PUBLIC CITIZEN HEALTH RESEARCH GROUP

Health Letter

SIDNEY M. WOLFE, M.D., EDITOR DECEMBER 2001 ◆ VOL. 17, NO. 12

"You Can't Leap a Chasm in Two Jumps"

This article is based on a review by Drs. Gordon Schiff and Quentin Young about to appear in Public Health Reports, *the journal of the U.S. Public Health Service.*

More than a quarter-century ago, the daredevil Evel Knievel learned the enduring truth of the adage quoted above when his rocket ride across the Snake River canyon in Idaho failed to reach the opposite side. Knievel lived to complete other feats of daredeviltry (some successfully, some not) but he never tried to ride a rocket across a canyon again.

The relevance of this opening paragraph to the prospects for a workable national health care system in the 21st century stems from a critique by two Chicago physicians and eminent health policy advocates reviewing the Institute of Medicine (IOM) report entitled *Crossing the Quality Chasm: A New Health System for the 21st Century*. The critique's authors, Drs. Gordon D. Schiff of Chicago's Cook County Hospital and Quentin D. Young, past president of the American Public Health Association and head of Chicago's Health and Medicine Policy Research Group, agree with the IOM panel's conclusion that U.S. health care is an unadulterated mess that sorely needs major surgery, but disagrees with the panel's gradualist approach to the problem of putting the essential changes into effect.

They endorse the *Chasm* report's assertion that "[t]he current system will not work to achieve the enormous changes that are needed....Correction of these problems calls for profound changes in the organization, delivery and financing of the U.S. health system."

Amen, say Schiff and Young, but if the desired goal is achieved, it won't be through "incrementalism," meaning "by first making modifications to quality and then reform[ing] the financing and delivery system. Unfortunately, you cannot bridge a chasm in two jumps—*health system reform must be pursued at the same time as quality reform*." (Italics supplied.)

Then, in reasoning that recalls the 1954 *Brown v. Board of Education* striking down the long-standing race-based "separate but equal" philosophy that had ruled everything from public transport to drinking fountains to schoolhouses, the critics continue, "[a]nd you cannot bridge the gap between black and white, rich and poor, health and health care by creating separate or stratified programs based on ability to pay. Instead, we need a universal financing system that includes everyone, spreading the costs and the benefits in a fair and efficient way. 'Everyone in and nobody out' has become a rallying cry for reform of our health system, and it beckons [to] those seeking to improve its quality as well."

There are, the IOM's *Chasm* report declared, six essential elements to an equitable health care system: It must be safe, effective, patient-centered, timely, efficient and equitable. The Schiff-Young paper comments, "...there is a worrisome gap between the IOM Committee's laud-

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able ideals and recommendations and the reality of contemporary health care. Without a universal national health insurance plan as a starting point to achieve care that...[assures] the six goals for improvement...these laudable aims are seriously handicapped. As the report's authors admit, 'equity in care implies universal access, a promise that has yet to be either made or kept.'"

The absence of universal access in the United States is a global scandal. No other highly industrialized country has so many citizens totally without access to even the most rudimentary health care. Consider these facts: there are almost twice as many people in the U.S. without access to health care than the entire population of Scandinavia where access is a universal right. To put it another way, more unserved or under served Americans than the total population of our most populous state, California. Are we getting our money's worth? Obviously not: our annual spending on the present non-system ($1.4 *trillion*, or about one-sixth of the U.S. gross national product) exceeds the entire GNPs of France or Italy and is not far below Germany's.

Schiff and Young characterize the *Chasm* report as containing "language which could easily have been lifted from a radical manifesto...a scathing indictment of the U.S. health care system." They state: "Without a more equitable system, 'highest quality care' will continue to be confused with preferential treatment in a marketplace that allocates multi-tiered care based on ability to pay." Schiff and Young go on to argue that, "Absent a guaranteed right to health care, other quality goals will be difficult to address, let alone achieve. These broader goals are continually moved to the periphery as increasing uninsurance and under-insurance make quality a remote concern for people who can't even get a foot in the door."

But even those who do get a foot in the door don't necessarily get what they should expect as a matter of course, say Schiff and Young. Even "insured" people experience:

- Fighting to get access to timely appointments and phone consultations;
- Tussling over access to tests and consultations;
- Arguing over conflicting formularies;
- Struggling to locate basic information on patients who have had to switch providers;
- Clashes over what coverage they have and for how long, and what happens when they change jobs, income categories, age groups, or have a serious or chronic "pre-existing" illness.

"The resources squandered on these non-health-enhancing, friction-generating activities are enormous," the Chicago critics comment. "Such impediments could all be non-issues in a system of universal coverage with clear uniform standards and protections. And a simple, uniform and equitable system would significantly enhance the resources available to address the real nitty-gritty issues of assessing and improving the quality of the actual care delivered."

The Chicago critics pose a challenge to the *Chasm* report's focus on chronic disease—a frequent source of trouble on the health care scene. The report says, "Chronic diseases should serve as a starting point for the restructuring of health care delivery because chronic conditions are the leading cause of illness, disability and death in the U.S., affecting almost half of the population and accounting for the majority of health care resources used." The critics' response: "While the [IOM] authors illustrate how today's health system is 'not well designed' for patients with chronic conditions...they fail to emphasize how chronically ill people are the untouchables in our present private insurance system."

