and Dimethyl sildenafil thione (sulfoildenafil) analogs of Sildenafil, an FDA-approved drug used as treatment for male Erectile Dysfunction (ED). Blister Pack Capsules: 053107, 071707, 102607, 121907, 3 count bottles: 071707, 092607A, 102607, 111707, 121907, 011708, 12 count bottles: 053107, 071707, 092607A, 102607, 111707, 120307, 121907, 011708; Palo Alto Laboratories Inc.

Aspire36, Next Generation Sexual Enhancer, Liquid Capsule Technology, proprietary blend of herbal ingredients, 725mg, single blister packs or 3 and 12 count bottles, 1,008,737 Capsules; Unap-

Methadone HCl Oral Solution, 20mg, 143 bottles; Misbranded; bottles labeled as containing 20mg Methadone HCl actually contains 260 mg Methadone HCl. VistaPharm Lot #: 135100, Whitney Lot #: 5364 L; Whitney Labs.

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 Supplement; Problem; Recall Information

ACEON®, (perindopril erbumine) Tablets, 2 mg, Bottles of 100, Rx Only, 23,676 units; Presence of foreign substance; possibility of trace amounts of latex. Lot # 3064835, exp. date 08/2009; Solvay Pharmaceuticals, Inc.

SPIRIVA HandiHaler, tiotropium bromide inhalation powder, 18 mcg per capsule, 30-capsule blister cards and 90-capsule blister cards, Rx only, 889,132 units; Product may not meet specifications for aerodynamic particle size distribution throughout shelf life. Lot #: 704577A, exp. date 10/2008; 705425A, exp. date 11/2008; 707703A, exp. date 02/2009; 707703B, exp. date 02/2009; 707987A, exp. date 02/2009; 708066A, exp. date 02/2009; 708307, exp. date 03/2009; Boehringer Ingelheim Pharmaceuticals, Inc.

ACEON®, (perindopril erbumine) Tablets, 4 mg, Bottles of 100, Rx Only, 23,676 units; Presence of foreign substance; possibility of trace amounts of latex. Lot 3063489, Expiration: 12/2009, Lot 3063490, exp. date 12/2009, and Lot 3064276, exp. date 01/2010; Solvay Pharmaceuticals, Inc.

ACEON®, (perindopril erbumine) Tablets, 8 mg, Bottles of 100, Rx Only, 23,676 units; Presence of foreign substance; possibility of trace amounts of latex. Lot 3063493, exp. date 12/2009, Lot 3064277, exp. date 01/2010, and Lot 3064278, exp. date 01/2010

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

Arctic Cat ATVs. The speed controller on the Model Year 2008 Arctic Cat 50cc and 90cc All-Terrain Vehicles (ATVs) could fail to return to the idle position when the throttle lever is released, or the speed controller could fail to be at idle on start up. This could result in loss of vehicle control, which could result in serious injury or death to the rider. Arctic Cat Inc., (800) 279-6851 or www.arctic-cat.com.

Bench Scale Adaptors. The Bench Scale Adapters can smoke, catch fire and melt, posing a fire hazard to consumers. American Weigh Scales, (866) 643-3444 or www.americanweigh.com.

Built to Grow Cribs. The 2nd Nature Built to Grow Cribs could fail to meet a federal safety standard for crib dimensions. When the mattress support is in the middle setting, the space between the mattress and the crib could be too wide, posing an entrapment hazard to infants. Stanley Furniture Company Inc., (888) 839-6822 or www.youngamerica.com.

Children's Jewelry. The "It's a Girl Thing" Bracelets, Necklaces, and Phone Charms could contain high levels of lead. Lead is toxic if ingested by young children and can cause adverse health effects. Bead Bazaar USA Inc., (800) 838-1769 or www.beadkit.com.

Children's Necklaces. Solder on the charm of the Children's Necklaces with Ballet Shoes Charms may contain high levels of lead, which if ingested by young children can cause adverse health effects. Parragon Inc., (888) 480-2854 or www.parragonrecall.com.

Childrens' Hooded Jackets. The Children's Sun Block Jackets and Hoodies have a drawstring through the hood, posing a strangulation hazard to children. In February 1996, CPSC issued guidelines (pdf) to help prevent children from strangling or getting entangled on the neck and waist drawstrings in upper garments, such as jackets or sweatshirts. Coolibar Inc., (866) 266-5422 or www.coolibar.com.

