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Charity Hospital venue disputed

The Times-Picayune | 05.06.09

By Gwen Filosa
Staff writer

Charity Hospital in New Orleans, formerly the city's largest health care provider for the uninsured, closed only because of the devastation left by Hurricane Katrina in 2005, attorneys for its managers told the Louisiana Supreme Court on Tuesday.

"We didn't close the hospital," said attorney Preston Castille Jr., who represents Louisiana State University in a lawsuit brought by former Charity patients in an effort to force a reopening of the facility. "If it was closed by anything, it was closed by the hurricane."

The Supreme Court heard oral arguments in an Orleans Parish Civil District lawsuit filed in January 2008 that asks the courts to order Larry Hollier, chancellor of LSU Health Sciences Center, to reopen the Tulane Avenue hospital that long served poor families that couldn't secure health care elsewhere.

Charity Hospital, at the time of its closing, was just one facility of the Medical Center of Louisiana at New Orleans, which also included University Hospital and various outpatient clinics.

A large Medical Center of Louisiana clinic reopened shortly after Katrina at the former Lord & Taylor store, and University Hospital reopened more than a year after the storm. The building known as Charity remains vacant.

The only issue before the Supreme Court on Tuesday was where the lawsuit should be heard: in Orleans Parish, which plaintiffs insist is the appropriate venue, or in East Baton Rouge Parish, where LSU's attorneys say the administrative decisions affecting Charity after Katrina were made.

But the arguments included emotional pleas from the plaintiffs' attorneys, who include Tracie Washington, former Criminal District Judge Calvin Johnson and Leonard Aragon, from a Phoenix law firm.

"We are trying to bring back care to the New Orleans metropolitan area, which is a local issue," Aragon said. "It involves four parishes in the New Orleans metropolitan area. It's not a statewide case."

The lawsuit was brought by seven former Charity patients, including Melvin LeBlanc, who was born at Charity in 1956 and lost his Lower 9th Ward home to Katrina. Hollier and other administrators are named as defendants.

Civil District Court Judge Ethel Julien ruled that Orleans Parish is the proper venue for the suit, but the state Supreme Court will have the final say. The justices did not indicate when they will rule.

The Legislature turned over the Charity Hospital system to LSU in 1997. Since 1926, Louisiana has provided health care for its poor residents without regard to a patient's ability to pay.

"It is quite clear this case belongs in East Baton Rouge," Castille said. "It is inappropriate to have a state agency travel across the state to address their administrative decision. We have to look to the state agency. That agency is located in East Baton Rouge Parish."

Aragon argued that the alleged facts of the lawsuit originated in New Orleans. "Agents physically closed the hospital and they didn't seek legislative approval," Aragon said. "All of the operative facts occurred in Orleans Parish."

Several justices questioned Aragon about why his clients are suing Larry Hollier, Dr. Michael Butler and Dwayne Thomas, all top administrators of Charity Hospital, instead of the LSU Board of Supervisors, which controls the budget for the system.

"The chancellor makes the day-to-day decisions about the hospital," Aragon said regarding Hollier. "The chancellor does everything. He is not just a mere employee."

<http://www.nola.com/news/t-p/neworleans/index.ssf?/base/news-10/124158797726600.xml&coll=1>

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LSU won't let facts get in hospital's way

The Times-Picayune | 05.06.09

Posted by James Gill, Columnist

The allegation that state and LSU officials are telling a pack of lies in order to screw the feds out of several hundred million dollars does not come from a source with any claim to disinterest.

It comes from a coalition that wants LSU to abandon its plans for a sparkling new medical complex and reopen Big Charity.

But the coalition has produced plenty of evidence that must require FEMA to consider the possibility of jiggery-pokery.

For LSU the stakes are high, because it will never raise the \$1.2 billion needed to extend its medical empire unless it can first persuade FEMA to pay the full value of the old hospital, \$492 million.

LSU claimed that Charity was no longer usable after the storm and applied for the full reimbursement FEMA is required to make when public buildings are more than 50 percent damaged in a disaster.

The Bush administration's version of FEMA didn't buy it. FEMA's best offer, after considerable haggling, was \$122 million. LSU has appealed and hopes for better luck with the new regime.

The coalition adjures FEMA not to be fooled, and accuses LSU, which wanted out of Charity long before Katrina, of grossly exaggerating the damage, unnecessarily keeping the hospital out of commission and leaving the ailing poor up the creek.

A couple of hundred soldiers, sailors and National Guardsmen worked on the Charity clean-up immediately after the storm, so the feds should not have too much trouble finding witnesses to ask if LSU is pulling a fast one.

In support of the proposition that that is indeed what is going on, the coalition cites two men who were in the thick of things throughout -- an emergency room doctor and an army staff sergeant. Each has averred, under oath, that Charity was sufficiently restored a month after the storm to resume treating patients, but LSU wanted it closed.

The recollections of Dr. James Moises and Sgt. John Johnson do not chime with LSU's. According to the LSU appeal, the Charity basement "was totally inundated by contaminated and corrosive floodwaters for more than 40 days, " and "all utility infrastructure" was out of commission "not for a few days or weeks, but for months." A long list of other woes included "catastrophic environmental failures within the building."

Not so, according to both Moises and Johnson, who say the basement was promptly pumped out, while decontamination teams fanned out on the higher floors.

Moises, in a deposition, said, "The cleanup was essentially complete by September 21. I observed at the time that the first three floors were spotless. Electric power had been restored and the air conditioning was functioning. I personally took pictures at some point in late September 2005 showing the immaculate state of Charity Hospital."

Johnson, a 20-year army veteran, is an electrical specialist in the 205th Engineering battalion, who has done three tours in Iraq and one in Afghanistan. Johnson, in an affidavit, described how he quickly restored power to the hospital and noted that "the chemical teams were meticulous." Johnson could "attest from personal knowledge that the emergency room was cleaner than it was before Katrina."

The testimony of two men -- even such apparently credible men as these -- hardly settles the issue, and maybe FEMA will decide LSU is entitled to hit the jackpot. But LSU's only response to the allegations has

been a legal quibble. It argues in a brief that the coalition has no standing to intervene and should simply be ignored.

LSU sure is a slow learner. Critics have complained that it has been secretive, high-handed and disingenuous throughout the Charity debate.

Those critics now have more ammunition. LSU appears not to care whether it is trusted or not. "Give us \$1.2 billion and go boil your head" is its message to the taxpayer.

http://blog.nola.com/jamesgill/2009/05/lsu_wont_let_facts_get_in_hosp.html

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Where should Charity Hospital case be heard?