Which gets to the unpleasant topic of "cherry picking"—the practice of insurers in all areas of that industry to prefer low risks in the hope of realizing high profits. "Despite reams of rhetoric from managed care companies about chronic disease management programs, the reality is that profits come from enrolling healthy people and avoiding sick people. *Actuaries, not actual clinicians, call the shots, as they work to identify and exclude the 5 percent of the population with chronic and complex illnesses who account for the majority (55 percent) of health care costs."* (Italics supplied.)

Individual cherry picking is not the whole story, Schiff and Young add. There is a wholesale side to this practice as well as a retail one: "When...specific sectors or whole communities (as has happened with the 1.7 million seniors dumped from Medicare managed care over the past four years) are found to be unprofitable, they are tossed out." So much for the ideal of cradle-to-grave health protection.

Although HMOs have the highest visibility, they are not the only cherry pickers on the scene. The present state of affairs, the Chicago critics say, "calls for renewed emphasis on professional and caring relationships—relationships that have been devalued in our current profit-driven system." The solution? "All of the unmeasured but immeasurable ways patients and providers can be rewarded when they work together to deal with illness will have to form the foundation of these caring relationships. And these relationships will need to be based on something more than mutual striving for the best financial deal."

Apparently there are no-nos in any quasi-official discussion of how to universalize health care, and the single-payer concept seems to be one of them. The IOM's *Chasm* report does not even mention single payer as an option, but (say Schiff and Young) "disappointingly dwells on tinkering with the ways physicians and plans are paid." Here is where one of the ugliest aspects of the present health care mess raises its head—conflict of interest. Under fee-for-service, the doctor's interests can be conflicted in ways that lead to ordering unnecessary tests and consults (as, for example, when the primary physician may unnecessarily refer a patient to a specialist who gives kickbacks, or to a laboratory in which he or she is financially interested, and thus benefits unethically). In the capitation situation, HMOs and physicians are rewarded for withholding needed

tests referrals, thus benefitting by holding down expenses and protecting the bottom line.

For all its inadequacies, fee-for-service "better aligns (albeit imperfectly) the interests of physician and patient in ways that promote trust, continuity, and incentives to satisfy the patient," Schiff and Young comment. "Conversely, the most poisonous aspect of marketplace managed care is the creation of a distrustful and adversarial relationship in the exam room. Patients, regularly forced to switch physicians by employers annually bargaining for a few dollars of premium discounts, wonder whether they can trust unfamiliar doctors incentivized to deny care. Meanwhile, physicians gamble by contracting to cover more 'lives,' speculating that they can turn a profit if they can recruit enough healthy patients, while dreading getting stuck with sick or costly ones."

This is what's at the root of the national health care crisis: the "bottom line," the very same thing that has brought journalism to its present shaky state. "The IOM Committee clearly understands this," say Schiff and Young, "yet [it] seems unwilling to name a central problem eroding quality—the transformation of health care from a service into a business. This transformation has recently been characterized by former editors of the leading U.S. medical journals as 'the invasion of medicine by commercial interests, now on a global scale [who] behave as though their only responsibility is to their shareholders.'"

It is as though a battle had broken out on the Harvard campus between the ethics of the Business School and those of the Medical School. A corporation's management (according to "B" school teaching) owes primary allegiance to the owners, while a physician's first duty (the "Med" school teaches) is to his or her patients. When a medical enterprise is owned by a corporation and finds itself "stuck" with too many sick people, it is obvious that something has to give. What is going to be done to restore to health a system that is critically (if not terminally) ill, is really "the question before the house."

Actually, it is before the House and the Senate, as well as an executive branch that shows little enthusiasm, or even interest, in doing something, anything, to address these fundamental problems. This is just fine from the point of view of bottom-liners (including the pharmaceutical industry, the leading lobbyists against any change in the status quo) who have brought the health care crisis to its present level, many of whom are making out like bandits under the current system. More law, it seems, is being made these days in the lobbies of the U.S. Capitol than in its legislative chambers. And this bodes ill for true reform.

As the authors of the critique see it: "Eight of the IOM Committee's 13 recommendations call for an expanded role for public sector leadership to support quality improvement. For the public sector to succeed in the roles outlined by the Committee, there must be a mandate and a mechanism. Both of these prerequisites are now being undermined by corporate America. Writing pre-September 11th, they state that "many with economically vested interests have worked to demonize 'government' and push aside public accountability and oversight (for instance, attempting to beat back even the most tepid Patient Bill of Rights legislation)." Will a new spirit and support for federal protections now prevail, now that terrorist bombings and mail attacks have awakened a renewed sense of understanding our vulnerabilities and need for governmental protections?

Neither the IOM's *Chasm* report nor the Schiff-Young critique maps out a campaign to bring the U.S. health care system into line with both common sense and First World practice, but in both documents is the implicit admission that whatever effective is done, it will take time.