Cribs. The wooden crib slats and spindles of Jardine Cribs can break, creating a gap, which can pose an entrapment and strangulation hazard to infants. Jardine Enterprises, (800) 646-4106 or www.jardinecribre recall.com.

Fax Machines. An internal electrical component failure can cause overheating of the HP Fax 1010 and 1010xi Machines, posing a risk of burn or fire. Hewlett-Packard Co., (888) 654-9296 or www.hp.com/go/fax1010recall.

Fireworks. The Oh Chute Parachute with Streamer Fireworks can become entangled in overhead power lines causing a shock hazard to users and bystanders. Fireworks Over America, (800) 345-3957 or www.fireworksoveramerica.com.

Fireworks. The Screech and Scream Fountain Fireworks can produce a loud bang and unexpectedly scatter debris, posing an injury hazard to the user and bystanders. Black Cat Fireworks, (913) 649-0537 or www.blackcatfireworks.com.

Girls' Sandals. The flower embellishments on the Nordstrom's Cadence-Lea and Trio-Lea Girl's Sandals can detach, posing a choking hazard to young children. Nordstrom Inc., (800) 804-0806 or www.nordstrom.com.

Glue Guns. The recalled glue guns can short circuit, causing the gun to smoke. This poses a fire hazard to consumers. Dollar Tree, Inc., (800) 876-8077 or www.dollartree.com.

Golf Carts. The hip restraints on the RXV Golf Cars can detach at the base, posing a fall and injury risk to consumers. E-Z-GO, (800) 774-3946 or www.ezgo.com.

Infant Garments. The snaps on Taggies™ Sleep'n Play Infant Garments can detach, posing a choking hazard to young children. Rashti & Rashti, (888) 594-3730 or www.rashtiandrashti.com.

CONSUMER PRODUCTS

Kawasaki ATVs. The throttle can fail to return to the idle position when released or could fail to be at idle on start-up. This could result in loss of vehicle control, posing a risk of serious injury or death to the rider. Kawasaki Motors Corp. U.S.A., (866) 802-9381 or www.kawasaki.com.

Key Chain Charms. The charms on the “Hip Charm” Key Chains can contain high levels of lead, which is toxic if ingested and can cause adverse health effects. Wal-Mart Stores Inc., (800) 925-6278 or www.walmartstores.com.

KYMCO ATVs. A manufacturing defect in the carburetor of the 2008 Model Year Mongoose Youth ATVs can cause the throttle to stick open, posing a risk of serious injury or death to the rider. KYMCO USA, (888) 235-3417 or www.kymcouusa.com.

Lawnmowers. The Honda Lawn Mower’s rear shield can break off allowing debris to be thrown toward the operator, which poses a laceration hazard to consumers. American Honda Motor Corp., (800) 426-7701 or www.hondapowerequipment.com.

Lip Gloss and Jewelry Sets. The lobster claw clasp on the bracelet of the “Faded Glory” Lip Gloss, Locket, and Bracelet Sets contains high levels of lead, which is toxic if ingested and can cause adverse health effects. Wal-Mart Stores Inc., (800) 949-3311 or www.faf.com.

Off-Road Motorcycle Clamp Kits. Some of the bolts included in the Pro Taper Clamp Kits Used With Off-Road Motorcycles (or sold separately) if installed incorrectly can break under extreme force such as a crash. This can cause the handlebars to separate posing a risk of serious injury to the rider. Tucker Rocky Distributing, (866) 217-7750 or www.protaper.com.

Off-Road Utility Vehicles. The Bush Hog Off-Road Utility Vehicle’s throttle cable can freeze in freezing temperatures. This can cause the engine not to return to idle when the driver takes his or her foot off the accelerator pedal. Bush Hog LLC, (877) 873-0143 or www.bushhog.com.

Outdoor Canopies. The Outdoor Canopies fail to comply with a voluntary flammability standard could pose a fire hazard to consumers. Wanda Technology Inc, (866) 312-8799 or www.bjs.com.

Paintball Gun Adapters. The Paintball Gun Remote Line Adapters can burst when over tightened, posing serious impact and laceration hazards to consumers. RAP4 (Real Action Paintball Inc.), (800) 404-9029 or www.rap4.com.

