

IN THE NEWS

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Learn about respiratory health at Chabert Daily Comet | 07.28.08

HOUMA – Locals can get ready for the cold and flu season by attending Leonard J. Chabert Medical Center's first annual Chronic Lung Day.

The C.L.A.S.S., or Chronic Lung Awareness Signs and Symptoms event, will be held from 10 a.m. to 3 p.m. Thursday in the education building adjacent to Chabert Medical Center, 1978 Industrial Blvd.

The event is free and open to the public. Officials hope to increase public awareness about lung disease, will feature staff consultations and demonstrations, displays by pharmaceutical vendors, educational literature, refreshments, and door prizes.

Free spirometry testing will be offered by the Pulmonary Department at Chabert with results reviewed by a physician on site.

http://www.dailycomet.com/article/20080728/HURBLOG/591515842/1224&title=Learn_about_respiratory_health_at_Chabert

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Cancer society hosts events

The Advertiser | 07.29.08

From staff reports

The American Cancer Society will offer the following programs and events in August for the Acadiana area:

Shooting For Hope Sporting Clay Shoot

Aug. 2: Tournament begins at 8 a.m. at GOL Shooting Center, 11919 La. 697, Maurice, and includes five-stand and flurry competitions, as well as a silent auction. All proceeds will benefit the Relay For Life of Vermilion Parish. Contact Ike Sagrera for more information at 319-3505.

Ride For Cancer

Aug. 9: Registration begins at 8 a.m. at Honda of Lafayette, 1708 N. University Ave. Entry fee is \$25 per rider and \$15 per passenger. Lunch will be provided to all participants upon arrival at the Paragon Casino and Resort. Please contact Denova Brown for more information at 278-5731.

Look Good...Feel Better

Aug. 11: This program is dedicated to teaching female cancer patients beauty techniques to help restore their appearance and self-image during cancer treatments. **Class begins at 2 p.m. at University Medical Center, 2390 W. Congress St., Lafayette.** Please call the American Cancer Society at 237-3797 ext. 0 to register for this free program.

Reflections of Hope Patron Party

Aug. 14: Party is set for 6 p.m. at the Wine Loft, 201 Settlers Trace. Contact the American Cancer Society at 237-3797 ext. 3 for more information.

Fore A Cure Corporate Golf Kick-Off

Aug. 21: Event starts at 6 p.m. at the Petroleum Club, 111 Heymann Blvd. Contact the American Cancer Society at 237-3797 ext. 3 for more information.

Reflections of Hope Gala: An Evening of Art & Wine

Aug. 23: Gala starts at 7 p.m. at the Lafayette Natural History Museum & Planetarium, 433 Jefferson St. Spirit of Hope awards will be featured and tickets are \$100 per person. Contact the American Cancer Society at 237-3797 ext. 0 for information or tickets.

<http://www.theadvertiser.com/apps/pbcs.dll/article?AID=/20080729/NEWS01/807290315/1002>

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Letter: Teachers shouldn't have nurse duty

The Advocate | 07.28.08

Doris Mueller

It was surprising to read in the July 20 Health pages of the People section that because of cuts in funding for school nurses, teachers are now being required to treat their students' medical conditions.

While nursing and education are fields whose members are dedicated to helping others, their training and talents are certainly not interchangeable. I can't imagine a nurse being expected to teach algebra class.

With so much being asked of our teachers these days, how can we expect them to solve this problem for us, too? Surely we can leave health care in the hands of those trained for it.

I believe most parents want to know that there is a trained health-care professional at their child's school to deal with possible allergic reactions, asthma attacks and other potentially serious illnesses. A school nurse can mean the difference between life and death if a child should have a life-threatening injury or illness.

If there is enough tax money to provide for sports teams at almost every school (which I think is good for the students), then surely there is enough to provide for something this important, as well.

Doris Mueller
Administrative Assistant/LSU student
Baton Rouge

<http://www.theadvocate.com/opinion/25967684.html>

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Study: 'Pre-dementia' is rising, especially in men

The Times-Picayune | 07.28.08

By MARILYNN MARCHIONE

The Associated Press

CHICAGO (AP) — A milder type of mental decline that often precedes Alzheimer's disease is alarmingly more common than has been believed, and in men more than women, doctors reported Monday.

Nearly a million older Americans slide from normal memory into mild impairment each year, researchers estimate, based on a Mayo Clinic study of Minnesota residents.

That's on top of the half million Americans who develop full-blown Alzheimer's or other forms of dementia — a problem sure to grow as baby boomers age. The oldest boomers turn 62 this year.

"We're seeing that in fact there's a much larger burgeoning problem out there" of people at risk of developing dementia, said Dr. Ronald Petersen, the Mayo scientist who led the study.

Dr. Ralph Nixon, a New York University psychiatrist and scientific adviser to the Alzheimer's Association, was blunt.

"We're facing a crisis," he said.

There are no treatments now to prevent this mental slide or reverse it once it starts.

But that may be changing. Researchers on Monday reported early, somewhat encouraging results from an experimental nose spray that seemed to improve certain memory measures in a study of mildly impaired people.

The drug, for now just called AL-108, needs testing in a longer, larger study. It is being developed by Allon Therapeutics Inc., based in Vancouver, B.C.

Doctors said it shows the potential for new types of medicines that target the protein tangles that kill nerve cells, instead of targeting the sticky brain deposits that have gotten most of the attention up to now.

The studies were reported at the International Conference on Alzheimer's Disease in Chicago.

Petersen is the scientist who defined mild cognitive impairment, or MCI, as a transition phase between healthy aging and dementia. It is more than "senior moments" like forgetting where you parked the car, but not as severe as having dementia, where you forget what a car is for.

People with it have impaired memory but not other problems like confusion, inattention or trouble putting thoughts into words.

The Alzheimer's Association says more than 5 million Americans have Alzheimer's, but no estimate for this "pre-dementia" has been available until now.