The critique puts it this way: "The real problem is not that the current incentives are skewed, but the entire orientation around monetary incentives is misdirected. Only by tapping into the immense reservoir of professionalism, and developing a culture and infrastructure that sustains rigorous science and caring relationships, will quality flourish. Nurses and doctors need support, in the form of time, training, accessible information, and practical timely guidance, not better sticks and carrots."

And, like the building of Rome, this won't be done in a day.

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Product Recalls

October 17—November 7, 2001

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

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 web site is *www.fda.gov*.

Class I Recall

Name of Drug or Supplement; Class of Recall; Problem	*Lot #; Quantity and Distribution; Manufacturer*
Hydrozyme Tablets, a dietary supplement sold in bottles of 90 and 250 and **HCl Plus Tablets**, a dietary supplement sold in bottles of 90; Products were manufactured using pepsin that American Laboratories, Inc., Omaha, Nebraska recalled due to Salmonella contamination	Hcl lot 21150, hydrozyme lot 21173, 21245, 21280; 1,133,560 tablets distributed nationwide; Biotics Research Corporation, Rosenberg, Texas
Treasure of the East brand Chinese herbal products; Products contain aristolochic acid, a potent carcinogen and nephrotoxin. Items include powder form and capsules: Guan Mu Tong—Product was listed in catalog as Mu Tong (Akebia caulis), but was actually Guan Mu Tong which contains aristolochia, sold as single ingredient powder and also as an ingredient to manufacture these combination formulas: Ma Dou Ling, Ba Zheng San, Dang Gui Si Ni Tang, Dao Chi San, Fu Fang Di Hu Tang, Gan Lu Xiao Du Dan, Kou Yan Ning, Long Dan Xie Gan Tang, Pai Shi Tang, Xiao Ji Yin Zi, Xin Yi San, Yang Yin Xiao Yan Tang	Products with "MFG NO." of 2000 08 (=August 2000) and lower are subject to recall; 1,332 bottles distributed nationwide; Tianjiang Pharmaceutical Co. Ltd., China. Recalled by Blue Light, Inc., Ithaca, New York

Name of Drug or Supplement; Class of Recall; Problem	*Lot #; Quantity and Distribution; Manufacturer*
Antiseptic Spray containing lidocaine 2.5% and benzalkonium chloride 0.14%, packaged in 3-fl. oz. containers, OTC, packaged under labels: Zee First Aid Antiseptic Spray, Medi First Plus Pain Relieving Antiseptic Spray, First Aid Antiseptic, First Aid Only Antiseptic Spray, Respond First Aid Antiseptic; Class III; Active ingredient lidocaine is sub-potent	Numerous lots; 247,596 bottles distributed in New York, California, Colorado, Illinois, Tennessee, Georgia and Florida; York Pharmaceuticals, Inc., Kansas City, Kansas
Aspirin (coated and uncoated); Class III; Dissolution failures (starting at two months of stability)	Numerous lots and sizes distributed under labels York, Health Care, Homebest, DG (Dollar General), Vitatrade, HyTop, Parade, Smart Choice, Our Family, Welby, DeMoulas, Southern Home, Quality Choice, Snyder, Navarro, Russian, Conney, Discount Drug Mart, Medic Drug, Vi-Jon; 1,755,615 bottles and 4,050,000 bulk tablets distributed nationwide; York Pharmaceuticals, Inc., Kansas City, Kansas

