

IN THE NEWS

[[HTTP://WWW.LSUHOSPITALS.ORG/MEDIA-RELATIONS/IN-THE-NEWS.HTM](http://www.lsuhs.org/media-relations/in-the-news.htm)]

[THURSDAY, JULY 17, 2008]

Our Views: Getting lost in Neverland
The Advocate | 07.17.08 2

Study: Low-carb diet best for weight, cholesterol
The Times-Picayune | 07.17.08 3

Ochsner Health System is among the nation's "Most Wired" hospitals, survey says
The Times-Picayune | 07.16.08 5

How Changes In Medicare Affect Patients
The Wall Street Journal | 07.17.08..... 6

Breast Cancer Self-Exams 'Do More Harm Than Good'
REDORBIT NEWS | 07.16.08..... 9

While the U.S. Spends Heavily on Health Care, a Study Faults the Quality
The New York Times | 07.17.08..... 10

Problems Persist With Red Cross Blood Services
The New York Times | 07.17.08..... 12

Gene Variation May Raise Risk of H.I.V., Study Finds
The New York Times | 07.17.08..... 17

Advocating a Treatment, but Denied Access to It
The New York Times | 07.17.08..... 19

Health proposal rankles Democrats
USA Today | 07.17.08..... 22

Premature babies grow up shy
USA Today | 07.17.08..... 23

Web site offers topics to discuss with doctor
The Daily Advertiser | 07.17.08..... 24

Lourdes bans smoking
The Advertiser | 07.17.08..... 25

Many hospital sold to Shreveport firm
The Town Talk | 07.17.08 26

Inflation, oil send costs of medical supplies soaring
Chicago Tribune | 07.17.08..... 27

Our Views: Getting lost in Neverland

The Advocate | 07.17.08

Advocate Staff

Dr. Irwin Redlener called it “an extraordinarily difficult and confounding set of circumstances.”

Redlener, who heads the Children’s Health Fund in New York, was discussing what he said is the failure of the Federal Emergency Management Agency to adequately address the needs of thousands of children who continue to need mental health services in the wake of hurricanes Katrina and Rita.

As FEMA empties trailer parks of evacuees from the 2005 storms, there is no adequate way to track families who still need assistance, although as many as 49,000 families might still be in need of support services, Redlener said.

Many members of these families continue to have significant mental health issues, but with no adequate tracking system in place, they could be lost in a “Never-Never Land” of bureaucratic intransigence, Redlener warned.

Redlener’s nonprofit organization has sent its mobile medical units into previous disaster areas to offer assistance, but nearly three years after Katrina, “we’re still here” in Louisiana, Redlener told Advocate reporters and editors during a recent meeting.

Redlener stressed that the storm survivors he sees are not interested in a life of dependency on someone else. They want to be self-sufficient, but often need a number of services to bridge them back to health and independence.

Redlener is certainly not the first person to express frustration with FEMA’s handling of the aftermath of the 2005 storms. But his comments underscore what we believe to be a larger reality:

FEMA never was designed to handle the kind of long-term needs created by a catastrophe such as Katrina, and it has been slow to react to the new demands placed upon it by this unprecedented event.

As a political reality, any prospect for real and enduring reform of FEMA will have to wait for the next presidential administration. But that could be too late for those people Redlener is trying to help.

<http://www.theadvocate.com/opinion/25543919.html>

[\[BACK TO TOP\]](#)

Study: Low-carb diet best for weight, cholesterol

The Times-Picayune | 07.17.08

By MIKE STOBBE

The Associated Press

ATLANTA (AP) — The Atkins diet may have proved itself after all: A low-carb diet and a Mediterranean-style regimen helped people lose more weight than a traditional low-fat diet in one of the longest and largest studies to compare the dueling weight-loss techniques.

A bigger surprise: The low-carb diet improved cholesterol more than the other two. Some critics had predicted the opposite.

"It is a vindication," said Abby Bloch of the Dr. Robert C. and Veronica Atkins Foundation, a philanthropy group that honors the Atkins' diet's creator and was the study's main funder.

However, all three approaches — the low-carb diet, a low-fat diet and a so-called Mediterranean diet — achieved weight loss and improved cholesterol.

The study is remarkable not only because it lasted two years, much longer than most, but also because of the huge proportion of people who stuck with the diets — 85 percent.

Researchers approached the Atkins Foundation with the idea for the study. But the foundation played no role in the study's design or reporting of the results, said the lead author, Iris Shai of Ben-Gurion University of the Negev.

Other experts said the study — being published Thursday in the New England Journal of Medicine — was highly credible.

"This is a very good group of researchers," said Kelly Brownell, director of Yale University's Rudd Center for Food Policy and Obesity.

The research was done in a controlled environment — an isolated nuclear research facility in Israel. The 322 participants got their main meal of the day, lunch, at a central cafeteria.

"The workers can't easily just go out to lunch at a nearby Subway or McDonald's," said Dr. Meir Stampfer, the study's senior author and a professor of epidemiology and nutrition at the Harvard School of Public Health.

In the cafeteria, the appropriate foods for each diet were identified with colored dots, using red for low-fat, green for Mediterranean and blue for low-carb.

As for breakfast and dinner, the dieters were counseled on how to stick to their eating plans and were asked to fill out questionnaires on what they ate, Stampfer said.

The low-fat diet — no more than 30 percent of calories from fat — restricted calories and cholesterol and focused on low-fat grains, vegetables and fruits as options. The Mediterranean diet had similar calorie, fat and cholesterol restrictions, emphasizing poultry, fish, olive oil and nuts.

The low-carb diet set limits for carbohydrates, but none for calories or fat. It urged dieters to choose vegetarian sources of fat and protein.

"So not a lot of butter and eggs and cream," said Madelyn Fernstrom, a University of Pittsburgh Medical Center weight management expert who reviewed the study but was not involved in it.

Most of the participants were men; all men and women in the study got roughly equal amounts of exercise, the study's authors said.

Average weight loss for those in the low-carb group was 10.3 pounds after two years. Those in the Mediterranean diet lost 10 pounds, and those on the low-fat regimen dropped 6.5.

More surprising were the measures of cholesterol. Critics have long acknowledged that an Atkins-style diet could help people lose weight but feared that over the long term, it may drive up cholesterol because it allows more fat.

But the low-carb approach seemed to trigger the most improvement in several cholesterol measures, including the ratio of total cholesterol to HDL, the "good" cholesterol. For example, someone with total cholesterol of 200 and an HDL of 50 would have a ratio of 4 to 1. The optimum ratio is 3.5 to 1, according to the American Heart Association.

Doctors see that ratio as a sign of a patient's risk for hardening of the arteries. "You want that low," Stampfer said.

The ratio declined by 20 percent in people on the low-carb diet, compared to 16 percent in those on the Mediterranean and 12 percent in low-fat dieters.

The study is not the first to offer a favorable comparison of an Atkins-like diet. Research published in the Journal of the American Medical Association last year found overweight women on the Atkins plan had slightly better blood pressure and cholesterol readings than those on the low-carb Zone diet, the low-fat Ornish diet and a low-fat diet that followed U.S. government guidelines.

The heart association has long recommended low-fat diets to reduce heart risks, but some of its leaders have noted the Mediterranean diet has also proven safe and effective.

The heart association recommends a low-fat diet even more restrictive than the one in the study, said Dr. Robert Eckel, the association's past president who is a professor of medicine at the University of Colorado-Denver.