Petersen's federally funded study involved roughly 1,600 people, ages 70 through 89, living in Olmstead County, which surrounds the Mayo Clinic in Rochester, Minn. All tested normal when they were enrolled in the study, but more than 5 percent had developed mild impairment when evaluated a year later.

Men were nearly twice as likely as women to develop it. That's a surprise, because some studies have found more women with Alzheimer's than men. But there may be a simple explanation:

Even though more men may be impaired, women outlive them and therefore have more time to develop full-blown dementia.

"This is a very large and important issue for our country and for the world," said Duke University psychologist Brenda Plassman. A smaller study she published earlier this year backs up the Mayo study's findings.

The mild impairment rate is two to three times larger than many researchers had expected, Petersen said.

"It's the iceberg under the tip," agreed Dr. R. Scott Turner, incoming director of the memory disorders program at Georgetown University Medical Center. A prime goal is finding drugs to treat the mild impairment before Alzheimer's develops.

The AL-108 study tried to do that. Scientists gave 144 people with mild impairment either a low or high dose of the drug or a dummy drug for 12 weeks. The study missed its main goal — a composite of various memory scores — and the low dose showed no effect. But those on the higher dose improved on some memory tasks after one month and benefits lasted a month after they stopped treatment, said the study's leader, Dr. Donald Schmechel of Duke University.

The study was sponsored by the drug maker.

In another study presented at the conference on Sunday and published on the Internet by the British medical journal The Lancet, researchers reported that dementia rates in developing countries may be considerably higher than official estimates and closer to rates in wealthy countries.

Scientists used a more liberal definition of dementia more suitable to poorer, less educated populations, where respect for family often means relatives don't regard dementia as a burden so much and may be less likely to report problems.

The study involved nearly 15,000 people in 11 sites from China, India, Cuba, Mexico and other nations. Dementia rates ranged from nearly 6 percent in rural China to nearly 12 percent in the Dominican Republic, said co-author Martin Prince of King's College in London.

The World Health Organization and the Alzheimer's Association were among the study's sponsors.

<http://www.nola.com/newsflash/index.ssf?/base/national-9/1217291654265890.xml&storylist=health&thispage=1>

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More fit Alzheimer's had less brain atrophy

The Times-Picayune | 07.28.08

The Associated Press

NEW YORK (AP) — Patients in the early stages of Alzheimer's disease who performed better on a treadmill test had less atrophy in the areas of the brain that control memory, according to a study released Sunday.

Magnetic resonance imaging (MRI) showed less shrinkage in the hippocampus region of patients' brains in the Alzheimer's patients with higher fitness scores. In Alzheimer's the hippocampus is one of the first parts of the brain to suffer damage.

Exercise and physical fitness have been shown to slow age-related brain cell death in healthy older adults.

The new study was released at the International Conference on Alzheimer's Disease in Chicago. Researchers at the University of Kansas Medical Center in Kansas City, Kan., studied the connection between cardiorespiratory fitness and regional brain volume in more than 100 people over 60. About half were healthy older adults and half were in the early stages of Alzheimer's.

In a statement, lead researcher Robyn A. Honea said the study suggests "that maintaining cardiorespiratory fitness may positively modify Alzheimer's-related brain atrophy."

But it isn't clear whether exercise helped avoid brain damage or if brain-damaged people had less ability to exercise.

The study was funded by the National Institute on Aging and National Institute on Neurological Disorders and Stroke.

<http://www.nola.com/newsflash/index.ssf?/base/national-9/1217212144242860.xml&storylist=health>

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Help wanted: U.S. has a shortage of trained health workers

Los Angeles Times | 07.27.08

By Mary Engel

Los Angeles Times Staff Writer



Allen J. Schaben/Los Angeles Times

Hector Hernandez, a respiratory care practitioner for 22 years, checks the tracheostomy tube of a 14-month-old patient at Kaiser Permanente Los Angeles Medical Center. People in his profession are largely unknown to the general public, even though they are lifesavers. The nation is experiencing a shortage of respiratory therapists and others in allied healthcare fields.

During a typical 12-hour shift, Hector Hernandez can be found in just about any corner of Kaiser Sunset, tending to premature infants and the elderly, to patients with asthma and those with AIDS, to heart attack victims and survivors of car wrecks.

He connects patients to ventilators, evaluates lung capacity and blood gases and administers oxygen and aerosol medications. Clad in green scrubs and white running shoes, he is often the first to arrive on a "code blue" -- the term that is broadcast when a patient has stopped breathing.

Yet most of those he sees probably could not name his occupation. Hernandez, 49, is not a doctor or a nurse but a respiratory care practitioner.

"A lot of people don't hear much about respiratory therapists," he said. "We're there. We help you. We're gone."

Many patients also probably don't know that there are barely enough respiratory care therapists to go around.

Most people have heard about the nationwide nursing shortage. But the country is also experiencing a shortage of trained workers in the "allied health professions" -- respiratory care practitioners, medical transcriptionists, radiographers and about 200 other occupations that make up about 60% of healthcare workers.

"We call them the hidden healthcare workforce," said Susan Chapman, director of allied health studies at the UC San Francisco Center for the Health Professions. "In the policy arena, there isn't a lot of attention being paid to those folks."

Yet the care they provide is vital. "You can't run a hospital without people to take the X-rays or do the lab tests," Chapman said.

According to a recent study, California, with its burgeoning population, lags behind the rest of the nation in the number of allied health professionals per capita.

If he wanted to, Hernandez, who has worked at Kaiser Permanente Los Angeles Medical Center in Hollywood for 22 years, could moonlight at three hospitals a week.

And as baby boomers like Hernandez, who now make up much of the allied health workforce, begin to retire, demand is expected to outstrip supply in at least nine of 15 occupations surveyed. Those with the highest projected need include pharmacy technicians, dental hygienists and physical therapist assistants.

"The aging of the population is a double whammy," said Michele Siqueiros, executive director of the nonprofit Campaign for College Opportunity. "It drives up demand [for health services] at the same time that people will be retiring from the very jobs that will be needed."

The campaign, a coalition of California business, labor and community groups, joined with Kaiser Permanente and the California Wellness Foundation last fall to commission the study.