WXVT15 | 05.06.09

Associated Press

NEW ORLEANS (AP) - Attorneys for Louisiana State University tells the state Supreme court that Hurricane Katrina closed the art deco building - and not LSU.

The arguments Tuesday were about whether to try a lawsuit seeking to reopen the hospital in New Orleans or Baton Rouge.

Seven patients sued to reopen the hospital. They want the suit heard in New Orleans. LSU wants the case heard in Baton Rouge.

Plaintiffs' attorneys, who include Tracie Washington, former Criminal District Court Judge Calvin Johnson, and Leonard Aragon, made an emotional plea.

Aragon said it's a case about the New Orleans metro area, and should be heard there.

Attorney Preston Castille Jr., representing LSU, said a state agency should deal with its administrative decisions where it is located.

http://www.wxvt.com/Global/story.asp?S=10311702&nav=menu1344_2

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Supreme Court hears oral arguments in Charity Hospital case

The Times-Picayune | 05.05.09

by Gwen Filosa, The Times-Picayune

Charity Hospital in New Orleans, formerly the city's largest health-care provider for the uninsured, closed only due to the devastation left by Hurricane Katrina in 2005, lawyers for its managers told the Louisiana Supreme Court today.

"We didn't close the hospital," said attorney Preston Castille, Jr., who represents Louisiana State University in a lawsuit brought by former Charity patients in an effort to bring the facility back online. "We denied it all along. If it was closed by anything, it was closed by the hurricane."

The state Supreme Court today heard oral arguments from an Orleans Parish Civil District lawsuit filed in January 2008 that asks the courts to order Larry Hollier, Chancellor of LSU Health Sciences Center, to reopen the Tulane Avenue hospital that for decades was the only place poor families could find health care.

The justices and attorneys on both sides referred to the facility as "Charity Hospital," which was part of the Medical Center of Louisiana at New Orleans, which encompassed Charity, University Hospital and the various outpatient clinics. MCLNO reopened shortly after Katrina at the former Lord & Taylor, and University opened in November 2006.

Charity Hospital remains vacant.

The only issue before the Supreme Court is where the lawsuit should be heard -- in Orleans Parish, which the plaintiffs insist is the appropriate venue, or in East Baton Rouge Parish, where LSU's attorneys say the administrative decisions over Charity post-Katrina were made.

But today's arguments included an emotional plea from the plaintiffs' attorneys, who include Tracie Washington, former Criminal District Court Judge Calvin Johnson, and Leonard Aragon.

"We are trying to bring back care to the New Orleans metropolitan area, which is a local issue," said Aragon. "It involves four parishes in the New Orleans metropolitan area. It's not a statewide case."

The lawsuit, brought by seven former Charity patients, including Melvin LeBlanc, who was born at Charity in 1956 and lost his Lower 9th Ward home to Katrina, sues three administrators, including Hollier.

The state Legislature turned over the Charity Hospital System to LSU in 1997. Since 1926, Louisiana has mandated health care for its poor residents without regard to a patient's ability to pay.

The seven justices didn't indicate when they will rule on the issue of which parish the lawsuit should be heard in.

"It is quite clear this case belongs in East Baton Rouge," said Castille. "It is inappropriate to have a state agency travel across the state to address their administrative decision. We have to look to the state agency. That agency is located in East Baton Rouge Parish."

Aragon argued that the alleged facts of the lawsuit originated in New Orleans.

Hollier's "agents physically closed the hospital and they didn't seek legislative approval," Aragon said. "All of the operative facts occurred in Orleans Parish. Nothing occurred in East Baton Rouge."

Several justices questioned Aragon over why his clients are suing Larry Hollier, Dr. Michael Butler and Dwayne Thomas, all top administrators of Charity Hospital, instead of the LSU Board of Supervisors, which controls the budget for the system.

"Can you even sue for these acts?" Justice Bernette Johnson asked. "Everybody sues the chancellor for acts rather than suing the board of supervisors."

Aragon replied, "For his official acts, yes. The chancellor makes the day-to-day decisions about the hospital. The chancellor does everything. He is not just a mere employee."

Charity Hospital was one of the last places running as residents fled the flooded city after Aug. 29, 2005, Aragon noted. Its employees returned, cleaning and preparing the hospital to resume operations only to have Hollier send in "agents" to empty the building and order it closed, he said.

"The hurricane did not close Charity Hospital," said Aragon. "Larry Hollier closed the hospital."

Aragon said that if the justices find that the lawsuit should have included the Board of Supervisors as a defendant, he would have no problem adding it to the list.

LSU's attorneys decried that as unfair play.

"Until now, we've had a lawsuit against the board disguised (as a lawsuit against three administrators)," attorney Skip Phillips told the justices. "This isn't vicarious liability. It's a question of who has the authority. Only the LSU Board of Supervisors could have made the decision, the plaintiffs allege."

LSU planned to close Charity Hospital in New Orleans long before Katrina, said Phillips, with the state Legislature's intention to start searching for a replacement.

Pressed by the justices to say who exactly closed Charity, Phillips said that it was the board of supervisors.

"We've never gotten that far into the record," Phillips said, of the lawsuit's progress at the Civil District Court.

http://www.nola.com/news/index.ssf/2009/05/lsu_lawyers_hurricane_katrina.html

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Group seeking people for Parkinson study
Shreveport Times | 05.06.09

The Parkinson Study Group is looking for people 30 and older with early stage Parkinson disease to participate in a clinical study.

The group is studying Coenzyme Q10 (CoQ). The study will evaluate the safety and effectiveness of high doses of CoQ in slowing clinical decline in patients who have early Parkinson disease.

Dr. Richard Zweig, a neurologist with LSU Health Sciences Center-Shreveport, will lead the local effort of this phase III clinical trial. Shreveport is among about 60 clinical sites in the United States and Canada. Each site will enroll about 10 participants.

<http://www.shreveporttimes.com/article/20090506/NEWS01/905060335/1060>

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Bill to merge state agencies killed

The Advocate | 05.06.09

By MARSHA SHULER

Advocate Capitol News Bureau

An effort to merge Louisiana's health and social services departments is dead for the 2009 legislative session.

State Rep. Joe Harrison, R-Houma, pulled the plug on his House Bill 815 as it came up for hearing in a House committee Tuesday morning.

Harrison said he was bowing to the wishes of Gov. Bobby Jindal's office to turn the legislation into a study resolution.