Name of Drug or Supplement; Class of Recall; Problem	*Lot #; Quantity and Distribution; Manufacturer*
Bronchial Mist, epinephrine inhalation aerosol, 1/2 fluid ounce (15 mL), 5.5 mg/mL epinephrine, plastic coated glass vials packaged with actuator; Class III; Dosage uniformity failure	Lot RD 1406 EXP 5/03; 4,608 unit doses distributed in Tennessee, Indiana, Connecticut, Kentucky, and Rhode Island; Armstrong Laboratories, West Roxbury, Massachusetts. Recalled by Alpharma USPD, Baltimore, Maryland
Burn Relief Spray, benzocaine 5.0% and benzalkonium chloride 0.14% packaged in 3-fl. oz. containers, OTC, packaged under labels: York Burn Relief with Aloe Vera Antiseptic/Anesthetic, Zee Burn Relief Spray with Aloe Vera, Antiseptic/Anesthetic, Medi First Plus Pain Relieving Burn Spray with Aloe Vera, Antiseptic Anesthetic, Burn Relief with Aloe Vera Antiseptic; Class III; Active ingredient benozocaine is super-potent	Numerous lots; 105,996 bottles distributed in New York, California, Colorado, Illinois, Tennessee, Georgia and Florida; York Pharmaceuticals, Inc., Kansas City, Kansas
Colocort, hydrocortisone enema, (retention)100 mg/60 ml, Rx only, disposable, single-dose bottle; Class III; Impurity specification failure at stability testing (18 months)	Lot numbers 9M6024, 9M6049, 9M6051, 0C6226, 0C6230, 0E6338, 0E6345, 0E6360, 0E6366, 0E6372, 0H6558, 421557, 431587, 441605, 441625, 481764, and 481782; 230,000 bottles distributed nationwide; Paddock Laboratories, Inc., Minneapolis, Minnesota
Etodolac Capsules, 200 mg, Rx, 100 capsule bottles; Class III; Misbranded: product label incorrectly declares product as tablets	Lot 014430 EXP 5/03; 1,582 bottles distributed in Pennsylvania and Kentucky; Taro Pharmaceutical Industries Ltd., Haifa Bay, Israel. Recalled by Taro Pharmaceuticals U.S.A., Inc., Hawthorne, New York
Etrafon Tablets, perphenazine and amitriptyline hydrochloride; Class II; Dissolution failure (18 month stability)	Lot 9-ANC-1 EXP 9/01; 15,477 bottles and 2,220 unit dose blister packs distributed nationwide; Schering Corp., Kenilworth, New Jersey
Hyoscyamine Sulfate, extended release capsules, 0.375 mg, 100 capsule bottles, Rx only; Class III; Sub-potency (9 month stability station)	Lots 0024E, 0043E; 800,000 capsules distributed in Ohio; Carlsbad Technology, Inc., Carlsbad, California
Levoxyl, levothyroxine sodium tablets, 25 mcg and 150 mcg; Class II; Subpotency (during stablity)	Lots: 6413 EXP 12/01, 6294 EXP 11/01; 57,272 units distributed nationwide; King Pharmaceuticals, St. Petersburg, Florida (formerly Daniels Pharmaceuticals). Recalled by King Pharmaceuticals, Inc., Bristol, Tennessee
Motion Sickness Tablets (meclizine HCl 25 mg), 8 Tablet cartons, OTC; Class II; Dissolution failure	PL Developments lots 2193, J1931, J1932 EXP 4/02, packaged under labels: Longs, Eckerd, Discount Drug Mart-Food Fair, and Valu-Rite; 34,782 blistered units (8 tablets per blister) distributed in California, Florida and Ohio; PL Developments, Farmingdale, New York
Nitro Tab, nitroglycerin sublingual tablets, 0.3mg; Class II; Mislabeled: 0.3 mg product labeling (exterior carton) incorrectly declares bottles to contain 0.4 mg tablets	Lot 021002 EXP 12/02; 1,260 bottles distributed in Ohio; Able Laboratories, South Plainfield, New Jersey
Oxycontin; Class III; Contamination—tablets contain particles of stainless steel and/or were manufactured with an unqualified excipient	Numerous lot numbers; 3,388,083 bottles of 100s and 257,797 blisters of 25 distributed nationwide and worldwide; The P.F. Laboratories, Inc., Totowa, New Jersey. Recalled by Purdue Pharma L.P., Stamford, Connecticut

DRUGS & DIETARY SUPPLEMENTS *cont.*

Name of Drug or Supplement; Class of Recall; Problem	*Lot #; Quantity and Distribution; Manufacturer*
Women's Tylenol Menstrual Relief Caplets, OTC, 500 mg acetaminophen and 25 mg pamabron film coated caplets, sold in 40 count bottles; Class III; Dissolution failure—acetaminophen component (stability)	Lot DJM099 EXP 9/02; 133,296 bottles distributed nationwide; McNeil Consumer Healthcare, Guelph, Ontario, Canada. Recalled by McNeil Consumer Healthcare, Fort Washington, Pennsylvania
Zestril Tablets (lisinopril), 10 mg, Rx, once-daily tablets, 100 tablets/bottle; Class II; Mispackaging—bottles labeled as 10 mg may contain 20 mg tablets	Lot R2817 EXP 02/03; 953 bottles distributed in Michigan and Ohio; IPR Pharmaceuticals, Carolina, Puerto Rico. Distributed by Zeneca Pharmaceuticals, repackaged by Prestige Packaging Inc., Farmington Hills, Michigan

MEDICAL DEVICES

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 information. You can also call the FDA's Device Recall and Notification Office at (301) 443-4190. To report a problem with a medical device, call 1-800-FDA-1088. The FDA web site is *http://www.fda.gov.*

Name of Device; Class of Recall; Problem	*Lot #; Quantity and Distribution; Manufacturer*
Invacare Electric Beds Junction Box; Class II; Faulty junction box may overheat and result in electrical failure with potential fire hazard	AC-Powered Adjustable Hospital Beds. All affected junction boxes identified with date of manufacture from 8/1/98 through 10/31/00; 222,022 distributed nationwide and worldwide; Invacare Corp. Sanford, Florida. Recalled by Invacare Corp., Elyria, Ohio
Toothbrushes (battery operated); Class II; Defective seal allows water into handle	Homedics PowerDent models HD-30, HD-30DP, and HD-30-12PK and PowerDent Jr. models HD-20, HD-20DP, and HD-20-12PK; 935,000 sold nationwide; Teamedics Shenzhen, China. Recalled by Homedics, Inc., Commerce Township, Michigan

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 1-800-638-2772. The CPSC web site is *http://www.cpsc.gov.*