It does not recommend the Atkins diet. However, a low-carb approach is consistent with heart association guidelines so long as there are limitations on the kinds of saturated fats often consumed by people on the Atkins diet, Eckel said.

The new study's results favored the Atkins-like approach less when subgroups such as diabetics and women were examined.

Among the 36 diabetics, only those on the Mediterranean diet lowered blood sugar levels. Among the 45 women, those on the Mediterranean diet lost the most weight.

"I think these data suggest that men may be much more responsive to a diet in which there are clear limits on what foods can be consumed," such as an Atkins-like diet, said Dr. William Dietz, of the Centers for Disease Control and Prevention.

"It suggests that because women have had more experience dieting or losing weight, they're more capable of implementing a more complicated diet," said Dietz, who heads CDC's nutrition unit.

<http://www.nola.com/newsflash/index.ssf?/base/national-9/1216256961253090.xml&storylist=health&thispage=1>

[\[BACK TO TOP\]](#)

**Ochsner Health System is among the nation's "Most Wired" hospitals, survey says
The Times-Picayune | 07.16.08**

Ochsner Health System has been named one of the nation's 100 "Most Wired" hospitals, according to a survey in the July issue of Hospitals & Health Networks magazine.

The magazine has ranked the most wired hospitals and health systems since 1999. Ochsner has made the list for the last five years.

In addition, Ochsner was listed among the "Most Wireless," a recognition extended to 25 of the nation's health systems.

Hospitals & Health Networks is a publication of the American Hospital Association.

http://blog.nola.com/tpmoney/2008/07/ochsner_health_system_is_among.html

[\[BACK TO TOP\]](#)

How Changes In Medicare Affect Patients

The Wall Street Journal | 07.17.08

By ANNA WILDE MATHEWS and JANE ZHANG

The major goal of the new Medicare law passed this week was to block a scheduled cut in fees paid to doctors. But there's also plenty in the law that directly affects Medicare beneficiaries.

Participants in the federal insurance program for older and disabled Americans will have lower out-of-pocket costs for mental-health services. Some widely used anti-anxiety and sleep drugs that Medicare previously didn't pay for will be covered. And the law aims to boost preventive health care, including making it easier and cheaper for new Medicare participants to get a physical checkup. Most of the new benefits will be phased in over several years.

There also are cutbacks. Consumers who relied on certain private insurance plans sold under the name Medicare Advantage could face tougher restrictions on which doctors they will be allowed to see. Another change: Doctors will be strongly encouraged to begin sending prescriptions to pharmacies electronically, rather than writing them by hand.

"There are some important changes in here," says Kirsten Sloan, an official with AARP, the lobbying group for older people. "It's meaningful."

Congress approved the Medicare law late Tuesday after months of wrangling. With votes of 70 to 26 in the Senate, and 383 to 41 in the House, the bill garnered enough votes to override a veto by President Bush, whose opposition centered on some of the cutbacks to the Medicare Advantage program. The Medicare bill has a total cost estimated at around \$20 billion, spread over five years.

Medicare participants getting mental-health treatment, such as visits to a psychiatrist, currently must pay 50% of the cost out-of-pocket. That compares with a co-payment of 20% for other doctor visits. The new law cuts the co-pay for mental-health services also to 20%, although the reduction phases in gradually, ending in 2014.

That change could make a big difference for Medicare beneficiaries like Karen Geer, who lives near Indianapolis. Ms. Geer, 46, spends more than \$4,000 a year on therapy for her bipolar disorder, mostly on visits with a social worker that cost \$80 a session. She says the therapy has helped her manage the disorder well, and she now does volunteer work in the community. But to help pay for it, Ms. Geer says she has given up getting Pap smears and other medical care.

Ms. Geer figures she'll save at least \$2,500 a year if her Medicare co-payments are reduced to 20% from 50%. "I think it will make a difference," she says. "I'll have more money to use on other services I need."

Some Medicare beneficiaries have not sought needed mental-health treatment because of the high out-of-pocket cost, says Dale Klatzker, president of The Providence Center, a community mental-health clinic in Providence, R.I. The clinic, which relies heavily on public funding, sometimes can't collect the 50% co-payments from Medicare patients when they can't afford it, he says. He expects the new Medicare law to boost patient visits and their ability to pay.

The American Psychiatric Association, a professional group, says the increase in coverage should attract more psychiatrists and other mental-health-care providers into Medicare. "It's a huge step forward," adds Andrew Sperling, director of federal legislative advocacy for the National Alliance on Mental Illness, a patient advocacy group. The change to the mental-health co-payment comes as Congress aims to pass another bill later this month that would require employers and private insurers to put mental-health coverage on par with that for physical maladies.

The new Medicare law also will add two widely used classes of medicines to the Medicare drug benefit, although the change won't take effect until 2013. One class is benzodiazepines, a group of drugs often prescribed for anxiety that includes Xanax and Valium. Last year, about 51 million benzodiazepine prescriptions were written in the U.S., according to research firm IMS Health. The other drug class is

barbiturates, sometimes used as sleep aids. Medicare will cover these drugs only for patients suffering from certain conditions, including a chronic mental-health condition, cancer or epilepsy.

The new law also takes a modest step toward encouraging some preventive care. Currently, Medicare will pay for new participants to get a "welcome-to-Medicare" physical within six months of joining the program. That period is being extended next year to 12 months, making it more convenient for many people. What's more, the cost of the initial physical will no longer be counted against a participant's annual deductible. Medicare's standard annual deductible is currently \$135. Medicare doesn't cover routine physicals after the one you get when you first enroll.

Congress also laid the groundwork for Medicare to add future preventive or screening services. In the past, such benefits, including mammogram screenings, required a special act of Congress to be included in Medicare coverage. Now, Medicare will be able starting next year to decide on its own whether to add certain preventive treatments. Some treatments the program is expected to consider adding are intense weight-loss counseling for obesity and certain genetic tests for breast cancer. "It really embeds prevention into the Medicare program in a way that it hasn't been in the past," says Timothy Gardner, president of the American Heart Association.

Much of the new law's cost will be paid through reducing outlays for the private Medicare Advantage plans. These plans, which can have richer benefits or lower co-payments than traditional Medicare, are offered directly to consumers by private insurers. They also are generally more expensive for the government than traditional Medicare, government analysts say.

The cutback most likely to be noticed by consumers affects a type of Medicare Advantage plan called private fee-for-service, which gives consumers access to a wide range of doctors. These plans are sold under names such as Humana Inc.'s Gold Choice and UnitedHealth Group Inc.'s SecureHorizons MedicareDirect Plans.

Under the new law, starting in 2011, fee-for-service plans will have to bring doctors who accept the plans into a network, similar to the way that health maintenance organizations, or HMOs, and preferred provider organizations, or PPOs, now do. Currently, the plans allow consumers to access any doctor, although individual physicians may choose not to accept a particular plan. The network requirement will apply only in geographic areas where consumers have at least two other Medicare Advantage plan options.

America's Health Insurance Plans, an industry group, estimates the change could affect around 80% of the 2.2 million people currently enrolled in private fee-for-service plans. But a House Democratic aide says enrollment in the rejiggered plans is still expected to grow. In his veto message, President Bush said the new Medicare law will "harm beneficiaries by taking private health plan options away from them," particularly with the new restriction on the private fee-for-service plans.