The allied health profession is a large and varied group. Some, like laboratory scientists (who analyze blood and other bodily fluids), need a bachelor's degree. Pharmacists, licensed social workers and physical therapists need advanced degrees.

But most allied health jobs do not require four years of college. Training programs after high school can lead to state certification to be an emergency medical technician (who provides emergency care and transport) or a pharmacy technician (who counts pills, labels bottles and works the pharmacy counter). Community colleges offer two-year associate degrees for medical radiographers (who position patients for mammograms and other imaging machines) and for respiratory care practitioners like Hernandez.

And although some jobs are relatively low-paying -- the median wage for an EMT in 2005-06 was \$12.19 an hour -- others pay two or three times that, according to the study. The median wage for dental hygienists was \$36.83. The highest median wage was for pharmacists, at \$53.03.

Yet despite the decent pay, to meet the need for clinical laboratory scientists -- median wage, \$32.36 an hour -- the state would have to produce 559% more graduates in that field alone in the next six years, the study found.

"Laboratory sciences are just critical to our delivery of healthcare in an acute-care hospital," said Roger E. Seaver, president and chief executive of Henry Mayo Newhall Memorial Hospital in Valencia. "But they are out of sight, out of mind."

The factors driving the shortages are similar to those behind the nursing shortage, experts say.

Allied health workers make more money in the clinic than in the classroom, leading to faculty shortages. Community colleges, underfunded and independently operated, do a poor job of letting students who are on a waiting list at one college know about available seats at another.

Attrition rates are high because many students are ill-prepared academically when they enter college and juggle classes with work and family obligations. Little is offered in the way of tutoring, counseling or financial aid.

Public-private partnerships to fix some of these problems in nursing education are already showing results, said Siqueiros, who is calling for similar steps -- and funding -- for the allied health fields.

Some hospitals, Kaiser among them, already work with community colleges to recruit and prepare students.

When Jerry Saldana became manager of respiratory care services at Kaiser Sunset, he knew that wages didn't explain the problems he was having filling vacancies: The starting salary for respiratory care practitioners right out of school is \$29 an hour plus full benefits. There just weren't enough applicants to go around. So he set up partnerships with East Los Angeles College, Mt. San Antonio College in Walnut and Concorde Career Colleges to do the clinical training, which makes up the program's second year, at Kaiser.

"We get to see the students here for a year, train them here," he said. "I've hired quite a few right out of school."

The worsening economy has sparked interest in the program among mid-career workers who have lost their jobs to downsizing or are seeking stable work. The field also attracts immigrants who worked in a health profession in their home countries.

"We're making some ground on the awareness side," said UC San Francisco's Chapman. "But we still have a long way to go to have a serious, sustained commitment to this. Like in nursing, it's not something that's going to be resolved overnight."

<http://www.latimes.com/news/la-me-shortage27-2008jul27,3,7797518.story>

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Hospitals, using single-bed rooms and improved ventilation, work to get healthier
Los Angeles Times | 07.28.08

By Lisa Zamosky



Mel Melcon / Los Angeles Times

FROM ROOM TO ROOF: At Kaiser Permanente's new Panorama City hospital, air is exhausted directly so infections aren't circulated.

WITH hospital-acquired infections claiming more American lives each year than AIDS, breast cancer or automobile accidents, it seems the very facilities built to heal us have themselves become dangerous places.

Two million patients each year suffer from a hospital-acquired infection, the federal Centers for Disease Control and Prevention say, and nearly 100,000 of them die as a result. Architects believe that doesn't have to be the case.

The right physical environment -- single-patient rooms; well-designed ventilation systems and air filters; easy-to-clean, nonporous surface materials; and plenty of sinks for washing hands -- could reduce the spread of infection, they say. They even have research supporting the concept, known as evidence-based design. Now hospitals across the country, including many in California, are using this information to reduce infections from the ground up. The Center for Health Design, a research and advocacy organization based in Concord, Calif., is currently working with 50 hospitals to design safer facilities. And some of Southern California's largest medical center replacement projects, including Los Angeles County-USC Medical Center and UCLA Medical Center, have incorporated elements of evidence-based designs. These include private patient rooms, ubiquitous hand-washing sinks and alcohol hand-sanitizing dispensers, isolation rooms for highly infectious patients and emergency departments with negative air pressure, which pulls infectious air away from other parts of the hospital.

"Private rooms are the most important design element that reduces the spread of infection between patients," says Richard Van Enk, director of infection control and epidemiology for Bronson Methodist Hospital in Kalamazoo, Mich. Bronson is a pioneer of evidence-based design and was among the first hospitals in the United States to build a facility with all private patient rooms.

The hospital's new design also incorporates two sinks in each patient room, one of which is dedicated for the exclusive use of the healthcare worker. Many easily cleaned surface materials such as water-based

low VOC (volatile organic chemical) paint, plastic counter coverings and linoleum floorings with antimicrobial properties were also used throughout the hospital.

Bronson measured the difference in infection rates between its old, multi-bed-room facility and new, private-room facility, which opened in December 2000, and discovered that the infection rate had dropped by approximately 11%. "The major change in that facility was the use of private rooms," Van Enk says.

Requiring patients to share space increases the risk of airborne infections. One of the most striking examples was the outbreak of severe acute respiratory syndrome -- SARS -- in Toronto in 2003. About 75% of those SARS cases were acquired in the hospital, according to a 2003 study published in the Journal of Emergency Nursing.

Multi-bed spaces in emergency rooms and ICUs, combined with few available isolation rooms with negative airflow pressure, hindered hospital workers' ability to treat and control the syndrome, which is spread by tiny atomized droplets from coughing individuals, much like influenza and chickenpox, said Roger Ulrich, a member of the board of directors for the Center for Health Design. "This underscored dramatically the need for single rooms, not only in intensive care units, not only in traditional wards, but in emergency departments. And the need for not only single spaces for each bed, but for appropriate ventilation and air filtration."

