PUBLIC CITIZEN HEALTH RESEARCH GROUP

Health Letter

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2,500 U.S. Deaths a Year Because of For-Profit Kidney Dialysis

There are two clearly unique attributes of the United States' health care system, which distinguish it from those in all other developed countries. First, there are more than 41 million people in this country who do not have health insurance, almost one out of every six people. Related to this steadily increasing problem of the uninsured is the second unique attribute of our system: an unprecedented amount of for-profit health services. In no other country in the world is there more than a shadow of the amount of for-profit health services being delivered in this country, such as nursing homes, hospitals, HMOs and dialysis centers — the subject of the paper published in the Journal of the *American Medical Association* (JAMA) by researchers from McMaster University Medical School and the State University of New York at Buffalo.

A study by researchers from Harvard Medical School and Public Citizen, published in the JAMA three years ago, found that for-profit HMOs scored lower on all 14 measures of quality of medical care than not-for-profit HMOs. In for-profit plans toddlers and adolescents were 12 percent less likely to get immunizations, women were 8 percent less likely to receive mammograms, 6 percent less likely to get early prenatal care, 5 percent less likely to get post partum checkups and 10 percent less likely to get pap smears. Twenty-seven percent fewer diabetics got the eye care they needed to prevent blindness and heart attack patients were 16 percent less likely to get life saving beta-blocker drugs. In that study, care for the sickest patients — diabetics and heart attack survivors — suffered most in for-profit plans. The McMaster study confirms that the most vulnerable — in this case patients with end-stage kidney disease — are significantly more likely to die when for-profit dialysis centers provide their care.

Since 1989 the number of uninsured has increased from 33 million to 41 million. The push for profit is driving down quality, demoralizing doctors and nurses, discouraging

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research and teaching and, as shown in the study recently published in JAMA, causing the deaths of many people each year. To make matters even worse, health costs are again rising extremely rapidly. It is time to reconsider non-profit, single-payer, national health insurance and eventually, the return to a not-for-profit system of delivering health services.

Since 1973, the United States federal government has funded the care of patients on dialysis through Medicare. Currently 75 percent of Americans receiving hemodialysis do so at private for-profit facilities and 20 percent of Americans receiving hemodialysis do so at private not-for-profit facilities. In Canada, not-for-profit facilities deliver 100% of hemodialysis.

The clearest answer to any scientific question comes from bringing together all of the high quality studies that have addressed the issue. In the last 15 years, medical researchers have developed and refined a new methodology for the scientific summary of information bearing on a specific health care delivery question. In this case, the question is: "What is the relative impact of private for-profit versus private not-for-profit dialysis care on death rates?" The method involves developing explicit criteria for deciding whether a study is eligible; conducting a comprehensive search to identify all relevant studies; applying the eligibility criteria to potentially eligible studies in an unbiased manner; examining the quality of the eligible studies; and conducting a rigorous statistical analysis of the data from the studies that ultimately prove eligible and of adequate quality. Medical researchers refer to such studies as systematic reviews.

An internationally acclaimed research team at McMaster University conducted a rigorous systematic review of studies comparing death rates at private for-profit and private not-for-profit dialysis centers. The team identified over 7,000 potentially eligible articles, of which over 700 passed an initial eligibility screen. The team then undertook an extremely important measure to eliminate any bias in the selection process of which studies to include in the systematic review. The team trained research staff to read through all the articles and use a black marker to obscure the results of the studies. Two reviewers then independently examined these articles with the results blacked out and determined study eligibility. As a result of this process the researchers could not select studies to reach a specific conclusion. Eight studies including data on over 500,000 patients met eligibility and quality criteria for the systematic review. All studies considered, or "adjusted for," patient's co-morbid illnesses, such as diabetes and hypertension, in their analysis.

The higher death rates result when for-profit companies cut corners to make sure they produce the required profit margin.

The results of these studies show that for-profit care resulted in an 8 percentincrease in death rates relative to private not-for-profit care. The findings were consistent across studies, and show that if U.S. patients received care in private not-for-profit dialysis facilities instead of for-profit facilities, 2,500 fewer patients would die each year.

The results are plausible, because private for-profit facilities have to both generate profits to satisfy shareholders, and pay taxes (typically these two expenditures are in the range of 10-15 percent of expenses). Not-for-profit facilities can spend this money on patient care. The higher death rates result when for-profit companies cut corners to make sure they produce the required profit margin.

This and previous studies suggest that for-profit providers respond to pressure to maximize profits by cutting corners in both in-patient and out-patient settings, and that severe consequences for patients result. This study again raises serious concerns about the dangers of private for-profit health care.

THE PUBLIC CITIZEN HEALTH RESEARCH GROUP
Health Letter

The Health Research Group was co-founded in 1971 by Ralph Nader and Sidney Wolfe in Washington, D.C. to fight for the public's health, and to give consumers more control over decisions that affect their health.