Having to stick with a network looks like a disadvantage to Ernest Matthews, an 80-year-old retiree in Athens, Pa., who has a private fee-for-service plan from a unit of Universal American Corp. Mr. Matthews says a big reason he likes the plan is because it allows him to go to doctors at the Geisinger Medical Center in Danville, Pa., for his cancer treatments. "I would rate the ability to pick and choose as the No. 1 issue," he says.

A Geisinger spokeswoman says the hospital does treat patients covered by traditional Medicare.

The Medicare law encourages more doctors to write electronic prescriptions. In a carrot-and-stick approach, the law initially boosts Medicare payments to physicians who make the change. Then, in later years, it docks doctors' fees if they fail to adopt the technology. One challenge: Although around 70% of all pharmacies can receive digital prescriptions, only 31% of independent drugstores now do so, according to SureScripts-RxHub LLC, which operates the main e-prescribing network. Only about 40,000 U.S. doctors currently prepare their prescriptions digitally.

http://online.wsj.com/article/SB121623946819959433.html?mod=2_1566_leftbox

[\[BACK TO TOP\]](#)

Breast Cancer Self-Exams 'Do More Harm Than Good'

REDORBIT NEWS | 07.16.08

By Lyndsay Moss

MEDICAL research can often produce conflicting advice on a number of health issues, making it difficult for women to know what to do for the best.

In recent years, much concern has been raised over the safety of hormone replacement therapy (HRT).

Millions of women around the world used HRT to control symptoms linked to the menopause.

However, a number of studies have linked the therapy to an increased risk of breast and ovarian cancer, leading to many women stopping treatment.

Despite this, some experts believe the benefits of taking HRT - such as improving quality of life - may outweigh the risks of developing cancer.

Women are advised to take HRT for as short a time as possible in order to deal with symptoms.

Similar concerns have been raised about the contraceptive pill, which has been linked to a small risk of breast cancer.

But earlier this year, women were told not to worry about the risk of cancer when using the Pill - because it can actually reduce the risk of developing cancers for several decades.

The research found that, in the long term, oral contraceptives cut the risk of ovarian and womb cancers.

Meanwhile, women planning to have a baby have also experienced conflicting advice about alcohol consumption in pregnancy.

In the past, mothers-to-be have been told that one or two units of alcohol a week during pregnancy was unlikely to harm their baby. But now, official government advice states no alcohol should be consumed during pregnancy because of the risks of foetal alcohol syndrome, which is responsible for abnormalities in babies.

http://www.redorbit.com/news/health/1480200/breast_cancer_selfexams_do_more_harm_than_good/#

[\[BACK TO TOP\]](#)

While the U.S. Spends Heavily on Health Care, a Study Faults the Quality **The New York Times | 07.17.08**

By REED ABELSON

American medical care may be the most expensive in the world, but that does not mean it is worth every penny. A study to be released Thursday highlights the stark contrast between what the United States spends on its health system and the quality of care it delivers, especially when compared with many other industrialized nations.

The report, the second national scorecard from this influential health policy research group, shows that the United States spends more than twice as much on each person for health care as most other industrialized countries. But it has fallen to last place among those countries in preventing deaths through use of timely and effective medical care, according to the report by the Commonwealth Fund, a nonprofit research group in New York.

Access to care in the United States has worsened since the fund's first report card in 2006 as more people — some 75 million — are believed to lack adequate health insurance or are uninsured altogether. And within the nation, the report found, the cost and quality of care vary drastically.

The findings are likely to provide supporting evidence for the political notion that the nation's health care system needs to be fixed. Both presumptive presidential nominees, Senator John McCain and Senator Barack Obama, argue that the country needs to get more value for its health care money, even if they do not agree on what changes would be most effective. But few people these days defend the status quo.

"It's harder to keep deluding yourself or be complacent that we don't have areas that need improvement," said Karen Davis, president of the Commonwealth Fund.

The study, which assesses the United States on 37 health care measures, finds little improvement since the last report, as the cost of health care continues to rise steadily and more people — even those with insurance — struggle to pay their medical bills.

"The central finding is that access has deteriorated," Ms. Davis said.

Even some experts who are quick to point to some of the country's medical successes, as in reducing the deaths from heart disease or childhood cancers, for example, also acknowledge the need for change.

"We need to generate better value in this country," said Dr. Denis A. Cortese, the chief executive of the Mayo Clinic.

In some cases, the nation's progress was overshadowed by improvements in other industrialized countries, which typically have more centralized health systems, which makes it easier to put changes in place.

The United States, for example, has reduced the number of preventable deaths for people under the age of 75 to 110 deaths for every 100,000 people, compared with 115 deaths five years earlier, but other countries have made greater strides. As a result, the United States now ranks last in preventable mortality, just below Ireland and Portugal, according to the Commonwealth Fund's analysis of World Health Organization data. The leader by that measure is France, followed by Japan and Australia.

Other countries worked hard to improve, according to the Commonwealth Fund researchers. Britain, for example, focused on steps like improving the performance of individual hospitals that had been the least successful in treating heart disease. The success is related to "really making a government priority to get top-quality care," Ms. Davis said.

The presidential candidates both emphasize the need to shift the country's health priorities, to provide more medical care that helps prevent people from developing disease and that helps control conditions before they become expensive and hard to treat. And the mounting evidence indicates that such issues

are not simply political talking points, said Len Nichols, a health economist at New America Foundation, a nonprofit group in Washington that advocates universal health care coverage.

More hospital executives and doctors understand their performance could be better, Mr. Nichols said.

Dr. James J. Mongan, the chief executive of Partners HealthCare System, a big medical network in Boston, agrees that "there's substantial room for improvement." Dr. Mongan is one of several health care leaders who is working with the Commonwealth Fund to develop a model for a better system.

Business leaders also see a pressing need for health care changes, said Helen Darling, the president of the National Business Group on Health, which represents big employers that provide medical benefits to their workers. The report "documents that it's been as bad as we have been thinking it is," she said.

But Ms. Darling and others were also heartened because some areas in the report said that the United States had shown marked improvement, including the measurements hospitals use to track how well they treated conditions like heart failure and pneumonia.

"It proves once again if you have quantitative information and metrics and make people pay attention, they change," Ms. Darling said.

But the report also emphasizes the inefficiencies of the American health care system. The administrative costs of the medical insurance system consume much more of the current health care dollar, about 7.5 percent, than in other countries.

Bringing those administrative costs down to the level of 5 percent or so as in Germany and Switzerland, where private insurers play a significant role, would save an estimated \$50 billion a year in the United States, Ms. Davis said.

"It kind of dwarfs everything else you can do," she said.

Much of the high costs are attributed to the lack of computerized systems that may link pharmacies and doctors' offices for filling prescriptions, for example, or that may enable insurers to more efficiently pay doctors' bills.

"An awful lot of the waste in this system is the antiquity of the information technology," Ms. Darling said.

Karen Ignagni, the chief executive of America's Health Insurance Plans, an industry trade group, argues that much of the higher administrative costs stem from the additional services provided by United States insurers, like disease management programs, and the burdensome regulatory and compliance costs of doing business in 50 states. A more uniform system could result in savings, she said.

http://www.nytimes.com/2008/07/17/business/17health.html?_r=1&ref=health&oref=slogin

Problems Persist With Red Cross Blood Services

The New York Times | 07.17.08

By STEPHANIE STROM



In 2004, auditors found that the Red Cross's operation in Philadelphia failed to recall some 600 units of blood collected using improper methods.