Name of Product; Problem	*Lot #; Quantity and Distribution; Manufacturer*
Baby Gates, Recall to repair; Plastic mounting hardware that attaches to the wall can crack or break, allowing the wooden gate to unlatch, and also creating small parts that pose a choking hazard to young children	Home Décor Swing wooden baby gates model numbers 1555/6 with manufacture dates before September 2001; 20,500 sold nationwide from June 1999 through September 2001; Evenflo Company Inc., Vandalia, Ohio (800) 576-0507 www.swinggate.com
Booster Seats, Recall to repair; Top half of the seat inserts can separate, and a child can fall from the chair	Model numbers 173, 173A and 173B; 1.5 million sold nationwide from January 1994 through August 1999; Safety 1st, Canton, Massachusetts (888) 579-1730 www.safety1st.com
Burners in Gas Water Heaters; Burners could produce excess carbon monoxide (CO), posing a risk of CO poisoning	American Proline, Envirotemp, Mor-Flo, Powerflex, Premier Plus and US Craftmaster. Serial number, located on the data plate on the front of the water heater, starts with 0124 through 0127, 30, 40, 50 and 75 gallon capacities; 16,000 sold at home centers and through contractors nationwide from June through September 2001; American Water Heater Co., Johnson City, Tennessee (800) 999-9515 email at support@americanwaterheater.com

CONSUMER PRODUCTS *cont.*

Name of Product; Problem	*Lot #; Quantity and Distribution; Manufacturer*
Candle Sets; Wax can drip and ignite the potpourri and candles also generate a significant amount of heat in close proximity, creating a fire hazard	Ambria brand, 9-piece set; 74,000 sold at Wal-Mart Stores nationwide from September 1 through September 20, 2001; Endar Corp., Temecula, California (800) 562-9974 www.endar.com or return to any Wal-Mart Store
Children's Board Books; Plastic lamination on the board book may peel off, posing a choking hazard	Bunny My Honey thick cardboard book; 78,670 sold nationwide from December 2000 through September 2001; Candlewick Press, Cambridge, Massachusetts (800) 883-0009 www.candlewick.com
Deep Fryer Basket Handles; Handles can come off, resulting in hot oil spattering the user	Presto CoolDaddy electric fryers, model numbers 0544404 (product number 21-419) and 0544504 (product number 21-439); 50,000 sold nationwide from July 2000 through June 2001; National Presto Industries Inc., Eau Claire, Wisconsin (866) 813-9545 www.gopresto.com/recall
Fluorescent Lights; Lights are improperly wired, posing a fire hazard	Sold in various shapes and sizes including domes, cylinders and rectangles. The label on the light contains the name, PROGRESS LIGHTING; 10,600 sold nationwide from March 1998 through July 1999; Progress Lighting, Spartanburg, South Carolina (866) 696-8593 www.progresslighting.com
Gas Ranges, Recall to repair; Delayed ignition of gas in ovens and broilers can put consumers at risk of burn injuries and fires	Sold under Wolf and Wolf Gourmet brand names, 30, 36, 48 and 60-inch natural gas and LP ranges with serial numbers beginning with 60-10 and followed by five digits and 11000957 through 11006106; 15,000 sold nationwide from January 1996 through June 2001; Wolf Range Co. Inc., Compton, California (866) 674-3554, and Wolf Appliance Co. LLC, Fitchburg, Wisconsin (800) 332-9513
Microwave-Hood Combinations; Units can overheat and catch fire	Whirlpool, KitchenAid and Kenmore brand names with serial numbers that begin with XC; 1.8 million sold nationwide from January 1998 through September 2001; Whirlpool Corp., Benton Harbor, Michigan (800) 785-8897 www.whirlpool.com
Mini-Bicycles; Bicycles do not have any brakes, which are required by federal standards	Runt model red, blue, black or chrome with black seats and handle grips, 24-inches long and 26-inches high with 6-inch wheels; 95,000 sold nationwide from January through July 2001; Wysco Inc., Baldwin Park, California (866) 868-7868 www.justgoscooters.com
Playpens; Plastic tabs on the playpen that lock the rails can break or loosen over time, allowing rails to turn inward, collapse and entrap an infant	Zip n Go, Okie Dokie, and Carters manufactured by Cosco, model numbers 05-361, 05-362, 05-363, and 05-364; 102,000 manufactured between May 1995 and December 1997; Dorel Juvenile Group, Columbus, Indiana (800) 314-9327 www.djgusa.com
Power Adapters; Adapters can overheat and melt a hole through the housing, posing a fire hazard, exposed wires pose a shock hazard	Used with Cisco Asymetric Digital Subscriber Line (ADSL) Routers 827, 827-4V, 826, SOHO77, SOHO77-50, 827-EUR; 95,000 sold worldwide from April 2000 through September 2001; Cisco Systems Inc., San Jose, California (800) 553-2447 www.cisco.com

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"...Makes You Stop and Think!"

