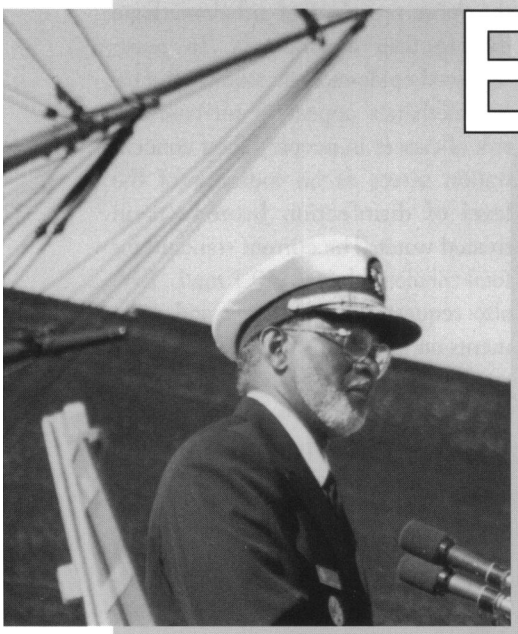
Public Health Service Bicentennial EVENTS



Boston, MA. On April 7, 1998, Surgeon General David Satcher kicked off the celebration of the 200th anniversary of the Public Health Service at the USS Constitution berthed at the Charlestown Navy Yard. Former Surgeon General Julius B. Richmond presented the first annual Department of Health and Human Services Regional Office Young Leader in Public Health Award, named in his honor, to Leslie D. Hsu, a student at the Harvard School of Public Health, for her work in creating hepatitis B vaccine programs in underserved communities.

Future Bicentennial events are being planned for July 3, 1998, in Philadelphia and later in the year in Dallas, Chicago, and Washington. ■

HRSA Launches Electronic News Room on World Wide Web

The Health Resources and Services Administration (HRSA) has joined other Public Health Service agencies online. The HRSA News Room features articles, press releases, fact sheets, and other current information about HRSA programs and initiatives.

The site offers: quick posting of news; archival searching capacity; color photographs; easy reader response forms; and links to other information sources.

The HRSA News Room can be reached at ***www.hrsa.dhhs.gov.*** ■

PRESIDENT'S COMMISSION FINISHES WORK

The President's Advisory Commission on Consumer Protection and Quality recommends the establishment of two councils, one public, one private: a permanent advisory council in the public sector would set national health care quality goals and track progress in meeting these goals. A Forum for Health Care Measurement and Reporting in the private sector would implement a comprehensive plan for measuring health care quality and reporting the results of such measures to the public.

The recommendations are contained in the Advisory Commission's final report, *Quality First: Better Health Care for All Americans,* which was presented to the President.

The Commission report finds that while most Americans receive high quality health care, documented quality weaknesses include a high level of avoidable health care errors, wide regional variations in health care practice, underuse of some services, and overuse of others. In addition to the recommendations noted above, the Quality Commission has also urged Congressional enactment of a national patients' bill of rights.

The full texts of the Commission's final report and of the Consumer's Bill of Rights as recommended by the Commission are available electronically at ***www.hcqualitycommission.gov.*** *The Liaison Office for Quality of the Agency for Health Care Policy and Research (ACHPR) also maintains a website at* ***intranet.ahcpr.gov/quality liaison,*** *which provides useful links to the Commission's work.* ■