For 15 years, the American Red Cross has been under a federal court order to improve the way it collects and processes blood. Yet, despite \$21 million in fines since 2003 and repeated promises to follow procedures intended to ensure the safety of the nation's blood supply, it continues to fall short.

The situation has proved so frustrating that in January the commissioner of food and drugs attended a Red Cross board meeting — a first for a commissioner — and warned members that they could face criminal charges for their continued failure to bring about compliance, according to three Red Cross officials who attended the meeting and requested anonymity because Red Cross policy prohibits public discussion of its meetings with regulators.

"If fear is a motivator, we're happy to help out in that way," said Eric M. Blumberg, deputy general counsel at the Food and Drug Administration, though he declined to confirm what the commissioner, Andrew C. von Eschenbach, said at the meeting.

Some critics, including former Red Cross executives, have even suggested breaking off the blood services operations from the rest of the organization, as the Canadian Red Cross did a decade ago.

The problems, described in more than a dozen publicly available F.D.A. reports — some of which cite hundreds of lapses — include shortcomings in screening donors for possible exposure to diseases; failures to spend enough time swabbing arms before inserting needles; failures to test for syphilis; and failures to discard deficient blood.

In some cases, the lapses have put the recipients of blood at risk for diseases like hepatitis, malaria and syphilis. But according to the food and drug agency, the Red Cross has repeatedly failed to investigate the results of its mistakes, meaning there is no reliable record of whether recipients were harmed by the blood it collected.

The Red Cross, which controls 43 percent of the nation's blood supply, agrees that it has had quality-control problems and is working to fix them. Both its officials and the drug agency point out that none of

the identified problems involve the most serious category of infractions. For instance, the Red Cross does a good job of testing for H.I.V. and hepatitis B, officials on all sides agree. And in general, Red Cross blood is regarded as some of the safest in the world.

Still, the drug agency says, the problems that remain in screening donors and following protocols for collection add unnecessary risk to blood transfusions, almost five million of which were done in 2007, according to the National Heart, Lung and Blood Institute.

"This is a critical piece of the public health infrastructure," Mary A. Malarkey, director of the Office of Compliance and Biologics Quality at the drug agency, said in an interview. "I know it's difficult to get so many people trained and properly supervised, but it has to be done."

This week, the agency sent the Red Cross the results of yet another recent investigation that makes Ms. Malarkey's point: From December 2006 to April 2008, the Red Cross distributed more than 200 blood products that it had already identified as problematic, according to the investigation report.

A Troubled History

While many Americans see the Red Cross as the ubiquitous organization that responds to disasters big and small, its disaster-relief operation, which spends \$400 million to \$500 million annually, is small compared with its blood business, which generated \$2.1 billion in revenue in the fiscal year that ended in June 2007.

In fact, the Red Cross is the world's largest single steward of blood, more than twice the size of the second-largest known blood collection operation. The rest of the world's blood supply is controlled by dozens of smaller organizations, only three of which have ever been under F.D.A.-requested consent decree.

After years of quiet complaints about the Red Cross's blood business, the F.D.A. reluctantly decided to go public with its concerns in 1993, obtaining a consent decree that required the Red Cross to strengthen quality control and training and improve its ability to identify, investigate and record problems.

"It was one of the hardest things I did as commissioner," said Dr. David A. Kessler, the F.D.A. commissioner from 1990 to 1997. Dr. Kessler said he had agonized that the move would cause undue alarm.

The news media, however, barely made note of it.

Fifteen years later, that consent decree, toughened in 2003 to allow the F.D.A. to impose fines for failing to properly identify, handle and report quality control problems, has produced only modest improvements, food and drug officials said.

"Leaving aside who's at fault here, it's not working," said Dr. Kessler, now a professor of pediatric medicine at the University of California, San Francisco. "Whether it's that the American Red Cross just doesn't get it, whether it's that the relationship between the regulator and regulated is beyond the point of repair is immaterial. It's just not working."

Dr. Kessler said Congress should intervene at this point.

Dr. Bernadine Healy, the former chief executive of the Red Cross who made repairing the organization's blood operations a paramount goal, said the best solution might be to spin off the Red Cross's blood services.

"Two-thirds of the revenue base of the Red Cross is blood, yet the Red Cross is run by people who think of it as primarily a disaster-relief organization, relegating blood to stepchild status," Dr. Healy said. "When is the last time you saw a Red Cross fund-raising appeal for money to make the blood supply safer or support its blood research?"

Dr. Healy said she tried to start such a fund-raising program when she ran the Red Cross, but met internal resistance to it.

The Red Cross has toyed with selling off its blood operations, or otherwise decoupling them from its disaster work, but has never done so, in part because of a belief that the billions in revenue from blood has subsidized its disaster operations. But its financial systems are so antiquated that no one really knows.

"I can't tell you that for sure because I can't find it out," said Kevin M. Brown, the Red Cross's chief operating officer. "I wish I could."

Mr. Brown noted, however, that the blood business was an integral part of the Red Cross. "It is consistent with our overall mission, which is saving lives," he said. "Having an ample and safe blood supply is critical to that mission."

Failing to Act

The frustrations of dealing with the Red Cross are illustrated by the story of Michelle Hoyte, a whistleblower who was first ignored, then dismissed.

Ms. Hoyte led a team of auditors who conducted a routine visit to the Red Cross blood services operation in Philadelphia in 2004. The team discovered that the facility, with the approval of a senior executive at the national headquarters in Washington, had decided not to recall some 600 units of blood collected using improper methods.

Such mistakes must be reported in writing to the F.D.A. within 15 days of detection, and the blood must be recalled. But Ms. Hoyte spent six months pleading with various supervisors to report the problem, first identified on Dec 18, 2003. Then she was fired.

"It wasn't just that I thought it was the right thing for them to do; they are required to tell the F.D.A. under the terms of the consent decree," Ms. Hoyte, who worked for the F.D.A. before joining the Red Cross, said in an interview. "They didn't want to hear it."

Ms. Hoyte, who unsuccessfully sued the Red Cross for wrongful termination, had received "excellent performance appraisals," according to the lawsuit, and received a bonus and merit raise in the two years before her firing.

The Red Cross contends that her dismissal had nothing to do with her insistence on abiding by the court order. It said in court papers that she had been warned of shortcomings in her performance.

The Red Cross also defended its handling of the episode. "They followed the process and did what they should have done," said Eva Quinley, the senior vice president for quality and regulatory affairs at the Red Cross.

But the Red Cross did not recall the components produced from that blood until Feb. 23, 2005, 14 months after the problem was discovered, according to an F.D.A. report. By then, those components would have been used or discarded, and whether they caused any problems for patients is unknown.

Determining how often, if ever, blood supplied by the Red Cross has been responsible for serious health problems is difficult. F.D.A. documents rarely spell out the consequences of the failures they catalogue, a reflection, to some degree, of the agency's concern about alarming the public. But often they simply do not know. "Patients who get blood transfusions tend to be pretty sick," Dr. Healy said. "If they spike a fever post-transfusion, no one is likely to suspect that the blood caused it."

Various records of F.D.A. inspections and correspondence with the Red Cross highlight poor follow-up, including falsified records.

On Nov. 19, 2001, for example, a patient receiving blood bought from the Red Cross's greater Chesapeake and Potomac region, which serves the Washington area, died of hepatitis, according to an F.D.A. report. The agency concluded that the Red Cross had failed to perform a thorough investigation.