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Low Quality HMOs Hide Performance Data from Public, Says *Journal of the American Medical Association* Study

As many as one half of all HMOs that participate in the nation's principal quality monitoring system stopped publicly disclosing their quality scores from one year to the next, according to a study in the *Journal of the American Medical Association*. The study, conducted by researchers at Harvard Medical School and Public Citizen's Health Research Group, found that poor quality HMOs were at least three times more likely than the best plans to drop out of public disclosure of their scores. "Many HMOs are manipulating the system. They're undermining quality assessment and misleading the public into believing that HMO quality is better than it is," said Dr. Danny McCormick, a study author and instructor of medicine at Harvard Medical School.

The study analyzed data from the National Committee for Quality Assurance's (NCQA) Health Plan Employer Data Set (HEDIS) program, the most influential HMO quality-monitoring program. Each year, HMOs voluntarily submit data on their performance on a defined set of quality indicators such as the percentage of women receiving a mammogram or children receiving immunizations. The NCQA then publishes HEDIS scores of participating HMOs. The authors examined whether HMOs' HEDIS scores in 1997 and 1998 predicted the likelihood of HMOs withdrawing from public disclosure of scores one year later.

"The selective withdrawal by lower scoring plans means that average published scores could improve even if actual quality were stable or even deteriorating," said Dr. David Himmelstein, a study co-author and associate professor of medicine at Harvard Medical School. "This means that the true quality of HMO care in the U.S. is currently unknowable."

The study also found large differences in quality among HMOs disclosing data. For example, in 1997, patients enrolled in plans in the bottom one-third were only half as likely to receive life saving beta-blocker drugs after suffering a heart attack as patients enrolled in the top one-third of HMOs (42 percent compared with 83 percent). "This underscores why patients need information on the quality of their HMO if they are to make informed choices," said Dr. McCormick.

"No other industry with so much impact on the public's safety is so free of public oversight," said Dr. Steffie Woolhandler, another co-author and associate professor of medicine at Harvard Medical School. "Airlines and car manufacturers are required to disclose data on the safety of their products. The HMO industry is showing that it too needs public oversight. Voluntary participation does not seem to work."

A full list of the 228 HMOs that withdrew from public disclosure of quality scores in 1998 and 1999 is available on Public Citizen's Web site at http://www.citizen.org/publications/release.cfm?ID=7204, or by writing to the Health Research Group at 1600 20th Street NW, Washington, DC 20009.

Blind to the Data: OSHA Looks the Other Way as Workers Exposed to Hexavalent Chromium

Consider these facts regarding a certain chemical:

- Up to a million workers exposed.
- Multiple studies confirm the chemical to be a potent lung carcinogen.
- Every major relevant scientific body agrees that it is a carcinogen.
- The agency that regulates it acknowledges that the levels it permits are associated with an excess risk of lung cancer.
- Evidence that many industries already meet a drastically lower exposure limit.

Everything you need to regulate a substance, right? Wrong. Not if the substance is the known lung carcinogen hexavalent chromium and the agency involved is the feeble Occupational Safety and Health Administration (OSHA). Work commissioned by OSHA itself shows that 9-34 percent of workers exposed at the current Permissible Exposure Limit (PEL) will die of lung cancer over a 45-year working lifetime. And still no meaningful action.

Hexavalent chromium is used in chrome plating, stainless steel welding and the production of chromate pigments and dyes. The plating and polishing, and airplane industries use hexavalent chromium extensively.

With the data confirming the link between hexavalent chromium and lung cancer, Public Citizen filed a petition in 1993 asking OSHA to

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Product Recalls

October 10—November 10, 2002

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 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. A Class I recall is a situation in which there is a 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*.

Name of Drug or Supplement; Class of Recall; Problem	*Lot #; Quantity and Distribution; Manufacturer*
Fluocinonide Cream, 0.05%, Rx only, 15g (0.53oz), 30g (1.1oz), and 60g (2.2oz) tubes; Class III; Product exceeded specification for degradant level (18 month stability)	Lot numbers: L106046, L106047, L106048, L108101, L108102, L108103, L110094, L110095, L110096, L202079; 63852 units distributed nationwide; Alpharma USPD, Inc., Lincolnton, North Carolina

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reduce its PEL from 100 micrograms per cubic meter (µg/m³) to 0.5 µg/m³, a 200-fold reduction. The agency agreed that ""there is clear evidence that exposure ... at the current PEL ... can result in an excess risk of lung cancer" and promised to take action. When that failed to happen, Public Citizen filed suit in 1997, losing in 1998 when the court ruled that the delay did not justify court intervention. OSHA promised a proposed rule to lower hexavalent chromium exposure in 1999, one of the reasons the court was mollified, but failed to deliver on that promise either.