Shared rooms also increase the spread of disease through contact, Ulrich said. For example, a patient in a shared room with methicillin-resistant Staphylococcus aureus, or MRSA, can, within hours, contaminate surfaces such as bed rails, tables and bathroom fixtures. In fact, a 2004 study published in the Journal of Hospital Infection showed that the contamination rates of surfaces with MRSA in surgical wards of a London teaching hospital were as high as 74% in spaces occupied by a patient with MRSA.

MRSA is resistant to many antibiotics and occurs most commonly in hospital patients or those in other healthcare facilities, such as nursing homes.

The evidence that shared hospital rooms contribute greatly to higher infection rates, as well as a host of medical errors, privacy violations and added patient stress, is so compelling that the American Institute of Architects -- in its 2006 guidelines for healthcare facilities -- called for single-patient rooms in medical/surgical and postpartum units as the standard for all newly constructed hospitals. The effect of such a change appears to be dramatic: Methodist Hospital in Indianapolis, for example, saw a 67% drop in medication errors when it changed its coronary intensive care unit to single-bed rooms.

The American Institute of Architects guidelines have now been adopted by more than 43 states, said Peter Bardwell, president of the institute's Academy of Architecture for Health. "This was the first document to state without equivocation that unless there is some indicator of extraordinary hardship, all newly constructed patient rooms should be single occupancy."

<http://www.latimes.com/features/health/la-he-architecture28-2008jul28,0,5907587.story>

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The Price of Beauty
The New York Times | 07.28.08
By NATASHA SINGER



Peter DaSilva for The New York Times

Dr. Donald Richey injects Karen Hetherington with Juvederm, a gel that helps reduce wrinkles, at his practice in Chico, Calif.

Dr. Donald Richey, a dermatologist in Chico, Calif., has two office telephone numbers: calls to the number for patients seeking an appointment for skin conditions like acne and psoriasis often go straight to voice mail, but a full-time staff member fields calls on the dedicated line for cosmetic patients seeking beauty treatments like Botox.

Dr. Richey has two waiting rooms. The medical patients' waiting room is comfortable, but the lounge for cosmetic clients is luxurious, with soft music and flowers.

And he has two kinds of treatment rooms: clinical-looking for skin disease patients, soothing for cosmetic laser patients.

"Cosmetic patients have a much more private environment than general medical patients because they expect that," said Dr. Richey, who estimated that he spent about 40 percent of his time treating cosmetic patients. "We are a little bit more sensitive to their needs."

Like airlines that offer first-class and coach sections, dermatology is fast becoming a two-tier business in which higher-paying customers often receive greater pampering. In some dermatologists' offices, freer-spending cosmetic patients are given appointments more quickly than medical patients for whom health insurance pays fixed reimbursement fees.

In other offices, cosmetic patients spend more time with a doctor. And in still others, doctors employ a special receptionist, called a cosmetic concierge, for their beauty patients.

Dr. David M. Pariser, a dermatologist in Norfolk, Va., and the president-elect of the American Academy of Dermatology, said some practices did maintain preferential policies for cosmetic patients.

“The message is that the cosmetic patient is more important than the medical patient, and that’s not a good message,” Dr. Pariser said.

At a time when dermatologists are trying to advance the idea of a national skin cancer epidemic, such a two-tier system is raising concerns that the coddling of beauty patients may divert attention from skin diseases.

A study published last year in *The Journal of the American Academy of Dermatology* found that dermatologists in 11 American cities and one county offered faster appointments to a person calling about Botox than for someone calling about a changing mole, a possible sign of skin cancer.

And dermatologists nationwide are increasingly hiring nurse practitioners and physicians’ assistants, called physician extenders, who primarily see medical patients, according to a study published earlier this year in the same journal.

“What are the physician extenders doing? Medical dermatology,” Dr. Allan C. Halpern, chief of dermatology at Memorial Sloan-Kettering Cancer Center in Manhattan, said in a melanoma lecture at a dermatology conference this year. “What are the dermatologists doing? Cosmetic dermatology.”

There are no published studies showing that the rise of beauty procedures has caused harm to medical dermatology patients. If patients with skin problems have difficulty getting appointments, it is because over the last 30 years the demand to see skin doctors has far outstripped the number of physicians trained in the specialty, said Dr. Jack S. Resneck Jr., an assistant professor of dermatology at the medical school of the University of California, San Francisco.

Dr. Resneck, who researches professional issues in dermatology, said about 10,500 dermatologists now practiced in the United States, the majority devoting little time to vanity medicine.

Even so, dermatologists perform several million beauty treatments annually, according to estimates by the American Society for Dermatologic Surgery, including more than two million anti-wrinkle injection treatments last year — an increase of 130 percent over 2005.

Several patients interviewed for this article said that they believed the dermatologists they visited for medical care treated them as potential cosmetic consumers. Dianne Ryan, who works for an airline in Dallas, went to a dermatologist in her insurance network three years ago after her husband pointed out a mole growing on the side of her foot, she said. The doctor dismissed the mole as benign, she said, but recommended she buy his brand of bleaching cream for pigmentation on her face.

A few months later, Ms. Ryan said, she sought a second opinion from another dermatologist, whose diagnosis was melanoma.

“I don’t know if dermatology, with all the new technology, is turning away from melanoma or whether it is the glamour and excitement,” said Ms. Ryan, who was called by this reporter after an exchange in a chat room of the Melanoma Research Foundation. “If you do an extreme makeover on someone, you are a hero.”

Dermatology is one of the fields — along with plastic surgery and behavioral sleep medicine — in which patients are not only willing to pay for quality-of-life treatments that may not be covered by insurance, but also willing to pay much more for such treatments than insurers would pay for a medical procedure that takes a similar amount of time.

Some health insurers reimburse a doctor \$60 to \$90 for a visit including a full-body skin cancer check that might take 10 minutes; for Botox injections to the forehead, a doctor might receive \$500 for 10 minutes, paid on the day of treatment.

According to a presentation for doctors from Allergan, the makers of Botox, a medical dermatology practice might have a net income of \$387,198 annually, but a dermatologist who decreased focus on skin

diseases while adding cosmetic medical procedures to a practice could net \$695,850 annually. The same material advises doctors to “identify and segment high priority customers.”