Power Supplies. The 13.8V DC Power Supplies are wired incorrectly, posing electrocution and fire hazards. RadioShack Corp., (800) 843-7422 or www.radioshack.com/recall.

Propane Storage Leaks. An odorant is added to propane to help alert customers to propane leaks, but rust inside a propane tank can cause the odor to fade. Some converted above-ground to underground converted tanks can have an increased susceptibility to odor fade, causing consumers to be unable to detect the odor of propane in the event of a gas leak. This can pose a fire and burn hazard to consumers using the Conversion Underground Propane Storage Tanks if there is a leak in the propane gas system. American Welding & Tank LLC, (866) 614-0910 or www.awtank.com.

Quick-Release Devices for Bicycles. The SunRinglé Hollow Quick Release Devices for Bicycles can unexpectedly fail or break when locked in position on the bicycle, causing the rider to lose control, which poses a serious fall hazard. Hayes Bicycle Group, (888) 686-3472 or www.hayesbicycle.com.

Remote Control Toy Cars. The remote control unit of Redcat Racing FM Remote Controlled Vehicles can lose its signal, causing the toy vehicle to lose control, posing a risk of injury to the user or bystanders. Redcat Racing Co., (602) 454-6445 or www.redcatracing.com.

Shoelace and Necklace Charms. The clasp in the Children’s Charm Craft Kits contains high levels of lead. Lead is toxic if ingested by young children and can cause adverse health effects. Action Products International Inc., (800) 772-2846 or www.apii.com.

Snowmobiles. Cracks could form in the starter ring-gear of the 550 LX, Trail Touring, and Trail Touring Deluxe snowmobiles and cause the ring-gear to fracture into several pieces. The broken pieces could be propelled out of the chassis of the machine at high speed causing serious injury or death to the rider and/or bystanders. Polaris Industries Inc., (888) 704-5290 or www.polarisindustries.com.

Snowmobiles. Friction between the fuel hose and the cylinder head cover of Ski-Doo® Snowmobiles can cause the hose to pierce. This can cause fuel to leak out, posing a fire hazard. BRP U.S. Inc., (888) 638-5397 or www.ski-doo.com.

Tire Swings. The hanger clamp on the Playground Tire Swings can fail causing the tire swing to detach. This poses a fall hazard to young children and risk of serious injury. Miracle Recreation Equipment Co., (800) 523-4202 ext 683 or www.miracle-recreation.com.

Toy Helicopters. The rechargeable battery inside the “Thunder Wolf” Remote Controlled Indoor Helicopters can overheat. This can result in the helicopter’s body melting, as well as a risk of fire or burns to consumers. Westminster Inc., (800) 618-0023 or www.thunderwolfhelicopter.com.

Water Pump Motors. The water pumps with the Water Pump Motors are labeled as containing a one-horsepower motor, but actually contain a 3/4-horsepower motor. Under certain conditions, the smaller motor could overheat, posing a fire hazard to consumers. A.O. Smith Electrical Products Co., (800) 280-8626 or www.regcen.com/pumprecall.

Youth Bed Toy Chests. The lid supports on the LaJolla Boat Bed and Pirates of the Caribbean Twin Trundle Beds fail to prevent the lid from closing too quickly, posing an entrapment and strangulation hazard to young children. Bayside Furnishings (a division of Whalen™), (877) 494-2536 or www.baysidefurnishings.com.

Warning: CT Scans May Cause Malfunction of Implanted Medical Devices

A new Food and Drug Administration Public Health Warning, released July 14th, warns that computed tomography scans (CT scans) can cause implanted electronic medical devices, including cardiac pacemakers, implantable cardiac defibrillators, neurostimulators, and drug infusion pumps, to malfunction. The malfunction occurs when high doses of radiation, which are more common in newer CT scans, cause inappropriate electronic discharges of these devices. Problems may be transient and benign but may also result in inappropriate discharge (shock) or resetting or reprogramming of the devices. No deaths have been reported to date; however, the theoretical risk is obvious as many implanted devices are life-sustaining.