In 2000, Public Citizen used the Freedom of Information Act to pry loose a government-funded study that showed more clearly than prior research that hexavalent chromium caused lung cancer (*Health Letter*, August 2000). In late 2001, however, the agency made hexavalent chromium a still lower regulatory priority, forcing Public Citizen to go back to court. Oral argument took place in the U.S. Court of Appeals in Philadelphia on November 5.

Meanwhile Public Citizen used the Freedom of Information Act to obtain OSHA's own hexavalent chromium exposure data, gleaned from hundreds of government inspections between 1990 and 2000. The results have just been published in the *American Journal of Industrial Medicine* (Volume 42, pp. 378-83).

The study showed that workers continue to be exposed to hexavalent chromium and that exposure levels do not appear to be decreasing over time. Twenty-one percent of measurements with hexavalent chromium violated OSHA's eight-hour PEL. The results also demonstrated that many companies are capable of meeting a substantially lower PEL. Over the decade, 13.7 percent of readings in which hexavalent chromium was present were at or below the 0.5 ug/m³ Public Citizen has requested, when averaged over an eight-hour period.

The study also found there has been a decline in the number of government measurements of hexavalent chromium, suggesting that the agency may not be adequately enforcing even its own weak standards. In addition, it found that state inspection agencies, permitted by law in some states to conduct inspections instead of OSHA, have significantly lower rates of citation than federal regulators when overexposure to hexavalent chromium occurs. An analysis of the effectiveness of state-run inspections is urgently needed, Public Citizen concluded.

"The dangers of exposure to the chemical are widely known, and now OSHA's own data demonstrate that, in many cases, it is technically possible to meet a safer standard. There is no reason for OSHA to delay issuing one," said Dr. Peter Lurie, deputy director of Public Citizen's Health Research Group and an author of the study with the Health Research Group's director, Dr. Sidney Wolfe.

DRUGS AND DIETARY SUPPLEMENTS *cont.*

Name of Drug or Supplement; Class of Recall; Problem	*Lot #; Quantity and Distribution; Manufacturer*
Isosorbide Mononitrate EXTENDED-RELEASE Tablets, 30 mg, 100 and 500 count bottles, PUREPAC, Rx Only; Class III; Dissolution Failure; 6 hour release (9 month stability)	Lots 135E1, 136E1, 137E1, 138E1, 139E1, 140E1 EXP 7/2003 and 173F1 EXP 8/2003; 116,721 bottles distributed nationwide; Alpharma USHP (formerly known as Purepac), Elizabeth, New Jersey
Nardil Tablets (Phenelzine Sulfate Tablets) 15 mg, 100 count bottles, Rx only; Class III; Subpotent; (9 month stability)	Lot 35401L exp. 9/30/02; 19,013 bottles distributed nationwide; Pfizer, Inc., Lititz, Pennsylvania
Night-Time Adult Cold Medicine, Original Flavor, 6 FL. OZ. (177 mL), clear plastic triangular bottle; Class III; Subpotent for one active ingredient-pseudoephedrine hydrochloride	Select Brand, 051L1C, Exp 12/04; 33,963 bottles distributed in Alaska; Vintage Pharmaceuticals, Inc., Huntsville, Alabama
Triamcinolone Acetonide Cream, 0.1%, NET WT. 1 lb. (453.6g) jar; Class III; Super-Potent	Lot# 110080; 5724 units distributed nationwide; Alpharma USPD, Inc., Lincolnton, North Carolina

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*
Contact Lenses; Class II; Firm cannot adequately document if product lot went through sterilization	ACUVUE 2 (etafilcon A), Lot B000GRS (-3.00 D, 8.7 B.C.); Lot B000WTK (-2.50 D, 8.3 B.C.); Lot B000WJK (-5.00 D, 8.7 B.C.); Lot B000JKV (+4.50 D, 8.7 B.C.); Lot B000JKW (+4.50 D, 8.7 B.C.); Lot B000JHJ (-8.00 D, 8.3 B.C.); Lot B000JHK (-7.00 D, 8.3 B.C.); 3,476 units distributed nationwide and internationally; Johnson & Johnson Vision Products, Inc., Jacksonville, Florida
Contact Lenses; Class III; Mislabeling on packages of multipak lenses	Lot number 0001707, expiration 2007/04; 50 six-pack cartons distributed nationwide; Ciba Vision Corp., Duluth, Georgia
Glucose Control Monitoring System; Class II; Stability	Duet and ProPak, In Charge, all non-expired lots and all codes and products; 1,894,480 units distributed nationwide and internationally; Lxn Corp., San Diego, California
Insulin Syringes (cases of 5 boxes of 100 or boxes of 100 each), .5cc 29GA x 1/2" (12.7mm); Class II; Product has a recessed cannula which makes it difficult to remove the bubbles	Numerous lot codes; 8,683,000 devices sold nationwide; Becton Dickinson & Co., Franklin Lakes, New Jersey

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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 *www.cpsc.gov*.