With this issue of Public Citizen's Health Letter, *we begin to offer an occasional feature that we hope will amuse, baffle, appall or enrage you—health-related items gleaned from the media that may have escaped general attention. Like humor columnist Dave Barry, we will welcome contributions from "alert readers."*

Bill Frist, a Republican from Tennessee, is the only medical doctor in the United States Senate, the man other lawmakers look to when questions of do's and don'ts in the health field arise. Dr. Frist was profiled in a feature article in the October 27 *Washington Post* that included this passage: "As a Harvard Medical School student in the 1970s, Bill Frist briefly made a habit of adopting stray cats from local animal shelters [and] then dissecting them. It was, he wrote later, a 'heinous and dishonest thing to do.'"

Another item in the *Post,* this time in the November 4 issue, disclosed that the state of Virginia has been playing fast and loose with the federal government's contributions to the state's Medicaid program. In order to make up for general revenue shortages caused by a popular cut in taxes on automobiles, the government at Richmond had been diverting money sent by Washington to augment the state's relatively meager support of health care for its less prosperous citizens.

Finally, an Associated Press report out of Chicago on November 5 quoted a medical products manufacturer, Baxter International Inc., as acknowledging that filters intended for use in kidney dialysis machines to prolong the lives of persons with end-stage renal disease were contaminated with a chemical solution that apparently caused some of at least 51 deaths worldwide–including four in the U.S.–that are now being investigated. Baxter International says it has closed down the facilities where the faulty products were made and, according to the AP, "is earmarking $100 million to $150 million for litigation and related expenses." The company, AP added, had "previously said it found nothing to indicate its products were at fault . . ."

Contributions from readers of the Health Letter *for "...Makes You Stop and Think" or "Outrage of the Month" should include a clipping or photocopy of any item, and should be mailed to Health Letter Clippings, 1600 20th Street NW, Washington DC* 20009 or faxed to 202-588-7796. E-mail entries to mccarthy@citizen.org will be accepted if they include actual attachments of the published item showing source and date of issue.

CONSUMER PRODUCTS *cont.*

Name of Product; Problem	*Lot #; Quantity and Distribution; Manufacturer*
Rattles; Sewn-on, spherical shaped fabric eyes on the rattles can detach, posing a choking hazard to small children	Lily Pad, Bitty Kitty, This Little Piggy, Goo Goo Goldfish, Smoochie Poochie, Crinkly Crown Dragon soft rattles; 455,000 sold nationwide from August 1999 through October 2001; Sassy Inc., Northbrook, Illinois (800) 781-1080
Refrigerators; Tubing in the cooling unit can crack and leak flammable gas, presenting a fire and burn hazard	Free-standing, combination gas and electric refrigerators, white with black trim, with Norcold logo; 360 sold nationwide from May 1999 through January 2000; Norcold Inc., Sidney, Ohio (800) 767-9101
Swings; Buckles can break and shoulder restraint straps can pull out of the back of the seat, causing young children to fall	2-in-1 Snug 'n Secure swings model number 4117-00; 250,000 sold nationwide from December 2000 through September 2001; Little Tikes Company, Hudson, Ohio (800) 815-4820 www.littletikes.com
Toy Boxes; Lid can fall suddenly, posing entrapment and strangulation hazards to young children. Spaces at the end of the hinge can also entrap fingers	Models 580-283, 581-283, 582-283, 583-283, 584-283, 589-283 and 598-283, 36-inches long by 19-inches wide and 21-inches high with different finishes; 4,500 sold nationwide and in Canada from July 1999 through August 2001; Palliser Furniture Ltd., Winnipeg, Manitoba, Canada (877) 840-7396 www.toyboxnews.com
Twister Portable Lamps, Recall to repair; Bulb can become hot, presenting a burn and fire risk	38 inches tall, with flexible neck, on plastic shade (some with Looney Tunes or Disney characters); 480,000 sold nationwide from January 1997 through June 2001; Emess Lighting Inc. and SLI Lighting Solutions Inc. (800) 366-2579 www.twisterlamp.com

Philip Morris Brags About its Killer Cigarettes

A study done by the Arthur D. Little Company for Philip Morris and released last summer found that in the Czech Republic, the government experienced a $147 million net gain in 1999 as a result of smoking by Czech citizens. The summary of the study found that "Based on up-to-date reliable data and consideration of all relevant contributing factors, the effect of smoking on the public finance balance in the Czech Republic in 1999 was positive..." Among the "positive" economic aspects of smoking for the government, according to the study, were "health care cost savings due to early mortality," "savings on housing for elderly" and pension savings "due to early mortality."

In other words, after decades of denying that cigarettes cause death and disease, Philip Morris was trying to turn the lethal properties of its profitable products into an advantage. The context included efforts to increase the tax on tobacco, which would decrease sales. The company—which controls 80 percent of cigarette sales in the Czech Republic—wanted everyone to know that the government was already a significant benefactor because of the deadly effects of smoking.