He said he would bring merger of the state Department of Health and Hospitals and the Department of Social Services up again in the 2010 Legislature.

"I've been told by the administration, DHH and DSS of their commitment to work on this," Harrison told the House and Governmental Affairs Committee.

Jindal issued an executive order recently establishing a panel to look at ways to streamline government and improve efficiency.

House and Governmental Committee Chairman Rep. Rick Gallot, D-Ruston, said Jindal needs the Legislature involved in the process.

"The executive branch has no authority to impose on the legislative branch some of the things included in there," Gallot said.

"We have to move forward as partners, co-equals. It has to be a more consolidated coordinated effort," Gallot said.

Prior to 1988, DHH and DSS were one organization and the state's charity hospitals were also under the agency umbrella, Harrison said.

"It was a very large arm of government — one functioning in a way that was proper instead of one split three ways," Harrison said. "What I am suggesting is moving that back."

<http://www.theadvocate.com/news/44426682.html>

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Legislators drill dentists on school program ban

The Advocate | 05.06.09

By MARK BALLARD

Advocate Capitol News Bureau

A House committee postponed a vote Tuesday on legislation that would prohibit dentists from practicing in schools.

The House Health and Welfare Committee had heard testimony much of the morning on House Bill 687.

The Louisiana Dental Association argued that invasive dental treatments should be done in a fixed dentist's office rather than in a school library or cafeteria.

About 1,000 dentists are willing to treat children on Medicaid, the government's insurance for the poor, said Baton Rouge dentist Marty Garrett, a past president of LDA.

Opponents from school systems and the mobile dentists who travel between schools argued that as many as two-thirds of the 753,900 children receiving Medicaid assistance simply have not seen a dentist in a fixed office or otherwise. Mobile dentists are willing to go where the children are and treat them in school, they said.

State Rep. Fred Mills, D-St. Martinville, said the bill sounded like a battle between associations and their competing arguments were confusing. He asked that a representative from a state agency testify as a neutral observer.

Dionne Richardson, the state's dental director, moved toward the testimony table.

But Chairman Kay Katz, R-Monroe, said the committee would have to vacate the room because another committee had planned a hearing.

State Rep. John LaBruzzo, R-Metairie, "called the question," which is a parliamentary procedure to force an up or down vote on HB687. His motion failed and Katz postponed further discussion until next week.

Richardson said after the meeting that officially the state Department of Health and Hospitals was staying neutral on the legislation. "Our primary concern is access for children," she said in an interview.

On personal level, however, Richardson said she opposed HB687.

Before returning to Louisiana to serve as the head of the DHH dental program, Richardson was a dentist providing dental care in Rochester, N.Y., schools. She said the service had been ongoing for more than three decades in upstate New York without a single bad incident.

"I'm disheartened as the state dental director that this couldn't have been resolved without going to the Legislature," Richardson said.

Louisiana would be the first state in the nation to have a state law that would ban dentists from working in the schools, said Ward Blackwell, executive director of the Louisiana Dental Association.

Other states regulate the practice through the state boards that licenses dentists.

HB687, sponsored by state Rep. Kevin Pearson, R-Slidell, would forbid dentists from treating children on school grounds. The LDA and its 1,800 or so members lobbied for the legislation, handing out blue stickers to supporters among the standing room only crowd.

Claudia Cavallino, a dentist in New Orleans, testified that she often doesn't discover important facts of a child's medical history until after questioning the parents.

Sue Catchings, head of Health Care Centers in Schools Inc., a nonprofit organization that contracts with the East Baton Rouge Parish school system to provide health care in public schools, said the legislation would end current school-based dentistry programs, which would be bad for children.

<http://www.theadvocate.com/news/44426747.html>

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Ban on school mobile dental clinics stalls

The Times-Picayune | 05.06.09

By Jan Moller
Capital bureau

BATON ROUGE -- A legislator's attempt to outlaw school-based mobile dental clinics stalled in a House committee Tuesday amid questions about where state regulators stand on the matter.

The House Health and Welfare Committee voted 9-8 to keep House Bill 697 by Rep. Kevin Pearson, R-Slidell, bottled up for at least another week.

Supporters of the bill, led by the Louisiana Dental Association, said mobile dental clinics amount to "Third World" care and that children are best served in fully equipped dental offices.

Advertisement

"All Louisiana children deserve first-class dental care," said Marty Garrett, a Baton Rouge dentist and past president of the Louisiana Dental Association, which is pushing the bill.

Mobile clinics have become a recent growing trend in Louisiana, where a majority of poor children lack access to care even if they qualify for Medicaid or LaCHIP health-care programs.

Opponents of the bill, including the Louisiana Primary Care Association, said there is no evidence that children are receiving substandard care in school-based clinics and said access would be reduced if Pearson's proposal becomes law.

The Federal Trade Commission also has weighed in on the matter, saying the bill "restricts competition among dentists and does not appear to provide any countervailing benefits."

Louisiana would become the first state to outlaw the practice by legislative fiat should the bill become law, though other states have moved to restrict such services through regulations issued by professional regulatory boards.

Barry Ogden, executive director of the Louisiana Board of Dentistry, which regulates dental care, said the board has not taken a position on the bill but might do so at its next meeting May 30.

Gov. Bobby Jindal's administration, which has taken a more active role in the legislative process this spring than in last year's regular session, also has not officially weighed in on the matter. But Health and Hospitals Secretary Alan Levine said the bill's opponents "make some valid arguments."

"The underlying issue here is access," Levine said.

The state Board of Elementary and Secondary Education voted recently to endorse the measure. But Joe Salter, director of government affairs for the Education Department, said that decision was based on inaccurate information provided by the bill's supporters and that the department is now rethinking its position.

<http://www.nola.com/news/t-p/capital/index.ssf?/base/news-7/124158799326600.xml&coll=1>

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EDITORIAL: Keep children smiling
The Times-Picayune | 06.06.09

Children need to visit the dentist regularly, just as they need checkups from their pediatrician or family doctor -- both are critical parts of staying healthy.

That's why it's hard to understand why Rep. Kevin Pearson of Slidell is sponsoring legislation that would actually make it harder for poor children to get access to this vital part of preventive health care. House Bill 687 would prohibit the practice of dentistry at elementary and secondary schools, with a few exceptions.

The bill is taking aim at mobile dental clinics that mainly serve children who are covered by Medicaid. The Louisiana Dental Association, which is backing the legislation, says the mobile clinic trend hurts "the lifelong relationship" between families and their dentists and asserts that such care is best provided in a "fixed, permanent" location.