Name of Product; Problem	*Lot #; Quantity and Distribution; Manufacturer*
Animal Toy Sponges; Eyes can detach, posing a choking hazard to young children	Whales, turtles and fish; 280,000 sold at Dollar stores nationwide from May 2001 through September 2002; Dollar Tree Stores Inc., Chesapeake, Virginia (800) 876-8077 www.dollartree.com.
Baby Walkers; Walkers can fit through a standard doorway and are not designed to stop at the edge of a step	Numerous model numbers; 50,000 sold in Arizona, California, Colorado, Texas, Michigan, Missouri and New York from January 2000 through August 2001; Bikepro, Inc. Pico Rivera, California (800) 261-2559
Baby Walkers; Walkers can fit through a standard doorway and are not designed to stop at the edge of a step	Honey model 820, 860, 862 and 802; 3,500 sold in Arizona, California, Texas, Illinois, North Carolina and New York from May 2001 through June 2002; Oriental International Trading Company, Los Angeles, California (866) 666-9868 www.bike-stroller.com
Bicycles; Frames can break apart, causing the rider to fall	Men's 26 inch, 21 speed dual suspension 2100 DH or PRO-X; 2,400 sold nationwide from April through August 2002; Lida Bicycle Co. Ltd., China. Contact Kent Bicycles (800) 451-5368 www.kentbicycles.com
Bicycles; Frames on some of these bicycles have been improperly manufactured which could cause the frame to break during use, resulting in falls and serious injury	Gemini models; 800 sold nationwide from December 2001 through September 2002; Cannondale Corp., Bethel, Connecticut (800) BIKEUSA www.cannondale.com
Ceiling Fans; Hanger bracket can break, which could cause the fan to fall from the ceiling	Islander, Louvre and Tropicana series; 60,000 sold nationwide from February 2000 through July 2002; Fanimation Design and Manufacturing Inc., Lebanon, Indiana (888) 284-8938 www.fanimation.com
Ceramic Jack-O-Lanterns; Flame of a candle placed inside could ignite the straw ribbon on the outside, posing fire and burn hazards	Tan with an opening in the back; 26,000 sold at Target stores nationwide from September 2000 through October 2002; Target Corp., Minneapolis, Minnesota (800) 440-0680 www.target.com
Cordless Rechargeable Staplers; There is a risk of injury from a fully loaded magazine striking a consumer in the face	Model 48201; 11,100 sold nationwide from June through September 2002; Swingline, a division of Acco Brands Inc., Lincolnshire, Illinois (800) 352-6853 www.swingline.com/customerservice
Dehumidifiers; Internal wiring can abrade on metal parts, presenting a risk of electric shock	Wood's Model WMD40W and Edison Model EMD40; 2,500 sold nationwide from March through June 2002; W.C. Wood Company, Ottawa, Ohio (800) 826-8578 www.wcwood.com
Halloween Candleholders; Flames from tea-light candle can ignite the candleholder, posing a fire and burn hazard	10 inch tall acrylic ghosts; 8,000 sold at Kohl's Department Stores nationwide from August through October 2002; Kohl's, Menomonee, Wisconsin (800) 694-2647 www.kohls.com
Laser Printers; Printers can overheat, posing a fire hazard	Models HL-1040, HL-1050, HL-1060 and MFC-P2000; 100,000 sold nationwide from June 1997 through December 2000; Brother International Corp., Bridgewater, New Jersey (866) 236-6835 www.brother.com/usa

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Drug Safety Withdrawals: Who is Responsible for Notifying Patients?

The following editorial, by Health Letter *Editor Dr. Sidney Wolfe, appeared in the December issue of* Pharmacoepidemiology and Drug Safety, *accompanying an article by Cook County Hospital (Chicago) physician Gordon Schiff concerning their experience there when the big-selling cholesterol-lowering drug, Baycol (cerivastatin) was withdrawn from the market.*

Schiff and colleagues are to be commended for stepping in and notifying those patients most at risk of cerivastatin (Baycol)-induced rhabdomyolysis [muscle breakdown] after the drug was voluntarily withdrawn from the U.S. because of 416 cases of rhabdomyolysis including 31 deaths associated with its use. Their finding that 40 percent of the patients notified had muscle-related symptoms consistent with myopathy [muscle pain or discomfort] and that five of eight symptomatic patients monitored had significantly elevated creatine kinase levels underscores the public health importance of their effort.

However, their study raises an important question concerning the responsibility of the FDA, the pharmaceutical industry, pharmacists and physicians to notify patients when a drug is withdrawn from the market.