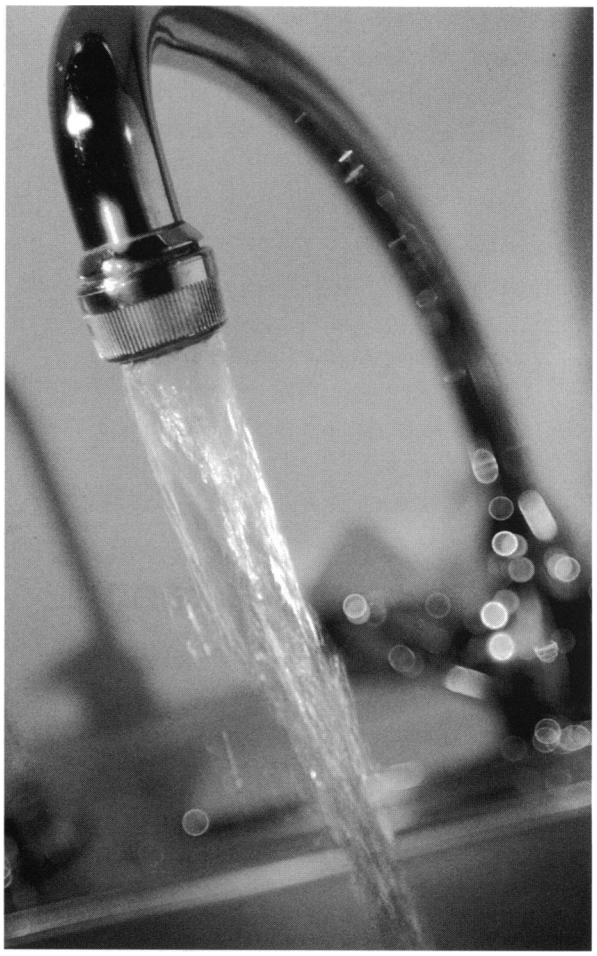
EPA ALERT

EPA Considering Raising CHLOROFORM GOALS FOR DRINKING WATER

In 1992 the Environmental Protection Agency (EPA) began a complex rulemaking process that would determine the risks associated with disinfection of drinking water. The process was to be a test of a "negotiated rulemaking"; representatives of state and local health and regulatory agencies, public water systems, elected officials, consumer groups, and environmental groups participated. The *Federal Register* of March 31, 1998 contained an 18-page notice from EPA describing how the agency, after completion of the first stage of the negotiated rulemaking, used data to assess the risks, benefits, and costs of reducing the level of public exposure to disinfectants and disinfection byproducts in drinking water.

EPA revealed that it was "considering changing the proposed MCLG [Maximum Contaminant Level Goal] for chloroform from zero to 0.3 mg/L." This change under consideration by EPA is based on a new confidence in selected animal toxicology studies that appear to show that chloroform, one of the trihalomethanes, acts to cause cancer by a mechanism involving liver tissue injury. Thus exposures to chloroform at levels below 0.3mg/L (above which animal liver tissue was damaged) could be safe for humans.

Disinfection byproducts include a broad range of halogenated organic compounds (among them chloroform and other trihalomethanes), many of which have not been characterized. The trihalomethanes, which include several carcinogens, are generally present in concentrations higher than those of other byproducts. Currently, they are the only regulated byproduct, but they also serve as a surrogate for other carcinogens.



Critics have suggested that the EPA conclusion relies on an unproved hypothesis while ignoring positive human data (*see* Commentary *page 321*). Increasing the MCLG for chloroform will certainly complicate the negotiation process because chloroform is the most prevalent of trihalomethane disinfection byproducts. In peer-reviewed epidemiologic studies, the trihalomethanes appear to increase the risk of cancer in people. Their concentration serves as an indicator of the level of disinfection byproducts in treated water. The current standard for total trihalomethanes is 0.1 mg/L. EPA also requested further data and comments on its analysis.

There is no question that disinfecting water remains critical to protecting the public from microbiological threats. The critical question that EPA is grappling with is the risk of cancer and reproductive and developmental effects from exposure to the disinfectants used and their byproducts. EPA has also considered the cost of modifying the disinfection methods to reduce dangerous exposures.

The latest step in the lengthy EPA review gives less weight than in the past to the findings in peer-reviewed studies by three Public Health Service researchers: Frank J. Bove of the Agency for Toxic Substances and Disease Registries, Kenneth P. Cantor of the National Cancer Institute, and Ronald Melnick of the National Institute of Environmental Health Sciences.

For EPA's Notice of Data Availability, *see Federal Register 1998 Mar 31;63:15674-92.* ■

EPA ALERT

EPA Should Redirect Some Research on TOXIC AIRBORNE PARTICLES

Recent studies have consistently shown that airborne particles are somehow associated with adverse health effects, especially for people with heart and lung ailments," said Jonathan Samet, Professor and Chair, Department of Epidemiology, Johns Hopkins University School of Hygiene and Public Health. As new EPA standards begin to take effect, he added, "further research must be done to determine precisely which particles pose the greatest health risks, and how. Gathering this information should be of the highest priority. The results will greatly increase the likelihood that money spent on regulating and controlling particulates will fully protect public health."