People who wish to avoid a cosmetic-driven practice should simply seek appointments with medical dermatologists who focus on skin diseases, said Dr. Alexa B. Kimball, the vice chairwoman of dermatology at Massachusetts General Hospital in Boston.

But many dermatologists now offer both medical treatment and beauty procedures, which can confuse patients. And some doctors differentiate between patients — either within their own practices or by treating cosmetic patients in stand-alone facilities called medical spas.

Lecturers at the annual meeting of the American Academy of Dermatology, held in San Antonio in February, encouraged such segregation.

For example, Dr. Jason R. Lupton, a dermatologist in Del Mar, Calif., advised young physicians to oblige cosmetic patients by giving them appointments within seven days; empty appointment slots could later be filled with general dermatology patients, he said.

In a follow-up telephone interview, Dr. Lupton said that, in his own practice, he accommodated medical and cosmetic patients equally.

In an interview, Dr. Susan H. Weinkle, a dermatologist in Bradenton, Fla., said that she typically spends more time with cosmetic patients because they come in wanting to look better, the kind of amorphous desire that takes longer to satisfy than defined medical problems. One of her staff members always calls a beauty client to follow up, she said.

“It is very rare that you would call an acne patient and say, ‘How are you doing with that new prescription?’” Dr. Weinkle said. “But with a cosmetic patient, the consultant calls them the next day.”

This dual-class treatment system is not limited to the fanciest of private practices. Even academic institutions like the University of Michigan Health System in Ann Arbor are openly catering to beauty consumers. The Web site of the dermatology department warns a medical patient seeking an appointment to obtain a referral from a primary care physician “regardless of your type of insurance.”

Meanwhile, the same Web site — www.med.umich.edu/derm/patient/cdlcappointment.shtml — promotes the attentiveness of its cosmetic doctors and encourages those seeking vanity procedures to ask about the “convenient” valet parking. The site was updated Monday to inform medical patients that the valet service is also available to them.

A new profession — called aesthetic practice consultant — has emerged to advise doctors in the care of cosmetic patients.

“Instead of laying on an exam table with a paper liner, you have them lay on a sheet,” said Deborah Bish, a former nurse who works as a practice consultant in Yardley, Pa. “You have to class it up for these patients.”

It makes economic sense that dermatologists competing for Botox dollars want to create enticing environments, said Julie Cantor, a lawyer and medical school graduate who teaches a course in medical ethics at the law school of the University of California, Los Angeles. But Ms. Cantor said research was needed to determine whether such environmental changes alter a doctor’s behavior with medical patients.

“If you really started treating patients differently based on their ability to pay out of pocket, that’s a real problem,” Ms. Cantor said. “People who want their wrinkles fixed to go to a wedding should not be treated better than those who have psoriasis.”

Dr. Richey, the Chico, Calif., dermatologist, said that in his practice, the attention to cosmetic patients had no bearing on the treatment of medical patients; he maintains daily walk-in slots for medical patients with urgent skin problems, and many of his patients visit both sides of his practice.

"I don't believe in differentiating," Dr. Richey said.

Nonetheless, some medical patients said that they believed other dermatologists brushed off their medical concerns in favor of marketing cosmetic procedures. Melissa Bundy, a health communications manager in Atlanta, said that several years ago she went to a dermatologist who seemed more interested in selling face treatments than in conducting a thorough skin cancer examination. She has since switched doctors.

"Cosmetic things, it's a really great business," Ms. Bundy said. "But it really does seem to be at the expense of people like me getting the medical services that we are looking for."

<http://www.nytimes.com/2008/07/28/us/28beauty.html?hp>

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Essay: Apology Shines Light on Racial Schism in Medicine

The New York Times | 07.29.08

By HARRIET A. WASHINGTON

Organized medicine has long reflected that most American of obsessions: race. For well over a century, the American Medical Association has been the nation's largest and most powerful physicians' group — and an overwhelmingly white one. Black physicians have their own, lesser-known group, the National Medical Association.

On July 10, a spotlight fell briefly on this schism. The A.M.A. made a rare public address to the N.M.A. to deliver an even rarer message: an apology to the nation's black physicians, citing a century of "past wrongs."

What wrongs, exactly? Dr. W. Montague Cobb could have answered that question at length.

Dr. Cobb — physician, physical anthropologist, civil rights activist, president of the National Medical Association in the 1960s — knew that the organization owed its very formation to racial barriers. It was founded in 1895 after the A.M.A. refused to seat three African-American delegates at its annual meetings in 1870 and 1872.

He also knew that black patients and doctors were often relegated to subterranean "colored" or charity wards or banned from hospitals altogether; they had responded with their own hospitals and medical schools, at least seven of which existed in 1909.

That year, the A.M.A. commissioned a well-known educator, Abraham Flexner, to visit and evaluate each North American medical school. His 1910 report, "Medical Education in the United States and Canada," raised a further hurdle for black doctors: it recommended that all but two black medical schools — Howard and Meharry — be closed. Unable to attract financing, the others did close, and the number of black physicians predictably fell.

By 1938, the situation had grown so dire that Dr. Louis T. Wright of Harlem Hospital declared, "The A.M.A. has demonstrated as much interest in the health of the Negro as Hitler has in the health of the Jew."

In 1963, when Dr. Cobb became president of the N.M.A., the United States had 5,000 black doctors out of 227,027 total. Although A.M.A. membership was often important to hospital practice, specialty training and professional achievement, many chapters and "constituent societies" — medical groups that were the gatekeepers to the larger organization — were closed to blacks.

And the A.M.A. repeatedly refused to force its constituent societies to admit blacks. In 1952, Dr. Martha Mendell, a white member of the Physicians Forum, a multiracial doctors group in New York, argued: "The claim of the A.M.A. that it is powerless to correct this practice because of the 'autonomy' of its component societies is an evasion of its responsibility. Surely, if the Southern medical societies decided to admit chiropractors to membership, the A.M.A. would quickly find the means of redefining this autonomy."