The FDA

Since virtually all drug safety withdrawals are done voluntarily by the companies making the drugs and there are no federal laws or regulations governing this process, FDA's involvement is at best a passive oversight function as to the completeness and promptness of the product withdrawals. In addition, such drug safe-

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CONSUMER PRODUCTS *cont.*

Name of Product; Problem	*Lot #; Quantity and Distribution; Manufacturer*
Polyester Pool Animals; Seams can separate exposing the polyester stuffing and foam beads which can pose a choking hazard to young children	Different animal shapes; 310,000 sold at Dollar stores nationwide April through August 2002; Dollar Tree Stores Inc., Chesapeake, Virginia (800) 876-8077 www.dollartree.com
Pull-along Caterpillars; Antenna can detach, posing a choking hazard to young children	Plan Toys brand wooden toy; 1,000 sold nationwide January through September 2002; BRIO Corp., Germantown, Wisconsin (888) 274-6869
Skateboard Ramps; Ramps can crack causing users to fall	Rage SSD (model 310937) and Skate Attack SSD (model 312912); 88,000 sold nationwide from March through September 2002; Gen-X Sports Inc., Toronto, Ontario, Canada (866) 846-4369 www.genxsportsinc.com
Snake Lights; Circuit board in the lamps can overheat and melt the plastic housing, posing a fire or thermal burn hazard	Model 8311 blue, red, green or multicolored; 5,000 provided at Chuck E. Cheese restaurants nationwide from July through September 2002; The Carlisle Co. Inc., Carson City, Nevada (800) 233-3931
Stuffed Teddy Bears; Plastic beads inside of the bears could come out of the seams, posing an aspiration hazard to young children	Red, yellow, blue and black, 6 inch tall; 57,000 sold at IKEA stores nationwide from August 2001 through September 2002; IKEA, Plymouth Meeting, Pennsylvania (888) 966-4532 www.ikea-usa.com
Treestands used by hunters; Cable that secures the treestand to the tree can break, posing the risk of falls and serious injuries	Model #CC501 and Model #GS3800BM; 9,000 sold nationwide through mid October 2002; API Outdoors, Tallulah, La., a division of Outland Sports Inc., Overland Park, Kansas (866) 215-2419 www.apioutdoors.com
Whirlpool Baths; Heating element can fail to shut off, posing a fire hazard	Jason AirMasseur and Air Whirlpool Baths; Jason AirMasseur and Air-Whirlpool; 800 sold nationwide from January through September 2002; Jason International Inc., North Little Rock, Arkansas (800) 255-5766

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ty withdrawals are posted on the agency's Web site (www.fda.gov) but most patients or physicians are unlikely to regularly use the site.

The Pharmaceutical Industry

The pharmaceutical industry, in the absence of the FDA having mandatory drug recall authority, sets the pace and scope of the safety withdrawal. The pace is quite variable and the scope may or may not involve immediately removing withdrawn drug products from the shelves of retail pharmacies. From a product liability perspective, it might be assumed that the company's best interests would be served by making sure no patients used the drug once the safety withdrawal was decided on. To accomplish this, the company could fund pharmacists to notify those patients who were using the drug, identified in the computerized pharmacy records now used by most pharmacists in this country. To our knowledge, this rarely if ever happens, confirming the idea that, with few exceptions, the pharmaceutical industry pays out only a small fraction of their profits for a given drug in the form of losses in litigation brought by people injured by the drug or families of those killed by the drug. Thus, companies are apparently willing to take their chances by not funding patient notification.

Pharmacists

The Model State Pharmacy Act, of the National Association of Boards of Pharmacy (NABP), states, in sections addressing drug recalls, that "The Pharmacist-in-Charge shall develop and implement a procedure for proper management of Drug recalls which may include, where appropriate, contacting patients to whom the recalled Drug product(s) have been Dispensed." These procedures are intended to "be adequate to deal with recalls and withdrawals due to: any action initiated at the request of the FDA ... any volunteer action by the Manufacturer to remove defective or potentially defective Drugs from the market." According to a summary of state pharmacy practice acts, 48 of 51 acts contain language about establishing such procedures for recalls and 34 of these states also include language concerning withdrawals of drugs, most of which are for safety reasons. Thus, in most states, pharmacists would not be complying with acceptable standards of practice were they not to notify patients in the event of a drug safety withdrawal. According to the Executive Director of NABP, no action by a state pharmacy board has been brought for violation of this aspect of the state pharmacy practice act. Unlike the widely-publicized situations in which patients' pharmacy records were used, in efforts paid for by drug companies, to get them or their physicians to switch to another drug, this use of pharmacy patient records is both ethical and an important public health effort.

The FDA should be given new legislative authority to impose mandatory drug recalls with an enforceable withdrawal schedule governing the level and rapidity of recall and patient notification.

According to one of the study authors, when the withdrawal of cerivastatin was announced, he sought information from two large pharmacy chains on their patient notification policies. At OSCO, a supervisory pharmacist told him that the chain was notifying all patients using the drug about the withdrawal but at Walgreen's, he was told that the chain thought there was no need to notify patients.