The *British Medical Journal*, not one to mince words, reported that "Smokers are doing their country a huge favor by boosting tax revenue, dying early, and not drawing a pension, according to a report by the tobacco giant Philip Morris." Tobacco expert Dr. Ken Warner of the University of Michigan School of Public Health said "Is there any other company that would boast about making money for the public treasury by killing its customers?" Columnist Ellen Goodman wrote that "America's own Philip Morris has a plan to balance government budgets and save billions on the rising costs of rising life expectancies? The Morris Plan, if I may call it that, is a 2001 equivalent to the Marshall Plan. It promises governments that cigarettes can help lighten the burden of elder costs. How? By shortening lives!" She continued that "Last March when the Czech Prime Minister was seen smoking in public, he defended himself, joking that "by smoking, I contribute to the stability of the state budget. By buying cigarettes I increase state revenues and I will die of lung cancer so the state won't have to pay me a pension." This "joke" was given more legitimacy by the findings of the Philip Morris study. But, Goodman continued, "There are, of course, nay-sayers. 'Probably some people find it quite difficult to accept that smoking can bring anything positive,' whined the Czech spokesman for the company."

Following an enormous amount of bad publicity because of this study, Philip Morris International sought to distance itself from the Arthur D. Little report its subsidiary had commissioned and issued a pitiful statement of apology.

"We understand that this was not only a terrible mistake, but that it was wrong," Steven C. Parrish, a senior vice president, said in an interview. "To say it's totally inappropriate is an understatement." He went on to say that Philip Morris has canceled plans for similar studies in Poland, Slovakia, Hungary, and Slovenia. The Czech report was prepared without the knowledge of officials at Philip Morris's New York headquarters, he said, and was done in anticipation of a debate over excise-tax increases on cigarettes in the Czech Republic. A Philip Morris spokesman said the company remains "concerned" about a tax increase, which public health experts advocate because demand for cigarettes falls as prices rise.

The bottom line, of course, is the bottom line. Philip Morris and other tobacco companies are desperately seeking to expand foreign markets, in the developed world as well as in the developing world, as they lose sales in the American market. Their implicit modest proposal—similar in design to Jonathan Swift's one to ease famine by eating children—is to ease the strain on the economy in developed countries by killing people earlier with its cancer and heart disease-causing "sticks". Jonathan Swift would be appalled by Philip Morris' modest proposal.

Living and Dying

An editorial by *British Medical Journal* editor, Richard Smith, poignantly addresses the issues surrounding death and dying and offers some specific suggestions and warnings about how this difficult process may be made more humane and tolerable. He begins by quoting Epicurus's not often enough remembered statement that "The art of living well and dying well are one." He follows with Montaigne's wisdom that "Death is one of the attributes you were created with; death is part of you. Your life's continual task is to build your death."

Moving from the more abstract, philosophical views about death and life, Smith goes on to say that "modern medicine may even have had the hubris to suggest implicitly, if not explicitly, that it could defeat death. If death is seen as a failure rather than as an important part of life then individuals are diverted from preparing for it and medicine does not give the attention it should to helping people die a good death. The new approach, which Smith calls a clarion call for change, states that "We believe it is time to break the taboo and to take back control of an area [death] which has been

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DEA Promotes Public Citizen Information

Many *Health Letter* readers are familiar with our publication *Questionable Doctors* which lists physicians and osteopathic doctors who have been disciplined by state medical boards and federal agencies, including the Drug Enforcement Administration (DEA). Doctors who prescribe or administer certain drugs subject to abuse are required to register with the DEA, which is responsible for sanctioning registrants who abuse the system.

When Public Citizen published the first *Questionable Doctors* report in 1990 we attempted to gather data from the DEA about doctors who surrendered their narcotics licenses or had voluntary restrictions placed on them. In order to obtain this information Public Citizen had to file suit against the DEA arguing that the Freedom of Information Act (FOIA) required disclosure not only of license revocations (which are published in the Federal Register) but also of license surrenders and restrictions. The offenses committed by doctors who surrender licenses are very often just as serious as those which result in revocation. But the DEA had contended that it would not give us data on license surrenders because to do so would invade the personal privacy of physicians who had surrendered their licenses and would interfere with the DEA's law enforcement efforts by lifting the cover on the voluntary DEA license agreements. After we filed suit, lawyers from the Justice Department decided that the DEA's position was indefensible as a matter of law, and the case was settled in January 1993 with an agreement that requires the DEA to provide us with license surrender and restriction information which we have since published.

Imagine our surprise that in the last couple of months, Public Citizen's Health Research Group has received several inquiries about DEA registrations from consumers and health care professionals who were referred to Public Citizen by the DEA—the very agency charged with maintaining this information. A quick investigation revealed that one of the "Frequently Asked Questions" on the DEA Diversion Control Program's web site is "Can you verify a DEA [registration] number?" The answer: "NO." Verification, it explained, can be obtained by requesting a copy of a physician's certificate, purchasing a list of active registrants (asking price: $270 for a single issue, $1,920 for a monthly subscription), or by contacting Public Citizen for "a list of all Medical Doctors and Doctors of Osteopath who either voluntarily surrendered a DEA registration or whose DEA registration was restricted."

Although we appreciated the DEA's recognition of our efforts regarding doctor discipline, the information on their web site was somewhat misleading. We do not publish a separate list of doctors disciplined by the DEA, but rather group all disciplined doctors by state and/or region so that patients can screen physicians who are likely to be practicing in their area. Moreover, *Questionable Doctors* is not designed to be a credentialing service for hospital administrators, but rather a research tool for consumers to help them choose a safe and competent doctor. We called and explained this to DEA who has now removed the Public Citizen reference from their web site.