Still, a smattering of influential black physicians did gain entree into the A.M.A. Doubtless heartened by that fact, in 1957 Dr. Cobb founded the Imhotep National Conference on Hospital Integration to forge a coalition between the medical associations.

The A.M.A. had eagerly joined the Imhotep initiative. But six years later, Dr. Cobb bitterly reflected that the association habitually absented itself from Imhotep meetings. What's more, the two medical groups increasingly found themselves on opposing sides of important antidiscrimination battles. As the National Medical Association campaigned for Medicare and Medicaid on behalf of its members' mostly black, often poor patients, Dr. Edward R. Annis of the A.M.A. censured both programs as "socialized medicine."

Without A.M.A. support, black physicians like Dr. Hubert A. Eaton of Wilmington, N.C., brought federal lawsuits to gain entrance to all-white hospitals.

And despite promises to oppose language in the Hill-Burton hospital construction law validating “separate but equal” facilities, the A.M.A.’s response was desultory at best.

Dr. Cobb’s patience was at an end, and perhaps his hand shook slightly — from indignation, if not from fatigue — as he responded in August 1963:

“For seven years we have invited them to sit down with us and solve the problem. The high professional and economic levels of these bodies and the altruistic religious principles according to which they are supposed to operate seem to have meant nothing. By their refusal to confer they force action by crisis. And now events have passed beyond them. The initiative offered is no longer theirs to accept.”

His declaration was prescient, for the black doctors and their white sympathizers won their civil rights battles. The Civil Rights Act of 1964 passed without active support from the A.M.A. Title VI of the act closed the Hill-Burton loophole: segregation within hospitals became illegal. Medicare passed in 1965.

But for African-American and other antisegregationist physicians, there remained a final bastion of racial exclusion to conquer: the A.M.A. To do so, these physicians resorted to the same strategies that had desegregated schools, lunch counters and monochromatic suburbs.

On June 19, 1963, the association had held its 112th annual convention in Atlantic City’s stately Traymore Hotel. As Dr. Annis descended from the ballroom lectern after delivering his presidential address, he was surprised to be met on the steps by Dr. John L. S. Holloman, an African-American A.M.A. member from New York City, who handed him a letter demanding that the A.M.A. remove all racial barriers to membership.

When it became clear that Dr. Annis had no intention of reading or responding to it before the assembled doctors, Dr. Holloman turned on his heel and left the ballroom to join 20 black and white physicians picketing outside. Reporters thronged the A.M.A. officers throughout the convention, clamoring to know why physicians were picketing the association as a racist organization.

These scenes of public protest and picketing continued until 1968, when the A.M.A. finally amended its constitution and bylaws to punish racial discrimination by permitting the expulsion of constituent societies.

Warmer relations ensued between the medical societies, and although a 1973 effort to amalgamate them failed, they did form the lasting liaison of which W. Montague Cobb had dreamed. Their more fruitful joint efforts include the 1992 creation of the Minority Affairs Consortium, and in 2004 the Commission to End Healthcare Disparities. In 1994, Dr. Lonnie Bristow became the first African-American president of the A.M.A.

Yet reminders of this rancorous history persist, and the A.M.A.’s apology remains pertinent, if long overdue. Consider this statistic: In 1910, when Abraham Flexner published his report on medical education, African-Americans made up 2.5 percent of the number of physicians in the United States. Today, they make up 2.2 percent.

Harriet A. Washington is the author of “Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present” (Doubleday, 2007).

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Well: Doctor and Patient, Now at Odds**The New York Times | 07.29.08**

By TARA PARKER-POPE

A growing chorus of discontent suggests that the once-revered doctor-patient relationship is on the rocks.

The relationship is the cornerstone of the medical system — nobody can be helped if doctors and patients aren't getting along. But increasingly, research and anecdotal reports suggest that many patients don't trust doctors.

About one in four patients feel that their physicians sometimes expose them to unnecessary risk, according to data from a Johns Hopkins study published this year in the journal *Medicine*. And two recent studies show that whether patients trust a doctor strongly influences whether they take their medication.

The distrust and animosity between doctors and patients has shown up in a variety of places. In bookstores, there is now a genre of "what your doctor won't tell you" books promising previously withheld information on everything from weight loss to heart disease.

The Internet is bristling with frustrated comments from patients. On The New York Times's Well blog recently, a reader named Tom echoed the concerns of many about doctors. "I, as patient, say stop acting like you know everything," he wrote. "Admit it, and we patients may stop distrusting your quick off-the-line, glib diagnosis."

Doctors say they are not surprised. "It's been striking to me since I went into practice how unhappy patients are and, frankly, how mistreated patients are," said Dr. Sandeep Jauhar, director of the heart failure program at Long Island Jewish Medical Center and an occasional contributor to *Science Times*.

He recounted a conversation he had last week with a patient who had been transferred to his hospital. "I said, 'So why are you here?' He said: 'I have no idea. They just transferred me.'"

"Nobody is talking to the patients," Dr. Jauhar went on. "Everyone is so rushed. I don't think the doctors are bad people — they are just working in a broken system."

The reasons for all this frustration are complex. Doctors, facing declining reimbursements and higher costs, have only minutes to spend with each patient. News reports about medical errors and drug industry influence have increased patients' distrust. And the rise of direct-to-consumer drug advertising and medical Web sites have taught patients to research their own medical issues and made them more skeptical and inquisitive.

"Doctors used to be the only source for information on medical problems and what to do, but now our knowledge is demystified," said Dr. Robert Lamberts, an internal medicine physician and medical blogger in Augusta, Ga. "When patients come in with preconceived ideas about what we should do, they do get perturbed at us for not listening. I do my best to explain why I do what I do, but some people are not satisfied until we do what they want."

Others say the problem also stems from a grueling training system that removes doctors from the world patients live in.