Physicians

Unlike pharmacists, most physicians do not have easy access to a list of those patients for whom they have prescribed a drug. For those that do, notification should be part of their responsibility to their patients. In a large outpatient clinic such as Cook County, it is more likely that such records can be accessed through the pharmacy database. Because of limited resources, the notification efforts at that medical facility were limited to the 67 patients simultaneously using cerivastatin and gemfibrozil, the more than 10,000 patients who had been prescribed cerivastatin without gemfibrozil were not notified. Since approximately one half of the cases of rhabdomyolysis in users of cerivastatin reported to the FDA were not simultaneously using a fibrate such as gemfibrozil, the notification of these additional patients would have been important.

A further issue raised by the study by Schiff, et al, involves the routine informing and monitoring of all patients on statins concerning early evidence of rhabdomyolysis. Given that 40 percent of notified patients had symptoms consistent with myopathy and that five out of eight such patients had significant elevations of creatine phosphokinase (CK), routine monitoring for CK should be done for all patients using statins. In addition, FDA should mandate government-approved MedGuides, patient information leaflets handed out at the time a prescription is filled, which inform patients of early symptoms of myopathy. Patients should be instructed, ideally by their physicians and, for double protection, in the MedGuide, that at the first sign of muscle pain, muscle tenderness, muscle weakness, tiredness or dark-

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"Dangerous Political Cowardice:" FDA Fails to Ban Dietary Supplement Ephedra

The following testimony, by Health Letter *editor Sidney M. Wolfe, MD, was given before a Senate committee in October and is the latest effort in our campaign to force the government to ban all dietary supplements containing ephedra alkaloids.*

Senator Durbin and members of the Subcommittee, thank you for the opportunity to testify on this important topic. Your hearing is essential because of the extreme, reckless negligence exhibited by dietary supplement companies who continue to sell ephedra-containing products and because of the industry-enfeebled Department of Health and Human Services, including the FDA, that has thus far allowed the companies to get away with continuing to manufacture and push these deadly drugs.

The U.S. Military Puts the HHS and the FDA to Shame

From 1997 through part of 2001, there have been 30 deaths among active duty personnel in the armed forces (Army, Air Force, Navy and Marines) in people who were using ephedra alkaloids. All were between the ages of their early 20s and early 40s and had been in good health prior to their deaths. There was no other explanation for their deaths. Since then, there have been three additional deaths associated with the use of ephedra products in the Army alone.

Partly as a result of these 33 deaths and other serious, non-fatal adverse events in the military associated with ephedrine, in July of this year memos were sent to all Army and Air Force military exchanges and commissaries worldwide stating that by the end of August (2002), all ephedra-containing products should be removed from the shelves in these military posts for six months until the results of the HHS ephedra review are released. According to a recent Army/Air Force bulletin, from Fort Monroe, Virginia (August 19, 2002) — "Training and Doctrine Command has joined with Forces Command in asking the Army Air Force Exchange Service to remove products containing ephedra, a compound normally found in diet products." It is extremely important that in explaining the basis for issuing this order, Dr. DeKonning, an army physician, stated that "The sale of ephedra-containing products by facilities on TRADOC [training and doctrine command] installations is seen by our soldiers as an affirmation that their use is safe and acceptable."

The U.S. Marine Corps had earlier — in February 2001 — banned the sale of ephedra-containing products on its military bases: "The Commandant of the Marine Corps banned the sale of dietary supplements containing ephedra alkaloids, or ephedrine, at Marine Corps Exchange stores worldwide as of February 1."

Sixteen months ago, the Canadian government warned Canadians "not to use products containing the herb Ephedra" because such products "may cause serious, possibly fatal, adverse effects." On January 9 of this year, Health Canada requested a recall of all ephedra products "with labeled or implied claims for appetite suppression, weight loss promotion, metabolic enhancement, increased exercise tolerance, body-building

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ened urine, to stop taking any statin drugs to reduce the likelihood that further muscle damage might occur. Routine monitoring of CK and contacting those patients with elevated levels should be included in this rhabdomyolysis-prevention strategy.

Remedies for the Lack of Patient Notification

Ultimately, the cost for such notification should be borne by the pharmaceutical company making the dangerous drug. Pharmacists and/or physicians, if the latter have record access, should be reimbursed for doing the company's work. In addition, the FDA should be given new legislative authority to impose mandatory drug recalls with an enforceable withdrawal schedule governing the level and rapidity of recall and patient notification. Currently, the agency lacks any authority to impose civil monetary penalties on pharmaceutical companies for any violation (or even repeat violations) of FDA laws or regulations and this new statutory authority is also sorely needed along with the authority over recalls.

Why were so many Cook County patients taking Baycol?