DYING, *from page 9*

medicalized, professionalized, and sanitized to such an extent that it is now alien to most people's daily lives."

This thoughtful statement, from a report by the British Debate of the Age Health and Care Study Group, was entitled *The future of health and care of older people: the best is yet to come.* Referring to the status quo in Britain, but in a manner certainly applicable in the U.S., Smith points out that "For the minority who die under the care of palliative care teams it is probably good, but there is a suspicion that for the majority who die in acute hospitals or nursing homes the experience is bad."

The authors of the above-mentioned report by the Age Health and Care Study Group delineate 12 principles of a good death:

- To know when death is coming, and to understand what can be expected.
- To be able to retain control of what happens.
- To be afforded dignity and privacy.
- To have control over pain relief and other symptom control.
- To have choice and control over where death occurs (at home or elsewhere).
- To have access to information and expertise of whatever kind is necessary.
- To have access to any spiritual or emotional support required.
- To have access to hospice care in any location, not only in hospital.
- To have control over who is present and who shares the end.
- To be able to issue advance directives which ensure wishes are respected.
- To have time to say goodbye, and control over other aspects of timing.
- To be able to leave when it is time to go, and not to have life prolonged pointlessly.

Smith advises that not all the focus should be on the process of dying and that death should be brought more into life. Suggestions made in the same report include the introduction of death education into schools. Another is to improve the quality and relevance of funerals. The British National Funerals College criticizes modern funerals for being, too often, "hypocritical, bureaucratic, dull, impersonal, and hurried." This criticism is surely true of too many funerals in this country as well. A good funeral is a life enhancing experience, and, here again we agree with Smith's wisdom, it makes sense that you think about yours now.

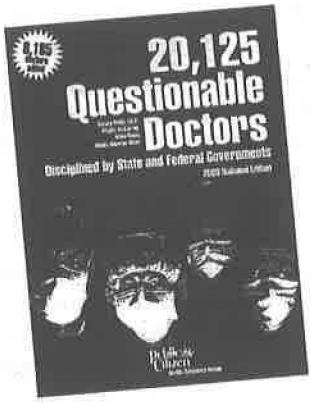
OUTRAGE, *from page 12*
hours because a severe infection ("necrotizing fasciitis") had developed that required removal of a large amount of soft tissue. The patient spent a day in intensive care, and was eventually discharged from the hospital on Friday, the 13th, 11 days after the 2nd surgery.

Following this, the patient required twice daily nursing visits to unpack, clean, and repack the abdominal wound. He had persistent abdominal pain and bouts of insomnia as well as depression, and was unable to resume work.

This episode—the forgotten retractor, resultant infection, re-operation, and long period of wound healing and convalescence—could have been averted by a simple instrument count, as mandated by California health department regulations but apparently ignored at that particular hospital.

The patient's claim to the hospital for $3,000,000 was rejected in January 2001. He is now suing the hospital as well as the surgeons for damages.

20,125 Questionable Doctors



To order ***Questionable Doctors*** by phone, please call 1-877-747-1616.

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"I Have Never Seen Anything Like This"

In August 2000, a 45-year-old San Diego man began passing air through his urethra when urinating, a symptom known as "pneumaturia." His doctor referred him to a urologist, and further testing disclosed a probable "colovesical fistula"—a tract leading from the colon to the urinary bladder, resulting in the passage of intestinal contents into the bladder. The patient was then referred for surgical repair.

He entered a hospital in Escondido, California about a month later, and the surgery began about 8:30 PM. Several hours later, one of the surgeons told the patient's father that the fistula was larger than expected and the surgery more difficult than had been anticipated, but that the bladder had been successfully repaired without incident or complication.

Post-operatively, the patient noticed a sharp pain near his right breast whenever he turned on his right side. When he reported this to the surgeon, he was told this was routine post-operative pain, and he was advised not to lie on his right side. He was discharged from the hospital on September 22, eight days after his admission.

Nine days later, on October 1, while the man was undergoing an abdominal x- ray, the x-ray technician returned to the room, sat the patient up, and began looking for a metallic object lying underneath the patient, but found none. He took another x-ray and found what he was looking for—not *under* the patient, but *in* him. The tech notified the radiologist, who immediately told the surgeon who had operated on September 14th. The patient was called to the surgeon's office, where he was met by the surgeon at the information desk and informed that "in all my years of surgery I have never seen anything like this." "This" was a nine-inch malleable retractor that had been left inside the man's abdomen during the surgery 17 days earlier.

"Doesn't someone count these items before and after surgery?" the patient's father asked. To which the surgeon reportedly responded, "It's strange, but [this] hospital is one of the only hospitals where I perform surgeries that does not require an instrument count. They count sponges, gauze, needles, but not instruments."

The surgeon advised immediate surgical removal, which he said would require only a small incision and would take no more than a half-hour. Wrong again: the procedure lasted several

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