"By the time you're done with your training, you feel, in many ways, that you are as far as you could possibly be from the very people you've set out to help," said Dr. Pauline Chen, most recently a liver transplant surgeon at the University of California, Los Angeles, and the author of "Final Exam: A Surgeon's Reflections on Mortality" (Knopf, 2007). "We don't even talk the same language anymore."

Dr. David H. Newman, an emergency room physician at St. Luke's-Roosevelt Hospital Center in Manhattan, says there is a disconnect between the way doctors and patients view medicine. Doctors are trained to diagnose disease and treat it, he said, while "patients are interested in being tended to and being listened to and being well."

Dr. Newman, author of the new book "Hippocrates' Shadow: Secrets from the House of Medicine" (Scribner), says studies of the placebo effect suggest that Hippocrates was right when he claimed that faith in physicians can help healing. "It adds misery and suffering to any condition to not have a source of care that you trust," Dr. Newman said.

But these doctors say the situation is not hopeless. Patients who don't trust their doctor should look for a new one, but they may be able to improve existing relationships by being more open and communicative.

Go to a doctor's visit with written questions so you don't forget to ask what's important to you. If a doctor starts to rush out of the room, stop him or her by saying, "Doctor, I still have some questions." Patients who are open with their doctors about their feelings and fears will often get the same level of openness in return.

"All of us, the patients and the doctors, ultimately want the same thing," Dr. Chen said. "But we see ourselves on opposite sides of a divide. There is this sense that we're facing off with each other and we're not working together. It's a tragedy."

<http://www.nytimes.com/2008/07/29/health/29well.html>

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ADHD children have greater risk of being overweight **Yahoo News | 07.25.08**

Children with attention-deficit/hyperactivity disorder (ADHD) are at increased risk for being overweight, regardless of whether or not they are currently receiving medications for the condition.

The results of prior research has suggested that the impulsivity and poor behavioral regulation that is common in children with ADHD may promote certain eating patterns that increase the risk of obesity, co-authors Molly E. Waring and Dr. Kate L. Lapane, from Brown Medical School in Providence, Rhode Island, note.

To investigate further, the researchers analyzed data from 62,887 children and adolescents included in the 2003-2004 National Survey of Children's Health.

Children with ADHD were identified based the response of the parent to the question: "Has a doctor or health professional ever told you that your child has attention-deficit disorder or attention-deficit/hyperactivity disorder, that is, ADD or ADHD?"

The prevalence of ADD or ADHD was 8.8 percent, the authors report in the journal *Pediatrics*, and approximately half the affected children were taking medication for the condition.

After accounting for demographic factors as well as depression and anxiety, ADHD patients who were not being treated with medication were 1.5-times more likely to be overweight than children without the disorder. The risk for ADHD among those who were currently receiving medications was only about 0.5-times higher than children without ADHD.

"Future work is needed to better understand the longitudinal and pharmacologic factors that influence the relationship between ADD/ADHD and weight status in children and adolescents," the investigators conclude.

http://news.yahoo.com/s/nm/20080725/hl_nm/adhd_children_dc;_ylt=Apg1BaeJw28b1U_qVJQNEm3VJRIF

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House Subcommittee Examines Rural Health Care Disparities Kaiser Network | 07.28.08

Critical telecommunication and work force challenges contribute to greater disparities in access to health care in rural areas, according to panelists at a House Agriculture Subcommittee on Specialty Crops, Rural Development and Foreign Agriculture hearing last week, CQ HealthBeat reports.

Wayne Myers of the Maine Health Access Foundation, representing the National Rural Health Association, said it is "extremely difficult and expensive" to recruit and retain physicians and health care providers in rural areas. Tom Morris, acting associate administrator for HHS' Health Resources and Services Administration's Office of Rural Health Policy, discussed current programs meant to retain doctors in rural communities including the National Health Service Corps -- where more than half of the participants go to practice in rural areas -- and the National Rural Recruitment and Retention Network, which over the past four years has placed about 2,900 clinicians in rural areas.

Subcommittee Chair Mike McIntyre (D-N.C.) said that federal grant and loan programs are essential to improving rural health care. McIntyre said, "With limited dollars available for rural health care programs, we must ensure they are used in ways that address the challenges and with sufficient federal coordination."

Karen Rheuban of the University of Virginia Health System said that rural grants are of little value without an effective Medicare reimbursement system for telehealth services, which improve rural health treatment options. According to Rheuban, Medicare has a "far less inclusive" definition of rural than that of USDA or Federal Communications Commission and, "The largest challenge we face, quite frankly, is a lack of reimbursement" for providing telehealth services.

Thomas Dorr, undersecretary of Agriculture for rural development, highlighted USDA's Community Facilities Program, which has invested more than \$1.75 billion in more than 1,000 rural health care facilities since 2001 (Parnass, CQ HealthBeat, 7/25).

http://www.kaisernetwork.org/daily_reports/rep_hpolicy.cfm#53541

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Drugstore Tobacco Sales Under Fire
The Wall Street Journal | 07.29.08
 By ANN ZIMMERMAN

Antismoking advocates are taking the battle against cigarettes to the aisles of pharmacies as well as retailers with in-store health clinics, arguing that stores promoting health care shouldn't also be selling tobacco products.

Tuesday, San Francisco's city board of supervisors will vote on whether to bar cigarette sales at pharmacies as of Oct. 1, a measure Mayor Gavin Newsom modeled after similar bans already on the books in Canada.

Other efforts have cropped up across the U.S. to pass state and city laws banning the sales of cigarettes at drugstores and retailers offering in-store health services. While no major ban has passed in the U.S. yet, widespread approvals of such measures would affect pharmacies such as CVS/Caremark Corp. and Walgreen Co., supermarket chains and big-box retailers, including Wal-Mart Stores Inc.

The issue is a particularly touchy one for Wal-Mart, the world's largest retailer. Wal-Mart is trying to expand business by positioning itself as a champion of affordable health care, attracting more customers to its pharmacies with cheap prices on generic drugs and opening health clinics in many of its stores, all of which sell tobacco products. Wal-Mart, however, doesn't have stores that would be affected by San Francisco's ban as proposed.