Advertisement

But for many children -- especially those who are poor -- the choice is between a mobile clinic at their schools and no care, or at best sporadic care. Even if the dental association doesn't understand that, doctors do. The Louisiana Primary Care Association and the Louisiana chapter of the American Academy of Pediatrics both oppose this legislation, arguing that it would remove one of the few opportunities for dental care that poor children have.

The bill does allow some limited care to continue at schools. Programs that provide sealants for children's teeth, administered by state universities, would be permitted. So would free services that include screenings, cleanings, radiographs and fluoride treatments.

Those exceptions indicate that this is an economic issue for dentists, not a quality of care issue. It seems that it's perfectly fine for children to get their teeth cleaned at school instead of in a "permanent, fixed" location, as long as they're getting the work done for free. Once money is involved, though, the association is alarmed about the risk to the dentist/patient relationship.

The number of Louisiana dentists who are willing to treat Medicaid patients has increased as the Legislature has increased reimbursement rates, and their willingness to take Medicaid patients is a good development. But it doesn't completely solve the access issue. According to the Louisiana Department of Health and Hospitals, only 37 percent of Medicaid-eligible children in Louisiana have seen a dentist. Clearly, there's a need that is not being met.

The Federal Trade Commission, which also opposes this legislation, calls it an anti-competitive measure that would reduce access to care for poor children. Visiting a private office creates hardships for poor families who may lack transportation and who will have to miss work to take their children to an appointment, the agency pointed out in a letter.

"Faced with such obstacles, it is likely that many children will not receive dental care at all," the FTC wrote. That's not just anti-competitive, it's anti-child. The Legislature should kill this measure.

<http://www.nola.com/news/t-p/editorials/index.ssf?/base/news-5/12415872368820.xml&coll=1>

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SUNO, city worker tested for possible swine flu

The Times-Picayune | 05.06.09

By Ramon Antonio Vargas

Staff writer

A Southern University at New Orleans employee and a city worker are among 27 people possibly infected with the swine flu in Louisiana, a university spokesman and city officials said Tuesday.

So far, just one New Orleanian has a confirmed case of the H1N1 virus: an 8-year-old boy who attends Audubon Charter School, where he is in second grade. The case is one of seven in the state that have been confirmed. Besides the 27 still being investigated, two other Louisiana cases tested negative for swine flu.

In addition to the SUNO employee, there is at least one other suspected local case, which involves a city of New Orleans employee. On Tuesday, state officials announced they are investigating six more suspected cases of swine flu, including three cases in Lafourche Parish, one in Lafayette Parish, another in Iberia Parish and one in St. Martin Parish.

The six new cases bring the total number of suspected cases in Louisiana to 27, officials said. None of the 27 people has been hospitalized, officials said.

State officials are awaiting test results for the two suspected New Orleans cases, as well as 25 others that have been sent to the Centers for Disease Control and Prevention in Atlanta for confirmation. State health officials said the three cases in Lafourche Parish involve two adults and one child, who is not in school. The one suspected case in Lafayette and another in St. Martin are both adults, officials said in a release.

--- No schools closed ---

The Iberia Parish case involves a student who attends Catholic High School in Lafayette. Officials are not recommending the closure of the school because there are no other known illnesses there and in accordance with updated CDC guidance.

In New Orleans, SUNO spokesman Eddie Francis said Tuesday that the state Department of Health and Hospitals informed the university about the situation over the weekend. State health officials did not recommend that SUNO close while awaiting lab results from the CDC, Francis said.

University officials said they don't know much about how the employee got sick. They would not say what the employee does at the university.

The city employee, meanwhile, began experiencing flu-like symptoms after returning to work from a recent trip to San Antonio. The employee has responded well to anti-viral medications, according to a statement from Mayor Ray Nagin's office.

The state has gotten results back for the first nine samples it sent to the CDC for swine flu testing.

Of those nine, seven came back positive for the virus Sunday. Along with the Audubon Charter student, they include five students at Cathedral Carmel High in Lafayette and a 10-year-old student at Lake Elementary School in Ascension Parish.

Two other cases -- one in St. Tammany Parish and the other in St. Martin Parish -- came back negative, officials said.

All of Louisiana's swine flu patients are being treated at home with anti-viral drugs. Their symptoms don't appear to be more severe than those of the common flu.

--- Watch for symptoms ---

Gov. Bobby Jindal said Monday that residents should follow strict hygiene measures, but he warned against unnecessary alarm. "At any time during active flu season, we would have thousands of Louisianians suffering from flu symptoms," he said.

At SUNO, officials said students should watch out for typical flu symptoms, which include a fever of 100 degrees or greater, persistent coughing or a sore throat.

Francis said the DHH recommended that any student or employee experiencing any of those symptoms should be examined by their doctor and should not return to work or class until receiving results from the doctor.

Citing DHH recommendations, he asked university community members to wash their hands regularly, cover their mouths when coughing and avoid contact with ill people. He also asked students and employees to consider carrying hand sanitizer.

<http://www.nola.com/news/t-p/metro/index.ssf?/base/news-34/124158793226600.xml&coll=1>

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Benefits outweigh pitfalls in creating an electronic records system for health care

The Times-Picayune | 05.06.09

By Mike Cassidy

SAN JOSE, Calif.-Talk of a nationwide electronic medical records system has centered on cost, feasibility and whether it will provide better care.

But there is one potential benefit to such a system that few have talked about: the possibility of mining a massive database of patients, doctors, medical strategies, procedures and prescriptions to rein in costs based on statistics. In other words, a health care system that pays for what works, according to the numbers, and doesn't pay for what doesn't.

It seems so Silicon Valley: a clear-eyed, numbers-based system that points us all in the right direction. And yet: silence.

"Part of why you don't hear it yet is because I don't think anybody has figured it out very well," says Emily Lam, director of health care and federal issues for the Silicon Valley Leadership Group.

That's fair enough. We are still in the early stages of the latest discussion on how to rescue our abysmal \$2.3 trillion-plus health care system. There are huge issues to wrestle with: 46 million without health coverage, increasing costs, misaligned incentives, an aging population, the influence of for-profit insurance and pharmaceutical industries, the self-interests of doctors, hospitals and the patients they serve.

Those promoting electronic health records emphasize that having comprehensive information at doctors' fingertips would improve patient care. Doctors would be flagged when prescribing conflicting medications. They'd be alerted to alternative treatments. Patients could more carefully track doctors' instructions and monitor their progress with chronic diseases, such as diabetes.