Furthermore, the drug agency found that the Red Cross had failed to investigate 134 cases of suspected post-transfusion hepatitis that occurred across all its regions from January 2000 to June 2002.

Ms. Quinley said procedures had been changed since then in an effort to ensure that such cases would be investigated.

A Fractured System

Until 1991, Red Cross blood operations were largely controlled by its regional chapters, which operated 53 blood centers in vastly different and often idiosyncratic ways. That year, Elizabeth Dole, then chief executive of the Red Cross, announced a sweeping overhaul that wrested control of the blood operations from the chapters and reorganized them into 10 regions, which were expected to adhere to a uniform set of standards and procedures.

That event is still referred to among many at the Red Cross as "the Divorce," a measure of the organization's entrenched culture.

While Mrs. Dole won praise for taking a bold step to address a long history of sloppy testing and record keeping that raised concerns among regulators and the public about blood being potentially contaminated with H.I.V., chapters and their staff and volunteers saw it as an effort by the national headquarters to control the vast amount of money the blood services generate.

That legacy persists.

"We have never truly moved away from independence to national, central standards," said J. Chris Hrouda, executive vice president and a 20-year veteran of the Red Cross's biomedical services, as the blood operations are known.

Nor did anyone anticipate the cost and difficulty of the reorganization, current and former executives said. At first the project was budgeted at \$120 million, but the cost of developing a centralized database has run to at least \$1 billion so far, according to estimates by former executives. The database would make it easier to track down flawed blood components and to flag donors who have been previously screened out because of diseases or travel to places where malaria is common.

"There is no system to meet our needs," Mr. Hrouda said. "We are six times the size of the next-largest blood operations, and clearly that's a hindrance."

A small company in Paris, Mak-System International Group, is working to create such a system, but Mr. Hrouda had no estimate of when it would be up and running.

Thus, the Red Cross's current blood operations, 36 regions grouped into seven divisions served by five testing laboratories, are still controlled by different systems that cannot easily "talk" to one another.

In the meantime, the Red Cross has incorporated technology intended to help it prevent mistakes when blood is collected.

The most frequent errors cited by F.D.A. investigators involve failing to ask donors questions that would reveal their ineligibility to give blood. For instance, an interviewer forgets to ask a donor whether he has traveled in an area where malaria is a problem. So increasingly, donors fill out online questionnaires, which helps ensure that all required questions are answered.

Blood collection is also error prone, governed as it is by strictly prescribed procedures. After phlebotomists locate a vein, they must scrub a 3-inch-by-3-inch area with antiseptic soap for 30 seconds,

then use an antiseptic swab and, starting at the point where they will insert the needle, work outwards in concentric circles. They must then allow the area to dry for precisely 30 seconds before inserting the needle.

To improve that process, Red Cross phlebotomists recently began wearing electronic devices that time each of those steps.

The organization is also improving oversight on the mobile units used to collect roughly 80 percent of the blood it processes by assigning full-time supervisors.

Such measures, however, are undercut by high turnover among employees, who are paid little better than minimum wage, former executives say.

Mr. Hrouda said there was no plan to address high turnover. "We think we're able to recruit people at the wages we pay and are good at training them," he said.

The F.D.A., however, sees the main problem differently. "Size is no longer an excuse," said Mr. Blumberg, the agency's deputy general counsel.

Ms. Malarkey, of the F.D.A.'s Office of Compliance and Biologics Quality, said: "Right now, the biggest issue confronting the Red Cross is what we refer to as their problem management. They have standard operating procedures by which they should be able to investigate, evaluate, correct and control to prevent recurrence of the issues we have identified again and again, but they have a lot of difficulty implementing those procedures and, frankly, in having people follow them."

Ms. Malarkey said a recent "adverse determination letter," the process through which the F.D.A. informs the Red Cross of violations it has identified and demands payment of fines, illustrated her point.

In that letter, dated Feb. 8, the drug agency listed 113 "events" involving 4,094 flawed blood components that were recalled by 15 of the Red Cross's 36 regions. The recalls occurred largely from April 15, 2003, to April 15, 2006. (It is not uncommon for letters to list hundreds of infractions — one 2005 letter identified more than 22,000 flawed blood components that were recalled — and recalls do not mean every blood product is returned.)

"We are not seeing what we were seeing in the late 1980s and early 1990s, where unsuitable blood was routinely being released," Ms. Malarkey said, "but they still need to make more progress, and we would like to see that progress made quickly."

<http://www.nytimes.com/2008/07/17/us/17cross.html?ref=health>

[\[BACK TO TOP\]](#)

Gene Variation May Raise Risk of H.I.V., Study Finds

The New York Times | 07.17.08

By NICHOLAS WADE

A genetic variation that once protected people in sub-Saharan Africa from a now extinct form of malaria may have left them somewhat more vulnerable to infection by H.I.V., the virus that causes AIDS. The gene could account for 11 percent of the H.I.V. infections in Africa, explaining why the disease is more common there than expected, researchers based in Texas and London say. The researchers said their finding had no immediate public health consequences. But if confirmed, it would offer an important insight into the biology of the virus.

The genetic variation has been studied in United States Air Force personnel, whose H.I.V. infections have been followed for 25 years. African-Americans who carried the variation were 50 percent more likely to acquire H.I.V. than African-Americans who did not, although their disease progressed more slowly, say researchers led by Sunil K. Ahuja, director of the Veterans Administration H.I.V./AIDS Center, San Antonio, and Matthew J. Dolan of the Uniformed Services University in Bethesda, Md. Their results were reported Wednesday in the journal *Cell Host & Microbe*.

David B. Goldstein, geneticist who studies H.I.V. at Duke University, said that the new result “would be pretty exciting if it holds up” and that many other researchers would now test it. “If the results are confirmed, it would mean that selection for resistance to malaria has created a vulnerability to infection with HIV-1,” he said, referring to the principal form of the virus.

The genetic variation, called a SNP, or snip, involves a change in one unit of DNA. This particular snip has a far-reaching consequence. It prevents red blood cells from inserting a certain protein on their surface. The protein is called a receptor because it receives signals from a hormone known as CCL5, which is part of the immune system’s regulatory system.

The receptor is also used by a malarial parasite called *Plasmodium vivax* to gain entry to the red blood cells it feeds on. About 10,000 years ago, people in Africa who possessed the SNP variation gained a powerful survival advantage from not being vulnerable to the ancestor of *Plasmodium vivax*. The SNP eventually swept through the population and the *vivax* parasite died out in Africa, to be replaced by its current successor, *Plasmodium falciparum*.

More than 90 percent of people in Africa now lack the receptor on their red blood cells, as do about 60 percent of African-Americans.

The possibility that the receptor has a bearing on H.I.V. infection first occurred to Robin Weiss, a biologist at University College, London, after he noticed that the virus seemed to be hitchhiking on red blood cells. Dr. Weiss, who wrote the new report with Dr. Ahuja and Dr. Dolan, showed in laboratory tests that H.I.V. latches onto the receptor in place of its intended guest, the CCL5 hormone.

The Texas-London research team is not certain how lack of the receptor promotes H.I.V. infection, but Dr. Ahuja said the red blood cells acted like a sponge for CCL5. Because CCL5 is known to obstruct multiplication of the virus, having lots of the hormone in the bloodstream may prevent infection. Conversely, people whose blood cannot soak up the hormone could be more vulnerable.