About 10 months before the August 2001 withdrawal of cerivastatin, Bayer underbid drug companies that had been previously supplying statins for Cook County. The bid had been won in the fall of 2000 and the switch began in November of that year. It is of interest that the three previous statins which had been used there were first lovastatin, then simvistatin, then pravastatin. These three earlier drugs have all been found in clinical trials to not only lower cholesterol but also to reduce the risk of mortality and/or major coronary events whereas for cerivastatin, the clinical benefits are unproven.

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effects, euphoria, increased energy or wakefulness, or other stimulant effects."

In answering the questions you have provided me, I will add, to the published references in our petition, information obtained since it was filed.

What is the basis for our September, 5, 2001 HHS petition (filed with Dr. Ray Woosley, now of the University of Arizona) to ban the manufacture and sale of all ephedra-containing dietary supplements?

The answer to this question must start out with two other questions:

Do drugs which are related to epinephrine (adrenaline) such as ephedrine, phenylpropanolamine, amphetamines and similar drugs cause an increase in blood pressure, constriction of blood vessels, an increase in heart rate or an increase in cardiac arrhythmias? The answer is unequivocally yes, and this has been known for decades.

Is there evidence that these drugs can cause strokes and heart attacks in people because of causing an increase in blood pressure, constriction of blood vessels, heart rate or cardiac arrhythmias?

In addition to the section in our petition presenting evidence for cardiovascular toxicity of ephedra, we have obtained a copy of an internal March 28, 2000 FDA memo from Dr. Janet Woodcock, Director of the Center for Drug Evaluation and Research (CDER) in response to being asked to review the strength of the evidence linking ephedra with life-threatening cardiovascular events and strokes. After a review by CDER's Office of Postmarketing Drug Risk Assessment (OPDRA), Dr. Woodcock concluded that "...at least 108 of the reports [clinically significant cardiovascular and central nervous system adverse event reports] OPDRA analyzed provide very strong evidence in support of a causal relationship between EADS [ephedra alkaloid-containing dietary supplements] and the adverse events, particularly in light of the known pharmacodynamic effects of ephedrine alkaloids."

We are now, with ephedra, where we were 10 years ago with PPA: clear, unequivocal evidence of danger but a time-delaying "need" by the industry to conduct studies.

What is the incongruity in FDA banning PPA (phenylpropanolamine) but allowing ephedra to stay on the market?

Given that there are now more reported cases of death, heart attacks, stroke and other adverse effects associated with ephedra than with PPA at the time of its ban, the situation represents a dangerous déjà vu. We are now, with ephedra, where we were 10 years ago with PPA: clear, unequivocal evidence of danger but a time-delaying "need" by the industry to conduct studies. (FDA unfortunately bought into the need for a case control study on PPA 10 years ago). With PPA, dozens or more lives were lost and many people permanently disabled between the time the FDA clearly should have acted and when itfinally got the drug (PPA) off the market. To repeat this fatal mistake with ephedra is to fail to learn the lessons of history.

Since we have petitioned the FDA to ban other weight loss products such as Meridia (sibutramine, Abbott), what benefit/risk analysis should be applied to weight loss products?

Over 30 years ago, in June 1968, FDA Medical Officer Dr. Robert O. Knox refused to approve the New Drug Application (NDA) for a diet drug. This disapproval touched off a dispute between the FDA and the drug's manufacturer, A.H. Robbins, that eventually led to the drug's approval and Dr. Knox's transfer to another area within the Agency. His reason: obesity is a chronic disease and there is no evidence that these drugs affect the course of the disease over the long term.

The drug Dr. Knox refused to approve was fenfluramine (Pondimin), a drug that ultimately became the "fen" portion of the notorious "fen/phen" combination, the portion that was removed from the market on September 15, 1997 because it caused heart valve damage and a potentially fatal adverse reaction of the lungs known as primary pulmonary hypertension.

At the time of our petition to ban Meridia on March 19 of this year, there were 19 reported cardiovascular deaths in people using the drug, again, far fewer than the number with ephedra. The fact that there is no evidence of long-term benefit with either drug and there is evidence of shorter-term risk means that the benefit/risk ratio for both is extremely unfavorable to patients.

Discuss what is known about the dosages taken by those experiencing serious adverse effects from ephedrine/ephedra. Is there a safe dose?

In a recent published review of FDA adverse reaction reports by researchers from New England Medical Center in Boston, in 36 of 37 patients with heart attacks, strokes or sudden deaths, the use of ephedra

(ma huang) was reported to be within the manufacturers' dosing guidelines. There are also a number of reports in which a so-called pharmacologic autopsy — post-mortem measurement of urine, blood and tissue levels — found low levels of ephedra consistent with recommended use. Given that there is no standardization of the amount appearing in the product and, more importantly, that there is enormous variation from person to person in sensitivity to such drugs, no dose is the only safe dose.

Discuss the effects that additional compounds such as caffeine have on the safety profile of ephedra, given that it is usually sold in combination with such stimulants.