And yes, they say, savings would result. Hospital stays could be better coordinated with the availability of staff and equipment, meaning they would be shorter. Redundant tests would be eliminated. More health care calls could be made without requiring a visit to the doctor.

As for using the same electronic information and powerful data mining tools to build a financial model that would discourage ineffective treatments?

"It's an ethical debate. It's a moral debate," says Dr. Robert Pearl, who as a Kaiser Permanente executive helps oversee the largest nongovernment electronic medical records system in the country. "It has to be held by people across the entire spectrum."

And it's a debate that should start now.

The beauty of these early discussions is that it's still hard to envision exactly what the system would look like. We are years-maybe 10, maybe more-from the possibility of a comprehensive national records system. Questions of ethics, law, logistics, technology and medicine still need to be settled. And so, we are free to talk about what a data mining component might look like. Or what we think it should look like.

The potential pitfalls are huge. Information identifying individual patients would have to be stripped from the files before any numbers were crunched. We'd need laws and regulations aimed at maximizing individual patient privacy and punishing those who would violate that privacy.

And who would control the information and determine which treatments are "effective" and which are "ineffective"? I'd vote for a government agency or a government-appointed panel of experts. Insurance companies, which appear to exist primarily to deny and decline coverage, would need to be kept at arm's length. Same for Big Pharma and other for-profit players.

The process has to be transparent. The raw data and the conclusions drawn from them should be publicly available. There needs to be an appeals process. And those who insist on a treatment deemed ineffective should have the option of paying full freight for the procedure (provided they find a willing doctor).

Is that the outline of a perfect system? Hardly. There are probably better ideas.

But here's the thing: Our health system is so dysfunctional that doing nothing isn't feasible. Coming up with something better is going to require all of us-doctors, insurers, patients, hospital administrators, big businesses, labor, government entities-to accept changes we are not entirely comfortable with.

Yes, there will be losers. But if we can get it right, the overall health-care system will come out a winner.

<http://www.nola.com/newsflash/index.ssf?/base/business-6/124161553557230.xml&storylist=health>

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State workers merit a raise
The Times-Picayune | 05.06.09
Mary H. Frieshon

Re: "Popular speaker tests his leadership," Other Opinions, April 29.

State employees are well trained, dedicated public servants. We are the state's most valuable resource. The annual merit increase is the only opportunity most employees have for a pay increase, as automatic cost of living increases are not included in our pay plan. Our last cost of living increase was granted in 1990.

With average service of 10-plus years, why is it surprising that 96 percent of us would be granted a merit increase based on job performance?
Advertisement

Each employee is granted a merit increase only after receiving at least a satisfactory performance planning review. The review is a detailed document with performance standards and expectations clearly outlined. The pay plan does have minimum and maximum pay scales for each position, so 4 percent raises are not infinite. In my 35-plus years as a state employee, I have spent many years at the top of the pay scale for a position with no raise.

Also worth noting is the fact that starting salaries for state employees are so low that attracting quality employees is an ongoing challenge and retention is impossible. This results in constant hiring and training of new employees which is a waste of time and resources.

Mary H. Frieshon

Administrative law judge

Disability Determinations

New Orleans

<http://www.nola.com/news/t-p/letterstoeditor/index.ssf?/base/news-13/12415872308820.xml&coll=1>

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State officials now investigating 5 new cases of H1N1 flu
The Town Talk | 05.05.09

BATON ROUGE -- Louisiana health officials have sent five more suspect cases to the Centers for Disease Control for testing to see if they contain the H1N1 virus.

Four of the cases involve students in Catholic schools in Lafayette -- two from Our Lady of Fatima, one from St. Pius Elementary and one from Cathedral Carmel where four students have been confirmed as having H1N1, commonly referred to as swine flu.

The fifth case is an adult from Gonzales in Ascension Parish. A swab from a Gonzales student already has been sent to CDC for testing but health officials say there appears to be a link between the girl and the man.

"This increases the total number of suspect cases to 21 pending CDC confirmation," Gov. Bobby Jindal said at an afternoon press briefing. He said that based on CDC reports showing that 99 percent of the cases sent to it have been confirmed as being swine flu, he expects that a high number of the cases from Louisiana will be confirmed.

Seven cases in the original group of nine sent to CDC last week came back positive for H1N1.

CDC is backlogged with cases sent from around the country, he said, so it could be more than four days before the state is notified of other results.

H1N1 is no more virulent than normal flu, the governor said, but it's attracting so much attention because "the big difference is people don't have built-in immunity and there's no vaccine" to stop the spread.

The CDC Web site earlier said Louisiana had 14 confirmed cases of H1N1 but was later corrected to show only 7. Jindal said he was told it was "a clerical error."

SUSPECTED H1N1 CASES

Lafayette Parish - 16 (up from 12 yesterday)

Ascension Parish - 1 (none suspected as of yesterday)

Orleans - 1

Beauregard - 1

St. Landry - 1

Iberia Parish - 1

CDC-CONFIRMED H1N1 CASES

Lafayette Parish - 5 Orleans - 1

Ascension - 1

CDC-NEGATIVE H1N1 CASES

St. Martin - 1

St. Tammany - 1

211 Line Active The state has activated the 211 statewide information and referral phone network to help people throughout the state get information on the H1N1 virus, how it is affecting their area and how they can take measures to prevent the spread of illness. Operators are being updated as the state reports additional information on the virus.

Protecting Your Family

Make sure you:

Cover your nose and mouth with a tissue when you cough or sneeze. Throw the tissue in the trash after you use it.

Wash your hands often with soap and water, especially after you cough or sneeze. Alcohol-based hand cleaners are also effective.

Avoid close contact with sick people.

If you get sick with influenza, CDC recommends that you stay home from work or school and limit contact with others to keep from infecting them. Avoid touching your eyes, nose or mouth. Germs spread this way.

Symptoms of the H1N1 virus (swine flu) include: fever, cough, sore throat, body aches, headache, chills and fatigue.

If you are experiencing these symptoms - Consult your doctor as soon as possible.

Visit www.FluLa.com for the latest information on the H1N1 virus.