Dr. Weiss said the red blood cell receptor was similar to another receptor, CCR5, which occurs on the surface of the white blood cells that are H.I.V.’s major target. A small percentage of Europeans have a mutation that prevents the CCR5 receptor from being displayed on the surface of white blood cells, and they are protected against H.I.V.

It is somewhat puzzling that the absence of the two receptors has the opposite effect — vulnerability to H.I.V. when the red cell receptor is missing, protection from it when the white cell receptor is withdrawn. The researchers offer an explanation that they concede is far from straightforward.

"If you found the paper plain sailing, most of my students didn't," Dr. Weiss said. As is often the case with provocative new findings, the researchers may have some way to go before convincing others that their observation is correct. Dr. Goldstein said that in parts of the United States, African-Americans have a higher infection rate than European-Americans, and that patients with a higher proportion of African genes may be more vulnerable to H.I.V. for reasons unconnected to the SNP. Nonetheless, the SNP would show up in a greater proportion of infected people simply because of their African heritage. If so, the gene's apparent association with H.I.V. infection could be just coincidental, not causal.

The researchers took steps to rule out this possibility, but Dr. Goldstein said those steps might not have been adequate.

Dr. Carl Dieffenbach, director of the AIDS division of the National Institute of Allergy and Infectious Diseases, said the new finding, if confirmed, would be intriguing because it pointed to the many ways in which pathogens have shaped the body's receptors.

Although H.I.V. is too recent an infection to have left an evolutionary mark on the genome, human ancestors would have been exposed to malarial parasites and to S.I.V., which infects monkeys, and the genome still bears the marks of these challenges to survival. Better knowledge of these adaptations will help understand the biology of H.I.V. infection, he said.

<http://www.nytimes.com/2008/07/17/science/17hiv.htm>

[\[BACK TO TOP\]](#)

Advocating a Treatment, but Denied Access to It
The New York Times | 07.17.08
By REED ABELSON



Cheri Gunvalson is suing a biotechnology firm for access to a drug that would help her son, Jacob, who has muscular dystrophy.

It is a case that pits a mother desperately seeking a medical treatment for her son against a biotechnology company for whom she claims to have worked tirelessly as an advocate.

In a lawsuit filed in federal court on Wednesday, the mother, Cheri Gunvalson, is suing the company for access to an experimental drug that she says could help her 16-year-old son in his battle with a rare but devastating disease, Duchenne muscular dystrophy. While the mother claims that executives repeatedly assured her that her son would get the drug, the company denies ever making such promises and says the drug is not ready for widespread use.

While the specifics of the case are unique, the dispute exposes the sometimes blurry boundaries between medical research and patients' hope for life-saving treatments. As more patients or their families work closely with companies on treatments for diseases like cystic fibrosis or Parkinson's, researchers and other experts say conflicts are increasingly frequent.

The issues raised are "increasingly common across a variety of conditions," said Dr. Charles Homer, the chief executive of the National Initiative for Children's Healthcare Quality in Cambridge, Mass.

For years, Ms. Gunvalson was among the fiercest proponents of medical research into Duchenne muscular dystrophy, a rare genetic disorder that was diagnosed when her son, Jacob, was 7 or 8 years old and since last year has confined him to a wheelchair. Ms. Gunvalson, with a master's degree in nursing, was instrumental in getting federal legislation passed to provide more research money for the disease, despite the challenges of working from her family's farm in rural Minnesota.

She also says she worked on behalf of PTC Therapeutics, the biotechnology company that is developing what she thinks is the most promising treatment for a genetic mutation aimed at about 15 percent of the boys with Duchenne. Many of the boys and young men who have the disease — it is nearly always a male condition — do not live past their 20s.

Because Jacob is no longer walking, he is not eligible for the clinical trial under way, which involves about 165 patients. And the company says it will not provide the experimental compound, PTC124, to any boy who is not involved in one of the drug's studies.

For Ms. Gunvalson, the stakes are high. PTC124 is "Jacob's last, best and only chance to slow, stop or even reverse the effects of his condition," according to her lawsuit. "Without it, Jacob will not survive."

Ms. Gunvalson is being represented by one of Minnesota's most prominent lawyers, Michael A. Hatch, the former state attorney general, who filed the suit in United States District Court in New Jersey. PTC Therapeutics is based in South Plainfield, N.J.

Executives say they never told Ms. Gunvalson that Jacob would get PTC124.

"I feel comfortable that we have been fair and honest to her and to all patients," said Stuart W. Peltz, the chief executive of PTC, in interview before the lawsuit was filed. "We haven't promised anyone the drug."

The company said Wednesday it had not had time to review the lawsuit and therefore could not comment on it.

While Mr. Peltz said he understood Ms. Gunvalson's desire to help her son, he said his job was to ensure that the drug in question went through the regulatory process as quickly as possible so that, if it works, it would be available to people with the disease. "I sympathize with her role and what her goal is," he said. "My role is to all the boys with Duchenne muscular dystrophy, all the Jacobs."

For patients with a fatal disease, who have no other options, being denied a promising drug can often mean losing all hope. One group, the Abigail Alliance for Better Access to Developmental Drugs, lost a lawsuit last year against the Food and Drug Administration in which it sought essentially unlimited access to experimental drugs for terminally ill patients. The group was founded by a man whose daughter, Abigail, died of cancer after a long battle to use experimental drugs that the regulators subsequently approved.

And there has been a movement toward allowing more patients to use experimental drugs, through what is called "compassionate use." Under the process, some patients enroll in single-patient studies or participate in a clinical trial, even if they do not meet the eligibility criteria and their results are not included in the final study.

Ms. Gunvalson's lawsuit seeks such an exception for Jacob, whose pediatrician also says he thinks Jacob should get the drug, arguing that there are no significant risks and the compound is "potentially life-saving."

But PTC Therapeutics insists there is too still little experience with the drug and that it cannot consider giving it outside the current studies. "This is not the appropriate time to be asking for compassionate use," Mr. Peltz said.

Doctors and researchers say the decision about whether an individual patient should be allowed compassionate use can be difficult, because the treatments are experimental, with limited information about whether they are effective — or even safe.

"The burden is on everyone to ensure that safety is kept in mind in each step and that we don't get ahead of ourselves in our enthusiasm," said Dr. Richard S. Finkel, a prominent expert in Duchenne at the Children's Hospital of Philadelphia, which is working closely with PTC Therapeutics on its PTC124 research.

Dr. Finkel, who is helping conduct the clinical trial, says he has other patients who also want the drug but also do not qualify. He says he is not recommending that these patients seek a compassionate-use waiver because of his concerns over safety.

Other experts say parents and patients can be too easily oversold on the benefits of any potential treatment, especially when working closely with the companies developing new therapies.

"The parents are inclined towards the hype because they want the silver bullet, and the companies are inclined towards the hype because they want the blockbuster drug," said Sharon Terry, the chief executive of the Genetic Alliance, a Washington advocacy group that brings together interested parties, including patients, to advance research into genetic diseases.

Researchers also say that companies like PTC Therapeutics may be reluctant to provide drugs for compassionate use out of fear that any problems that arise would make it more difficult to get regulatory approval.

And deciding which patients would qualify for access outside a clinical trial is complicated. Medical ethicists say giving the drug to one patient without making it available to others raises troubling questions. "There are definitely issues of fairness," said Dr. Susan Goold, the director of bioethics at the University of Michigan medical school.