Both caffeine and ephedra can stimulate the sympathetic nervous system so their combined use increases the cardiovascular risks. In addition, the frequent use of these products in the context of exercise, also a stimulant to the sympathetic nervous system, makes for a triple dose of stimulation — in combination with ephedra and caffeine — which probably accounts for the growing number of deaths while young, otherwise healthy people are exercising.

In July 1995, according to the agency, "FDA proposed banning OTC (over-the-counter) bronchodilators containing ephedrine, ephedrine hydrochloride, ephedrine sulfate and racephedrine hydrochloride because of abuse and misuse. According to the U.S. Drug Enforcement Administration, ephedrine is being used to make illegal drugs. And, the FDA has found that some drug manufacturers promote ephedrine for unapproved uses, such as weight control and muscle enhancing." The fact that the FDA has not finalized this proposed ban of ephedrine in OTC products should not be used as an excuse for the failure to ban dietary supplements containing ephedra. The proposed OTC ban is still in the works.

Is the FDA still part of the Public Health Service or is it a drug sales promoting adjunct to the pharmaceutical and dietary supplement industries?

This is not and has never been a question of scientific or medical evidence. It is a question of politics, and the extraordinarily dangerous political cowardice of the FDA and HHS Secretary Thompson in the face of massive lobbying by ephedra-makers in Washington. Is the FDA still part of the Public Health Service or is it a drug sales promoting adjunct to the pharmaceutical and dietary supplement industries? De facto drug pushers include those who refuse to use their legal authority to remove a well-documented hazard to the public health from the market. There is no doubt that these products will be banned in the United States. The question is not whether, but when. Delaying tactics such as the RAND review are costing lives as the day of reckoning for ephedra is thereby delayed. There are few issues that the American Medical Association (AMA) and Public Citizen agree on. Tobacco and ephedra are two of these. The FDA has been rejecting the opinions of its own consultants and staff (such as Dr. Woodcock) on the dangers of ephedra alkaloids.

OUTRAGE, *from page 12*
with only 90 percent of the data.

The agreements were often lacking other crucial elements. Only a median of 5 percent of studies addressed plans for data analysis and interpretation, opening the doors to industry mischief in the forms of data massaging or the reaching of conclusions with an eye on marketing rather than science. Extraordinarily, a median of 0 percent of study contracts required the data to be published. This allows industry to suppress unfavorable findings and report only results that are advantageous to its bottom line. The failure to publish makes a mockery of the research process; as far as the scientific community is concerned, studies that are not published in some form are studies that did not occur. Meanwhile, participants have been exposed to risk in their altruistic efforts to advance scientific knowledge.

A relatively simple solution to this morass would be for the Association of American Medical Colleges to draft a standard contract that could be modified as needed. Universities should be denied accreditation if they fail to develop such a contract; similarly the National Institutes of Health should refuse to fund institutions that have not implemented the contract. Medical journals should also refuse to publish articles unless the authors can certify that all of the elements of the ICMJE guidelines were in place. Finally, the ICMJE itself should also be conducting studies to determine to what extent its guidelines are being followed. Absent that, the guidelines will remain what they are now: well-intentioned ideas that may insulate the industry from government regulation but are barely followed.

The Corruptible Academic-Industry Partnership

The past decade has seen a ballooning in private industry support for biomedical research. While the federal government was once the major funder of medical research, corporations are now the primary sponsors. Much of this research still occurs in academic settings, but the increasing prevalence of industry funding and the growing phenomenon of universities taking out patents on technologies they develop has fundamentally altered the biomedical research environment.

Over the last several years, there have been a slew of examples of the dangers of these entanglements. In one, a researcher at the University of California, San Francisco was deserted by her university after the drug company that supported her research was unhappy with her findings and threatened a lawsuit if she published the results. In another, a researcher at the University of Toronto became the target of hate mail from one of her colleagues after she sought to publicize the adverse effects of a drug in a company-sponsored study she had conducted.

Up until now, there have been only limited quantitative data on this issue. Recently, a group of researchers at Duke University published the results of their study of medical schools in the U.S. They sought to describe the provisions in academic-industry agreements to ensure the integrity of the scientific research (*New England Journal of Medicine*, October 24, 2002, pp. 1335-41). In particular, they sought to establish whether the agreements in multicenter studies (those conducted at more than one institution) were in compliance with the 2001 International Committee of Medical Journal Editors (ICMJE) guidelines for scientists' involvement in study design, access to data and publication.

To put it mildly, the results were dismal. One provision of the ICMJE guidelines is that all investigators in multicenter studies, not just the coordinating institution, should have access to all the data. The universities reported that a median of 1 percent of their studies had provisions for such access. In one study that was not a focus of the report, even the principal investigator did not have unfettered access to the data, forcing him to publish a paper

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