Additional Facts

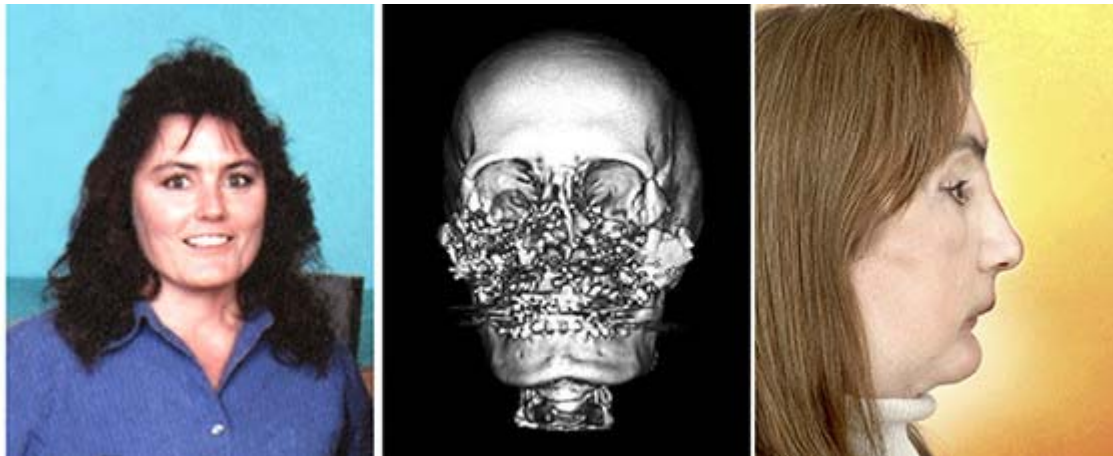
What you need to know about the flu pandemic

- * Ongoing coverage from USA TODAY.
- * Video from KXTV-TV in Sacramento, answers from a doctor who specializes in infectious diseases.
- * Interactive tracking map from USA TODAY.
- * Centers for Disease Control and Prevention.
- * CDC Twitter page.
- * Twitter links to all posts tagged with #H1N1 and #swineflu.
- * World Health Organization.
- * Links to state health agencies.
- * Federal flu pandemic site.
- * State Department, advisory on travel in Mexico.
- * Centers for Disease Control and Prevention, if you're traveling to Mexico.

<http://www.thetowntalk.com/article/20090505/NEWS01/90505012>

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Face-Transplant Patient Emerges
The Wall Street Journal | 05.06.09
 By RON WINSLOW



Cleveland Clinic

Connie Culp, left, before the injury that destroyed most of her face in 2004. Center, a CT scan shows the extent of the damage inflicted by a shotgun blast. At right, Ms. Culp after her December 2008 surgery.

A 46-year-old Ohio woman revealed Tuesday that she is the first U.S. recipient of a face transplant, a procedure that embodies both the promise of major medical advances and the ethical and economic challenges they can pose for society.

Connie Culp underwent a 22-hour procedure at the Cleveland Clinic in December to restore function to a face that was ravaged by a shotgun blast in 2004. The wound left her without a nose, lower eyelids, upper jaw, palate and other features, and she had been unable to breathe on her own, eat solid food, smell or smile. Ms. Culp had been unable to leave her home without being shunned by others and teased by children.

At a news briefing Tuesday, the team of eight doctors that performed the operation reported that the surgery will enable her to drink from a cup, eat solid food, smell and breathe through her nose. The surgeons removed most of the face of a deceased donor and placed it onto Ms. Culp like a mask, incorporating portions of her own visage. About 80% of the patient's face was replaced.

video

Doctors Perform Successful Face Transplant

1:21

Surgeons at the Cleveland Clinic performed the first near-total face transplant on a 46-year old woman. The 22-hour procedure will enable her to eat solid food, smell and breathe through her nose again, doctors say.

Health Blog

* Face Transplants: Further Reading

"We think this...procedure has changed her life dramatically," said Maria Siemionow, director of plastic-surgery research at the clinic and the leader of the surgical team. The clinic had disclosed the surgery in December, but not the patient's name.

Ms. Culp decided to go public because she is about to return to her hometown and clinic officials worried she would be besieged by media inquiries, according to Eileen Sheil, the clinic's executive director for public and media relations. In addition, Ms. Culp told clinic staff that she wants speak out on behalf of others whose lives are affected by prejudice against the way they look.

The operation reflects how doctors are advancing the frontiers of transplant surgery, devising increasingly complex procedures and using them to improve lives, not just to save them. French surgeons performed the first partial face transplant in 2005. Just Tuesday, the University of Pittsburgh Medical Center said its doctors performed the first double hand transplant in the U.S. Hands have been transplanted for about a decade.

Unlike, say, heart or kidney transplants, which are focused on one specific type of tissue, the face involves skin, muscle, nerves, glands and other structures.

Patients receiving any tissue from a donor need to take antirejection drugs that carry risk of infection, posing an ethical problem when the transplants aren't done to save or prolong life. Indeed, doctors said that concern has lately been more of an impediment than the technical ability to perform such procedures.

Expense is another issue. While the clinic didn't provide data on what Ms. Culp's procedure cost, doctors estimated it would be \$300,000 to \$400,000 -- steep for a procedure that isn't considered life-saving. And that doesn't include much of the extended care associated with transplant surgery. (Doctors donated their time in Ms. Culp's case.)

While it is hard to say how many people in the U.S. might be candidates for such a procedure, clinic officials believe it is in the thousands. Many soldiers in the Iraq war, for example, suffered major facial injuries.

The ethical concerns associated with the procedure help explain why doctors emphasized that Ms. Culp's face transplant wasn't done for aesthetic reasons. "The fact that there has been some recovery of function is important," said Eric Kodish, chairman of bioethics at the clinic. "This is not cosmetic surgery in any sense of the word."

[Connie Culp, second from left, who underwent the first face transplant surgery in the U.S.] Associated Press

Connie Culp, second from left, who underwent the first face transplant surgery in the U.S., at a news conference at the Cleveland Clinic in Cleveland on Tuesday.

The circumstances surrounding Ms. Culp's injury weren't addressed Tuesday, but news reports prior to her surgery say she was shot by her husband in an apparent murder-suicide attempt in 2004. He also survived and is serving a seven-year prison sentence. In the years before the transplant, Ms. Culp had 30 different reconstructive surgeries, but none effectively restored the lost functionality.

Ms. Culp was chosen for a transplant for both the seriousness of her injury and what doctors described as a positive attitude, making it more likely she would stick to a medication regimen.

The first concern among doctors was whether blood vessels that needed to be attached to vessels in the donated tissue would be too scarred from previous surgeries, said Frank Papay, chairman of the dermatology and plastic-surgery institute at the Cleveland Clinic and a member of Ms. Culp's surgical team. But it turned out her vessels were OK.