While people active on behalf of a company or cause may feel they are owed access to certain drugs, participation in medical research does not work that way, Ms. Goold said. Any involvement in such a cause, she said, should come from a desire to advance medical science, not help a specific patient. "You have to recognize this may not directly benefit your loved one," she said

The issues need clarification, said Patricia Furlong, the president of Parent Project Muscular Dystrophy, a parent advocacy group that has helped find financing for PTC Therapeutics' research. Ms. Gunvalson has been active in the group.

"Who and how and by what criteria" do you become a special exception, said Ms. Furlong. She said federal regulators needed to be more specific about how someone can get access to experimental drugs without enrolling in studies. "Everybody needs help," she said.

Mr. Peltz of PTC Therapeutics insists that the company was mindful of the need to be clear about what parents should expect. "We've tried to be very careful on this," he said.

But in her lawsuit, Ms. Gunvalson paints a more complicated picture. She says she helped persuade the company to apply for federal research grants, which the company denies. She also describes a close relationship with several of the executives, including one senior vice president, Claudiá Hirawat. At one point, Ms. Hirawat invited Ms. Gunvalson and Jacob to stay overnight at her home, according to the lawsuit.

Ms. Gunvalson also says that at a period when Jacob was still able to walk she was advised by company officials not to enroll him in a preliminary 28-day study to determine if the drug had any effect at all, with the understanding that she would be able to enroll Jacob in a later trial.

Mr. Peltz insists the company never advised Ms. Gunvalson about whether to participate. "It's not our job," he said.

But there are some signs of ambiguity, at least, in the company's communication with Ms. Gunvalson, including an e-mail message an executive sent to her in January 2008, about the request for Jacob to receive PTC124.

"I can definitely tell you we're saying no because we're trying to create an even better yes," said the e-mail message, sent by Diane Goetz. "When it's all over you'll understand exactly what I mean and why, but we're not there yet. I know it's hard for you but please hold tight. The best path forward is still very much on the agenda." The company says it has made every effort to be clear in repeated communications with Ms. Gunvalson.

Jacob's pediatrician, Dr. John Parkin, said he, too, thought the company was going to give Jacob the drug after a conference call with the company in the fall of 2006. "I had the general impression that they were going to give it to him," he said.

Jacob, too, says he has been bitterly disappointed after thinking "so many times," as he said in an interview, that he would receive the drug. "I wish I could get it," he said.

<http://www.nytimes.com/2008/07/17/business/17dystrophy.html>

[\[BACK TO TOP\]](#)

Health proposal rankles Democrats **USA Today | 07.17.08**

WASHINGTON (AP) — Democratic lawmakers said Wednesday that the Bush administration is considering a new federal rule that would withhold government funding from health care providers and organizations that refuse to hire workers who won't perform abortions or provide emergency contraception.

Federal law already prohibits discriminating against any individual or institution that refuses to perform abortions or provide a referral for one. The Health and Human Services Department is considering requiring health care providers and organizations to certify their compliance with the law.

The problem, lawmakers and abortion rights groups said, is that the document defines abortion as including the administration of certain contraceptives; namely, the morning-after pill. If the rule took effect, facilities would be compelled to employ workers unwilling to perform everyday job duties, lawmakers said.

"If the administration goes through with this draft proposal, it will launch a dangerous assault on women's health," said House Speaker Nancy Pelosi, D-Calif.

The 39-page document circulating on Capitol Hill was labeled as a draft and a proposed rule. HHS officials issued a statement on the proposal, but they provided little detail about its status.

"Over the past three decades, Congress has passed several anti-discrimination laws to protect institutional and individual health care providers participating in federal programs," the statement said. "HHS has an obligation to enforce these laws, and is exploring a number of options." Copyright 2008 The Associated Press. All rights reserved. This material may not be published, broadcast, rewritten or redistributed.

http://www.usatoday.com/news/health/2008-07-16-health-proposal_N.htm

[\[BACK TO TOP\]](#)

Premature babies grow up shy

USA Today | 07.17.08

By Liz Szabo

Are premature babies born to be shy?

New research suggests that children born prematurely are more timid and less likely to get married and have children.

Researchers say they're just starting to understand how being born prematurely affects personality. Until 20 to 30 years ago, few premature babies survived. Even today, very small or premature newborns are much more likely to have serious health problems, such as cerebral palsy.

But now that doctors can save most preemies — and some of the earliest survivors are reaching adulthood — researchers are accumulating evidence that even those without medical disabilities have more problems socializing or taking risks.

HEALTH BLOG: Latest pregnancy studies

Among the findings:

- The earlier babies are born, the less likely they are to marry, become parents or earn a high salary, suggests a study of nearly 1 million Norwegians, now ages 20 to 36, in today's New England Journal of Medicine.

ON THE WEB: Find more information about shyness

- In two studies of people in their early 20s in this month's Pediatrics, researchers found that former preemies were less likely to leave home, live with a romantic partner or be sexually active. They were also more inhibited and more apt to obey social conventions.
- And three new studies — including the Norwegian paper — find that former preemies are more likely to have symptoms of autism, a condition that affects interpersonal skills.

Taken together, the studies suggest that people born prematurely experience a "spectrum of social and emotional difficulties that range in severity from quite mild to severe," says Catherine Limperopoulos of McGill University in Montreal, lead author of one of the autism studies.

Bernardo Carducci, director of the Shyness Research Institute at Indiana University-Southeast, notes that preemies are born with underdeveloped nervous systems. He says it's possible that causes these children to become easily overstimulated, leading them to turn inward rather than outward toward new friends and experiences.

Dag Moster, co-author of the Norwegian study, notes that today's medical advances may allow premature babies to develop more like their peers who are full-term.

And experts note that an introverted personality isn't all bad. Delaying sexual activity can protect adolescents from physical and emotional harm, Limperopoulos says.

And Moster says his study shows that ex-preemies have a lower divorce rate and are no more likely to be unemployed or arrested. "It should be emphasized that a lot of these children grow up to do very well," says Moster, a pediatrician at University Hospital in Bergen, Norway.

http://www.usatoday.com/news/health/2008-07-16-shy-premature-babies_N.htm

[\[BACK TO TOP\]](#)

Web site offers topics to discuss with doctor

The Daily Advertiser | 07.17.08

Gary Curtis, CEO

Recently, the federal government placed newspaper ads throughout the country highlighting hospital quality. In select communities, the ads offered hospital-by-hospital comparisons of two quality measures. The goal of the ads is to direct people to the Web site www.hospitalcompare.hhs.gov and to help begin a dialogue about health-care quality.

At Louisiana Health Care Review, we support this and other efforts to bring information about health-care quality that will help people make better decisions. Critical to making this information readily available are the recent successful efforts by hospitals, nursing homes and other health-care providers to improve their patient-care quality. Today, hundreds of health-care providers have made this commitment, and the results are outstanding.

Key measures of health-care quality such as heart attack and pneumonia rates have improved significantly in Louisiana. These indicators will get a further boost when the state's Right-to-Know Web health-care site becomes active next year. The bill creating this law was just signed by Gov. Bobby Jindal. Until then, I urge people to go to the hospital, compare Web sites, become familiar with key quality measures and start asking questions about health-care quality when talking to your doctor.

Gary Curtis, CEO

Louisiana Health Care Review

<http://www.theadvertiser.com/apps/pbcs.dll/article?AID=/20080717/OPINION03/807170325>

[\[BACK TO TOP\]](#)

Lourdes bans smoking
The Advertiser | 07.17.08
Marsha Sills

Smoking will no longer be allowed on the campuses of Our Lady of Lourdes Regional Medical Center and its affiliated medical complexes.