This new concern adds to the controversy about unnecessary high-dose radiation exposure and subsequent increased risk of cancer caused by CT scans. With the rapid adoption of CT scans since their introduction in the 1970s it has been posited that annually up to one-

third of CT scans are not medically justified, exposing patients to needless radiation (see *Health Letter* April 2008). Now it appears that the radiation from CT scans can cause device failure.

Several precautionary steps should be taken for patients with implanted electronic devices:

- A preliminary “scout” image, in which the CT scan takes a lower-radiation X-ray, should precede all CT scans to check for the presence of an implanted device.
- It should be determined whether the CT scan is medically necessary in a patient with an implanted device and whether an alternative diagnostic tool may be used.
- The physician responsible for the device should be consulted before the CT scan.
- If necessary, determine whether the device will be subjected to the CT

scan’s x-ray beam and if so, employ methods to decrease the peak radiation exposure, such as longer scans at lower radiation levels.

- If the device is life-supporting or life-sustaining, do not turn it off. Instead, a safer mode, in which the device can monitor and alert but cannot intervene (e.g. shock), may temporarily be used but appropriate emergency precautionary steps should be taken in case problems develop.
- Non-life-sustaining devices may be turned off for the duration of the scan to avoid malfunction.
- Lastly, any devices should be evaluated for appropriate, post-scan functioning before the patients leaves the imaging center.
- Patients should contact their healthcare provider as soon as possible if they suspect their device is not functioning properly after a CT scan.

“Mistakes Were Made”: Disclosing Medical Errors

Disclosing medical errors has been the recent subject of several newspaper and journal articles and TV programs. Mounting evidence shows that physicians and medical institutions that say “I’m sorry” to patients are more often met with understanding than with lawsuits. As a result, the culture of owning up to errors and letting patients and their families know that they have been harmed is very slowly making inroads and changing the prior practice of concealment. Still, only an estimated 30 percent of errors are disclosed to patients even when the Joint Commission on Accreditation of Healthcare Organization now requires that patients be informed about all outcomes of care, including “unanticipated outcomes” occurring in hospitals.

Full disclosure of medical errors does not mean that patients need forego the option of suing. If they feel that an apology and settlement do not suffice to compensate them for their harm or cover their damages, they can seek legal redress. In most cases, this will require the patients’ getting legal counsel before making any decision, in order to balance the power differential between patients, on the one hand, and health care providers and institutions, on the other, even when these are willing to admit their errors.

At present, there are four main reasons why a policy of disclosure makes sense:

1. Disclosure humanizes the provider and takes the burden of concealment off him or her. Physicians are expected to tell the truth. The practice of deceptive behavior is therefore corrosive to their self-esteem and reputation, and tarnishes the profession as a whole. The guilt that accompanies willful silence or deception may therefore trump the awkwardness

and discomfort of admitting a mistake. Moreover, compounding a mistake with a cover-up is, quite literally, adding insult to injury. Patients are justifiably incensed when they find out they have been lied to and dismissed as well as mis-treated.

2. Disclosure provides the patient with the tools to decide what action to take. Patients expect honesty and are entitled to know when they have been wronged. Bioethicists underscore that full disclosure respects patients’ autonomy and enhances their decision-making capabilities. Greater information alters the intrinsic inequality between patient and provider, thereby empowering the later. Seven studies that have assessed patients’ preference for error disclosure have found that patients want to be told about medical errors in their care. A majority of patients also want to know about “near misses,” errors that did not cause harm because of chance or early intervention.

3. Disclosure may reduce the number of legal actions. This may seem counterintuitive, because admitting a mistake may appear to increase providers’ vulnerability to lawsuits. Traditionally, attorneys have counseled clients to “admit nothing” and avoid the possibility of self-incrimination. And, for those who have confessed to making a

mistake, the legal profession has devised a way to circumvent the issue: a total of 35 states have adopted legislation that makes an apology offered to a patient not admissible in court.