Dr. Papay recalled that when doctors were ready to remove clamps that would enable blood to flow into the donated tissue, "It was a cadaver face, it was pale and white. We released the clamps, it turned rosy pink." There was a "collective sigh" of relief in the operating room.

Ms. Culp's appearance is different from before the shooting but, except for excess skin doctors plan to remove in 12 to 18 months, she has a near-normal-looking face.

At the briefing, she thanked the family that allowed facial tissue to be donated and the doctors and nurses who cared for her. Ms. Culp didn't take questions or describe how her life has changed, but has told people at the clinic that she remembers the first kiss from her grandson that she could feel. Before the surgery, she had so much scar tissue her face had no feeling.

<http://online.wsj.com/article/SB124155639530788847.html>

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Flu Fighters

The New York Times | 05.05.09

By Randy Cohen

“Wash your hands when you shake hands; cover your mouth when you cough,” President Obama urged us at last Wednesday’s news conference when discussing the swine flu. “I know it sounds trivial, but it makes a huge difference. If you are sick, stay home. If your child is sick, keep them out of school. If you are feeling certain flu symptoms, don’t get on an airplane, don’t get on a — any system of public transportation where you’re confined and you could potentially spread the virus.” Is such modest, homespun advice merely good manners, or is it a moral injunction?

This guidance rises to the level of ethics because it concerns the effect of our actions on other people. Etiquette codifies behavior that is merely a matter of form and hence apt to have a trivial impact on others. Whether or not to rob a guy? Ethics. Whether or not to curtsy after robbing a guy? Etiquette. Similarly, the old-school demand that a man on a bus surrender his seat to a woman — any woman, no matter how robust — is etiquette, a social convention (and a sexist one at that). A better approach is for a seated passenger, man or woman, to offer a seat to anyone in need, regardless of gender — a frail older man, a very pregnant woman, a weary Joe Biden (should he muster his courage and return to public transportation). This is ethics (albeit small-scale ethics): an effort to assist those who need it.

And so is Obama’s hand-washing recommendation, echoing the wise counsel that our parents gave us when we were children and that Ignaz Semmelweis gave to medical students in the maternity clinic at the Vienna General Hospital in 1847. It is an ethical imperative, meant to mitigate the harm we might do to others. That hand-washing also diminishes your own chance of becoming ill makes it more desirable, though it does not further elevate the moral status of the act. In ethics, intent counts; the reason why you wash your hands matters. (That’s not to deny, of course, the virtue of sparing the community the costs of your infirmity — medical care, missed work — a rationale sometimes used to justify seatbelt or helmet laws.)

The Takeaway With Randy Cohen

Those presidential dictates, while fundamentally ethical, are not universally applicable. Some employees, particularly low-wage workers, risk losing pay or even getting fired if they stay home from work to avoid infecting their coworkers. If we expect individuals to act ethically, we have a societal obligation to protect them when they do — for instance, by guaranteeing paid sick days to all.

Another argument for a community response, for the practice of civic virtue: even if someone displays impressive individual rectitude, he may still unknowingly infect other people with swine flu (or, if you prefer a more pork-chop-friendly designation, the H1N1 virus). Dr. Michele Barry, the dean of Global Health at Stanford University, says, “You may not be aware you are transmitting it early on.” People can be contagious for as long as six days before displaying any symptoms — and, she adds, “longer in kids and immuno-compromised folks.”

Some healthy people have taken aggressively individualistic action, asking a friend or relative who is a doctor for prescriptions for Tamiflu, an antiviral medication, to keep around the house just in case. To make such a request is unwise, to honor it unethical. In most cases, doctors “should certainly not be in the business of writing prescriptions for those they have neither examined nor taken a medical history” from, says Dr. Tia Powell, who is the director of the Montefiore-Einstein Center for Bioethics. And while it can be awkward for a doctor to turn down the aunt who will host the family’s next Thanksgiving dinner, that is what medical ethics requires (as I discussed in “The Ethicist” in 2005, responding to a query about avian flu).

A healthy person should not ask such a thing even of his or her own physician. To hoard antiviral medications can make them unavailable to those in immediate need. Temporary local shortages have been reported from New York to Honolulu. Even if there were unlimited supplies of antiviral agents, Barry would caution against their prophylactic use, except by people traveling to the center of the epidemic, because using such medications improperly can breed Tamiflu-resistant strains of the virus.

Thus some individual actions, like the presidentially endorsed washing of hands, are genuinely ethical, while others, like stocking up on antiviral medications, are not. Each must be judged on its merits. What's more, universally esteemed acts do not obviate the need for community actions. And even those we deem outside the realm of ethics, that we consider to be matters of etiquette, can still be valuable social lubricants. Samuel Johnson was a great defender of politeness, calling it "fictitious benevolence" and asserting that "the want of it never fails to produce something disagreeable."

<http://ethicist.blogs.nytimes.com/2009/05/05/flu-fighters/?ref=health>

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Cooking Up Millions of Viruses for a New Vaccine

The New York Times | 05.05.09

By DENISE GRADY



Béatrice de Géa for The New York Times

Research assistants at New York Medical College on Tuesday prepared to harvest swine flu virus that had been grown in eggs.

VALHALLA, N.Y. — As soon as Doris Bucher learned that a new strain of swine flu had turned up in the United States, she e-mailed the Centers for Disease Control and Prevention offering to send materials that might be useful in making a vaccine.

Her colleagues at the C.D.C. had a better idea. Less than a week later, they sent a sample of the new type of virus, influenza A(H1N1), to Dr. Bucher, an associate professor of microbiology and immunology at New York Medical College.

Dr. Bucher, a cheerful, fast-talking scientist who has been involved in flu research for 40 years, runs a laboratory here in Westchester County that is highly regarded for its skill at turning flu viruses into “seed stock” — a form of the virus that will grow rapidly in eggs so that drug companies can use it to make hundreds of millions of doses of vaccine.

Federal health officials have not yet decided whether to call for a swine flu vaccine, but they say it is important to be ready for quick production of millions of doses. Because the virus is new, some people may need two shots to build immunity. The vaccine would probably be separate from seasonal flu vaccine, meaning a total of three shots might be recommended for certain people.

Creating the seed stock is an essential first step for any vaccine. So the C.D.C. has sent samples of the new strain to about 10 other government and academic laboratories in this country, Australia, Britain, Hungary and Russia. For the past five years, Dr. Bucher’s laboratory has provided seed stock for one of the virus strains included in the seasonal flu vaccine used all over the world.