The policy takes effect on Aug. 4, but the change is "long overdue," said William "Bud" Barrow, Lourdes president and chief executive officer, at a press conference Wednesday.

"We represent the healing ministry of Jesus Christ. ... Tobacco is opposite of that. It represents disease, sorrow....," Barrow said.

The move is a growing trend among health complexes. While statistics and science showing the harmful health effects of smoking, most hospitals, including those in Lafayette, still maintain designated smoking areas on campuses to accommodate visitors, employees, and even patients.

Lourdes is hopeful their policy may encourage other facilities to consider the change.

Lafayette General Medical Center currently has a smoke-free policy under consideration, according to Patrick Gandy, Lafayette General's interim CEO.

The Lourdes effort is a chance to improve the health of the hospital's patients, employees, but the community, as well, said Henry "Hank" Perret, a local attorney who chairs the hospital's board of directors. After the loss of his son to cancer, Perret and his family created the Miles Perret Cancer Services to provide services and support to those with cancer and their families.

"We feel this focus on wellness is something for all of us in the community. We hope it garners the support of all of our employees and patients," Perret said.

Barrow said he realizes there may be push-back from employees and patients.

"We assume that there may be some patients who may decide not to come here because of this ... but we're helping to protect people from that which is harmful," Barrow said.

The policy applies to the hospital's network of centers: Heart Hospital of Lafayette, Lourdes Imaging Network and Lourdes AfterHours and prohibits smoking on all properties owned, operated or leased by Lourdes, including parking lots, sidewalks and all outdoor areas.

Currently, patients may be given hospital privileges that allow them to leave their floor and go outside. Often, these patients request to go outdoors so they may smoke.

"This will help boost the healing rates of patients," said Dr. Bryan LeBean, Lourdes' chief of staff.

Employees had already been notified of the change prior to Wednesday's press conference. Barrow said resources have been available to employees who were trying to quit smoking. Those resources will still be available to them, he said. The hospital also offers a smoking cessation program on its campus that is open to the community.

<http://www.theadvertiser.com/apps/pbcs.dll/article?AID=/20080717/BUSINESS/807170315/-1/NEWSFRONT2>

[\[BACK TO TOP\]](#)

Many hospital sold to Shreveport firm

The Town Talk | 07.17.08

Town Talk staff

The Shreveport-based Allegiance Health Management, LLC, announced Wednesday that it will take over ownership of Allegiance Hospital of Many, LLC, which is doing business as Sabine Medical Center.

A United States Department of Agriculture-approved financing package to purchase Sabine Medical Center includes \$2.8 million to construct a new entrance, an emergency medicine department and front lobby along with renovations of the existing facility, which will include increasing space for outpatient services.

Allegiance Health Management works in the specialty medical field of rural hospitals, inpatient geriatric psychiatric hospitals, intensive outpatient psychiatric services and long-term acute care hospitals. Allegiance currently operates medical centers in Louisiana, Texas, Florida, Oklahoma, North Carolina, Mississippi, Georgia and Arkansas.

<http://www.thetowntalk.com/apps/pbcs.dll/article?AID=/20080717/BUSINESS/807170324/-1/NEWSFRONT2>

[\[BACK TO TOP\]](#)

Inflation, oil send costs of medical supplies soaring

Chicago Tribune | 07.17.08

By Bruce Japsen

Inflation is racing through the economy at a pace not seen in years, touching even the medical gloves used by hospitals, as manufacturers cope with high oil prices.

The cost of living in June shot up at the fastest rate in 17 years, with the Labor Department reporting Wednesday that consumer prices jumped 1.1 percent, a much faster clip than anticipated.

Inflation is corrosive to paychecks, cutting deeply into consumers' earning power, but the phenomenon hurts even more in an economy struggling to maintain growth. Inflation also hurts companies when they can't pass on higher costs because of competitive pressure.

Much of the inflation pressure now is due to oil prices, and its impact is most obvious at the gas pump, though high food prices are also hurting shoppers at the grocery store. While oil prices have dropped steeply the past two days, they remain at historically high levels.

There are myriad ways the impact of high oil prices touches consumers—or is likely to soon—and the medical supplies used by hospitals and sold in drugstores are one example.

Consumers can see the results at retail outlets such as Walgreen Co. stores, where the retailer says a box containing 120 of its store-brand latex gloves has almost doubled in price. A customer who could get two boxes for \$9.99 a year ago now pays a sale price of \$7.99 for one box. Oil is used in the manufacture of gloves.

Medical manufacturers, distributors and hospitals all are coping with rising prices, and they are making crucial decisions about whether to raise customer prices or hang tough and eat the higher costs to protect relationships or fend off competitors.

From the thousands of gloves used each day to plastic bed pans, blood bags, syringes and tubing used for delivering medications to patients, prices for many everyday medical products are under pressure because they rely on petroleum, industry players say. In some cases, suppliers like Mundelein-based Medline Industries Inc. are seeing costs double or triple for products.

"The price of oil is going to work its way into many, many things in the health-care system," said Todd Swim, a worldwide partner with the Chicago office of Mercer, an employee benefits consulting firm that advises large companies on their workers' health-care issues.

While a single glove can amount to pennies, that cost adds up for a hospital. Medline says it's not uncommon for a 200-bed hospital to use 16,000 gloves a day, or about 6 million a year at a cost of \$200,000 a year. A hospital that paid \$2.70 two years ago for a box of 100 latex gloves might pay \$3.50 to \$3.80 today.

Rising costs spreading through the economy led Ben Bernanke, chairman of the Federal Reserve, to offer a new warning Wednesday about the significant risk to the nation's economic outlook. Energy prices are partly to blame, with gasoline prices jumping 35 percent in the last year.

"Upside risks to the inflation outlook have intensified lately," Bernanke told lawmakers in Washington.

In the hospital business, suppliers say they are experiencing price hikes for disposable protective apparel such as gowns and drapes thanks to price hikes in polypropylene. Meanwhile, foam used to make stretchers or beds and oil-based resins used to make syringes and other medical products are triggering price hikes.

As one example, the hundreds of thousands of gowns hospitals may use to protect patients, medical staff and visitors from germs and bodily fluids are made from polypropylene fabrics. Such gowns, which used to cost 50 cents each, have jumped by 40 percent, to 70 cents each, Medline said.

Both Deerfield-based Baxter International Inc. and Lake Forest-based Hospira Inc., which make IV systems and medication bags, have been telling investors and Wall Street analysts that managing the fuel hikes is becoming more difficult.

"So far, strategically we have made the decision to absorb those costs," Baxter Chief Financial Officer Robert Davis told Wall Street analysts at a recent conference. "And pretty soon if we are not passing those through at some point, we'll have to continue to evaluate whether that's doable."

Because hospitals sign long-term contracts with manufacturers and buy in large volumes that allow them to negotiate better deals, the immediate impact for some customers has been somewhat muted, but administrators are looking for alternatives.

In the case of gloves, Loyola University Medical Center in Maywood said housekeeping and food/nutrition staffs have switched from latex gloves "to less expensive vinyl gloves," a hospital spokesman said.

<http://www.chicagotribune.com/business/chi-thu-inflation-pricesjul17,0,3580746.story>

[\[BACK TO TOP\]](#)