Nevertheless, several major medical centers have found that adopting a policy of full disclosure can reduce legal settlements and save the institution money. In 1987 the VA Medical Center in Lexington, Kentucky, adopted a policy of notifying patients or their families of malpractice. This policy was accompanied by proactive investigation, full disclosure, and offering to settle early and for a reasonable amount when appropriate. In addition, those harmed from error at the hospital were informed of their right to file a tort claim and were advised concerning remedies against the government. While the number of claims rose over the years, the claims experience became more favorable. Compared to other VA hospitals the VA Medical Center in Lexington is in the top quartile for the number of claims filed and in the bottom quartile for the total payout per year. More dramatically, the University of Michigan Health System found that, when physicians were encouraged to disclose errors and apologize, claims decreased from 262 to 83 between 2001 and 2007 and legal fees were reduced

continued on page 2

WARNING

Patient advocates and lawyers alike caution patients to be wary of any quick apology by doctors or hospitals followed by a settlement offer. Contrite providers are no substitute for money, particularly when correcting the medical error (or dealing with its consequences) is quite costly. Unless injured patients have access to appropriate legal counsel from the onset of the process, they may be unaware of future medical costs and unwittingly agree to unacceptably low offers. Moreover, they may be lulled into thinking that whatever is offered is the best they can get, which may not be the case.

While the change from the previous dictum of “deny, deny, deny” to that of “admit, apologize, and make amends” is welcome, it may be prompted more by concern for the bottom line by the erring doctor or institution than by a recommitment to moral rectitude.

from page 12

by over 50 percent by 2002. The average time to resolution of claims was reduced from 20.7 months to 9.5 months in five years. More recently, academic medical centers such as those at Stanford and Johns Hopkins have adopted similar policies aimed at informing patients of adverse events. Both report favorable outcomes as a result of the new policies.

Studies looking at other personal injury situations have tended to find that apologies can promote the successful resolution of these cases. A straightforward explanation of what happened can clear the air, open communications, and turn an adversarial situation into a productive negotiation.

4. Disclosure provides an opportunity to assess mistakes and provide

redress. Ultimately, the goal is not to get physicians and hospitals off the hook, but to prevent errors. Both adverse outcomes and ‘near misses’ can serve as sentinel events to alert practitioners that something is wrong and needs to be fixed. It will take better training, stricter monitoring of care, and more research before the medical culture of secrecy and concealment gives way to greater openness and honesty in dealing with patients. Medical schools and teaching hospitals are just beginning to prepare physicians-in-training to disclose their mistakes, avoid jargon, express regret, and state what can be done to correct the situation and avoid similar errors. Although there are no universally held “best practices” in this field, some have devised lists of suggestions for divulging medical errors to patients.

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Botox, Mark Spitz, Nadia Comenici and Willie Nelson

Last month, Allergan, maker of Botox, launched a massive drive to convince people that Botox can be an important component of achieving their “personal best.” Spearheading the effort are former Olympians swimmer Mark Spitz and gymnast Nadia Comaneci.

It is a sad day when these two superb Olympic athletes — whose performances earned a total of 14 gold medals combined – prostitute themselves for undisclosed amounts of money to help Allergan sell Botox. Instead of tens of millions of people watching the athletes’ performances in the past as they strived for their personal best, people will now be able to watch videos of doctors’ performances as they inject Mark Spitz and Nadia Comaneci with Botox.

This sends a terrible message to athletes, young or old, and to others

that they should not accept the way they look as they age but, rather, should try to look their “personal best” by the Botox-enhanced pretense that they are younger than they really are.

Another trouble with this slick marketing campaign is that botulinum toxin (available as Botox and Myobloc) can cause life-threatening adverse reactions. In January, Public Citizen petitioned the Food and Drug Administration (FDA) to immediately increase its warnings about Botox and Myobloc; adverse reactions can include paralysis of the respiratory muscles and difficulty swallowing (dysphagia), a condition that can allow food or liquid to enter the respiratory tract and lungs, causing aspiration pneumonia. While the data in our petition mainly related to problems associated with the medical use of Botox, adverse reactions can

occur with cosmetic use as well. Since when did “personal best” involve subjecting oneself to a possibly risky procedure?

Two weeks after our petition, the FDA issued an alert about the dangers of injecting botulinum toxin but stopped short of forcing drug makers to send out warning letters to doctors or putting a black box warning on the drug as we had requested.

The more rational approach to dealing with the lines that inevitably occur with aging comes from singer Willie Nelson, whose song I was reminded of by University of Minnesota Professor of Journalism Gary Schwitzer.

*This face is all I have, worn
and lived in
And lines below my eyes are like old
friends...*

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