“Our job is to make it grow really well,” she said. “We’re good at this.”

One of the group’s strengths has been in developing a “high-yield donor,” meaning an influenza virus that grows well in eggs and that, when injected into eggs along with a new strain like H1N1, will swap some of its genes with the new strain. An array of new viruses results, and the researchers can sort through it to pick ones that have donor genes inside the ball-shaped viral particles, so they will grow well in eggs, but that will retain the new strain’s traits on the outside — enabling the vaccine to spark immunity when injected into people.

The unlikely headquarters of this major player in the world's supply of flu vaccine is a modest cluster of small to midsize laboratories with a half-dozen freezers, a walk-in incubator at 95 degrees Fahrenheit and a walk-in cold room. In the midst of it all is Dr. Bucher's cluttered office, her desk awash in documents like "virus certificates" from the C.D.C. and handwritten bills for 84 dozen eggs.

A vial containing millions of swine flu viruses in a milliliter of fluid (about a fifth of a teaspoon) arrived at her lab on April 28, packed with dry ice in a plastic foam box inside a cardboard carton stamped, "infectious substance affecting humans."

The viruses had been grown from a cotton swab rubbed in the nose and throat of a child in California who received one of the first diagnoses of the flu in this country.

Dr. Bucher's team opened the box in a laboratory hood, a specially ventilated compartment that prevents any samples from escaping, and set to work. Wearing specially fitted masks, double gloves, surgical caps and other protective gear, their first task was to make more of the virus, by injecting it into fertilized eggs from leghorn hens. Creating seed stock is a quirky business that melds high-tech science and simple tools from 100 years ago. In one lab, members of the team amplify virus genes, cut them up with enzymes and analyze their origins. In others, their colleagues candle eggs, mark the shells with a pencil, pierce them with a drill bought at Sears and shoot them full of swine flu viruses.

Basically, the process involves repeated rounds of injecting the two types of virus into eggs, and sorting and purifying what grows. Each round of virus growth takes about 42 hours. The ultimate goal is to create a uniform seed stock from a single virus, and to produce 80 vials of it, each containing millions of viruses, that will be sent to drug companies, the C.D.C. and the Food and Drug Administration. Dr. Bucher said she expected to ship out those 80 vials by May 25.

Members of the research team said they were used to working with flu viruses, and this one did not alarm them. Rene Devis, a research associate, admitted that he did feel a bit concerned at first.

"But you do what you have to do, especially if you can help save a life," Mr. Devis said. "You don't think of yourself."

The swine flu came along just about a week after Dr. Bucher's team had finished a seed stock for the next seasonal flu vaccine and started work on other projects.

Now they are back to flu viruses, and working so hard that Dr. Bucher fears they will burn out.

What if they make a seed stock, and then health authorities decide there is no need to make a vaccine after all?

"We'll put it in the freezer," Dr. Bucher said.

http://www.nytimes.com/2009/05/06/health/research/06vaccine.html?_r=1&ref=health

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Obama Seeks a Global Health Plan Broader Than Bush's AIDS Effort

The New York Times | 05.05.09

By SHERYL GAY STOLBERG

WASHINGTON — President Obama asked Congress on Tuesday to spend \$63 billion over the next six years on a new, broader global health strategy that would reshape one of the signature foreign policy efforts of his predecessor, George W. Bush.

Mr. Bush made combating global AIDS a centerpiece of his foreign agenda. The program he created — the President's Emergency Plan for AIDS Relief, or PEPFAR — is regarded as one of his most significant achievements. But the plan Mr. Obama outlined Tuesday envisions a more far-reaching approach to global health that would focus not only on AIDS, but also on tropical diseases and other treatable and preventable illnesses that kill millions, many of them children, each year.

"We cannot simply confront individual preventable illnesses in isolation," the president said in a statement released by the White House that cited the swine flu outbreak as an example. "The world is interconnected, and that demands an integrated approach to global health."

In announcing the request, the White House said Mr. Obama was seeking \$51 billion to fight AIDS, tuberculosis and malaria during the six years and \$12 billion for other global health priorities. His budget proposal calls for \$7.4 billion for AIDS, malaria and tuberculosis in 2010, an increase of \$366 million over this year.

But as a candidate, Mr. Obama promised to expand PEPFAR "by \$1 billion a year in new money over the next five years" and said that he would provide "\$50 billion" by 2013 to fight the pandemic." The White House said Tuesday that Mr. Obama would meet the \$50 billion goal, but over six years instead of five. The White House did not provide additional specifics on how the money would be spent in future years.

"We continue to support PEPFAR," Deputy Secretary of State Jack Lew said. "We're saying we want to take what we know works and expand it because we can make a big difference in the world."

But some AIDS advocacy groups were furious on Tuesday and accused Mr. Obama of breaking his promise. Officials at the Infectious Diseases Society of America, which represents infectious disease specialists, called the increase "meager" and said poor countries were cutting back on their health budgets because of the worldwide economic crisis.

"They are expanding the mandate, but not expanding the pie," said Dr. Paul Zeitz, executive director of the Global AIDS Alliance, a Washington-based advocacy group. "To me, this is a betrayal of trust."

But Mr. Obama's plan drew praise from Bono, the rock star and antipoverty advocate. "Today, 'Doctor Obama' leads the next chapter in the U.S. response to global health crises," he said in a statement released by One, the advocacy group he founded.

The White House released the numbers on Tuesday to provide a preview of a more detailed budget proposal it plans to release on Thursday. Two senior advisers to Mr. Obama — Gayle Smith, an expert on African affairs and developing nations, and Dr. Ezekiel J. Emanuel, a health policy expert — briefed advocacy groups on the plans on Tuesday, while Mr. Lew made a surprise appearance at the regular White House briefing to talk to reporters.

The plan appears to closely reflect the thinking of Dr. Emanuel, who is the older brother of Rahm Emanuel, the White House chief of staff. Last year, Dr. Emanuel and Colleen C. Denny published a commentary in the Journal of the American Medical Association in which they argued for a broader global public health approach.

"By extending funds to simple but more deadly diseases, such as respiratory illnesses and diarrheal illnesses, the U.S. government could save more lives — especially young lives — at substantially lower

cost,” they wrote, adding that Pefpar “fails to address many of the developing world’s most serious health threats.”

<http://www.nytimes.com/2009/05/06/health/policy/06medical.html?ref=health>

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