Supporters of the sales bans say they are trying to reduce tobacco-related illnesses by limiting access to cigarettes, which have established health hazards. By ratcheting up the social unacceptability of cigarettes, supporters believe they can deter young people from starting tobacco habits.

Opponents portray the efforts as selective legislation that will have little impact on smoking rates, while making retailers choose between selling what customers want and offering affordable health care.

The San Francisco vote is being closely watched. The city "was the first to ban smoking in workplaces and other public places, and has been a catalyst for other jurisdictions," said Matt Myers, president of the national Campaign for Tobacco-Free Kids. "If San Francisco prohibits the sale of tobacco in pharmacies, we could well see this prohibition spread across major areas of the nation."

A study by researchers at Yale University found that 82% of 1,000 California pharmacists surveyed and 72% of 988 adult consumers questioned support a ban of tobacco products at pharmacies. The proposed San Francisco ban is supported by the California Pharmacists Association, the California Medical Association, and the American Cancer Society, among other groups.

Leading up to the San Francisco vote, backers have had trouble winning legislative approval of bans. Ban measures introduced this year in Rhode Island, New Hampshire, Tennessee and Illinois to bar stores and pharmacies with health clinics from selling tobacco and, in some cases, alcohol, all stalled. A bill in New York that would have applied to all pharmacies, including those in big retailer and supermarket outlets, also foundered.

Opponents of the tobacco bans believe stores will get out of the clinic business if they are forced to choose between providing health care and selling cigarettes. "We do not understand how forcing retailers to choose between having an in-store clinic and selling tobacco products serves the broader goal of providing consumers with easier access to high-quality, affordable health care," says Tine Hansen-Turton, executive director of the Convenient Care Association, which represents the roughly 1,000 health clinics located in retail outlets in the U.S. The clinics are primarily staffed by nurse practitioners and clinical nurse specialists who treat common ailments such as sore throats and sinus infections.

It is a tough call for retailers, which would be forced to give up a big source of revenue and lose a significant customer draw. Grocery stores, drugstores, wholesale clubs and mass merchandisers accounted for 19% of tobacco sales in the U.S. last year, or at least \$13 billion.

But a few big retailers already have given up cigarettes. Target Corp. quit the sales habit in 1996 believing that new laws restricting cigarette sales made them too labor-intensive to dispense. The chain says the financial impact was minimal. Earlier this year Wegmans Food Markets Inc., a Northeastern-based food-store chain, discontinued sales because of "the destructive role smoking plays in health," Chief Executive Danny Wegman said at the time.

Wal-Mart stopped selling cigarettes in its Canadian stores in 1994 as the provincial government of Ontario was adopting a law that would bar stores operating pharmacies from selling cigarettes, a ban seven other Canadian provincial governments later approved.

Cigarettes have gotten harder to buy in recent years. About a decade ago, state laws began prohibiting retailers from selling tobacco products to individuals under age 18, and in some cases, age 19. Most states also began enacting laws requiring stores to keep cigarettes behind cash registers or separate customer service counters instead of easily accessible, free-standing kiosks.

While cigarette sales have fallen 18% in volume terms since 2000, 17.4 billion packs were sold last year. Over that same period, sales of other tobacco products--moist snuff, roll-your-own tobacco and small cigars -- increased by the equivalent of 1.10 billion packs of cigarettes, according to researchers at the Harvard School of Public Health.

Retailers are grappling with the ethics of reconciling a health care business with tobacco sales. In November, CEO Thomas Ryan of CVS said his company was considering eventually halting the sale of cigarettes.

"We have a vision in our company to strive to improve human life, and it is a challenge around cigarettes," Mr. Ryan said at a conference. "It's a big number from a dollar standpoint...We've had internal battles and discussions. I wouldn't rule it out at some point down the road."

Wal-Mart wouldn't comment on legislative attempts to ban cigarettes, but in the past, CEO Lee Scott has indicated customer preferences dictate what it sells at its stores. "There are still a tremendous number of our customers who smoke," Mr. Scott told Wall Street Journal editors at a recent meeting in New York. "We've got a market to serve, and second we've got shareholders to think about," he added.

Doug McMillon, head of Wal-Mart's Sam's Club unit that sells its tobacco products mainly to convenience stores, said halting cigarette sales is something he has "thought about. I don't expect it to happen in the next year. It's a big business, so it makes it harder to stop," he said at the Journal meeting.

In a letter to San Francisco Mayor Newsom, the National Association of Chain Drug Stores doubted prohibiting the sale of tobacco products in drugstores would reduce smoking. "Such a ban would only succeed in making an arbitrary determination as to which retailers would be permitted to sell products that remain legitimately for sale in the state and in the nation," the letter said.

Local jurisdictions mulling a ban are each drawing the line on tobacco sales in a different place. The San Francisco proposal wouldn't affect sales at grocery stores with pharmacies or warehouse clubs such as Costco Wholesale Corp. Backers reason that grocery stores and warehouse clubs don't market themselves as promoting health care, said Mitch Katz, director of San Francisco's Department of Public Health.

"Supermarkets draw a cross-section of people, but a pharmacy attracts a vulnerable population -- people with illnesses," Dr. Katz said.

New York Assemblyman Sam Hoyt drafted a bill earlier this year to restrict the sale of tobacco-related products in pharmacies, including those in grocery stores and big-box retailers. He said he acted after Wegmans halted cigarette sales, because he didn't think enough retailers would follow its lead voluntarily.

The bill didn't make it out of committee, but Mr. Hoyt said he'll try again next year.

A bill drafted by the Illinois State Medical Society earlier this year drew a rebuke from the Federal Trade Commission, which criticized portions of it as potentially anti-competitive. In addition to banning tobacco products and alcohol at stores with walk-in health clinics, the bill would require permits to operate clinics, curb clinic price-comparison ads, and require more physician involvement.

After the Illinois bill stalled in committee, members of the Illinois State Medical Society have tackled a revision, and plan to introduce the new version this fall, said Dr. Shastri Swaminathan, a Chicago psychiatrist and president of the Illinois State Medical Society.

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