Samet was the chair for a National Research Council committee that recently released its report, *Research Priorities for Airborne Particulate Matter,* which examines EPA's plans for research and identifies the 10 most critical needs for strengthening the scientific data. The report, the first of four, lays out a comprehensive 13-year national program for the study of particulate matter, with emphasis on critical information needed before the next scheduled review of the standards in 2002.

EPA recently set stricter standards for particulate matter—a broad class of materials that originate from industrial manufacturing processes, forest fires, automobile exhaust, fossil fuel combustion, wind erosion, and a variety of other sources. The standards were changed after several epidemiologic studies found associations between exposure to the particles and serious health consequences, including the exacerbation of asthma and other respiratory tract diseases—which in some cases led to premature deaths.

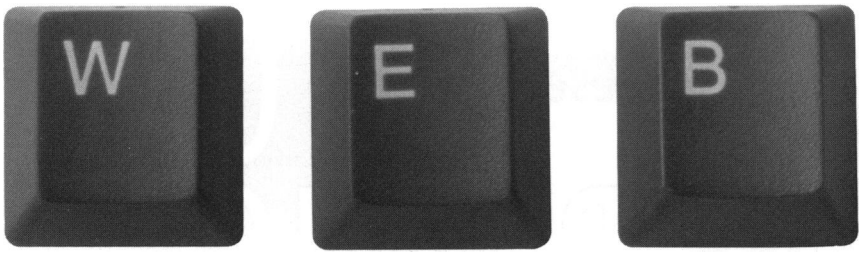
The new standards, set in July 1997, for the first time target particulates smaller than 2.5 microns in diameter. When inhaled, these tiny particles are more likely than larger ones to reach deeply into the lungs. EPA must review the standards and the scientific data on which they are based every five years to determine whether revisions are warranted. In the meantime, the agency is beginning a national outdoor air monitoring program to determine which geographic areas are not in compliance. States with areas not meeting the standards will have to develop plans to control particulates.

EPA estimates that compliance could prevent 15,000 premature deaths each year. However, because of scientific uncertainties surrounding the standards and limited data on the health risks from exposure, Congress directed EPA to conduct a major research program to improve understanding of these risks. In addition, Congress asked the National Research Council (NRC) to provide independent guidance to EPA on the program.

The NRC committee concluded that EPA should redirect some research and maintain an integrated study program ensuring that the most serious public health risks posed by the particles are addressed.

To that end, according to the report, EPA should devote more funds to studying the types of particles most likely to be harmful to human health, the ways those particles cause damage, and the levels of exposure people actually receive.

Copies of Research Priorities for Airborne Particulate Matter: 1. Immediate Priorities and a Long-Range Research Portfolio *are available from the National Academy Press, 2101 Constitution Ave. NW, Washington DC 20418; tel. 202-334-3313 or 800-624-6242; for $35 plus shipping charges of $4 for the first copy and 50 cents for each additional copy.* ■



Clinical Practice Guidelines WANTED

The Agency for Health Care Policy and Research (AHCPR) is inviting health care organizations as well as other public and private sector organizations to submit their clinical practice guidelines for inclusion in the National Guideline Clearinghouse™ (NGC), a comprehensive electronic database.

The Clearinghouse was developed in partnership with the American Medical Association (AMA) and the American Association of Health Plans (AAHP) to promote widespread access to guidelines. "The relative explosion of scientific literature, combined with increasing demands on physician time, has created a pressing need to provide physicians with easier access to credible, peer-reviewed scientific information," said Yank D. Coble, MD, AMA Trustee and chair of the AMA's Practice Parameter Partnership.

The NGC will make clinical practice guidelines available to the public via the World Wide Web beginning in the fall of 1998. The invitation to submit guidelines appeared in the *Federal Register*.

To be included in the NGC, guidelines must meet the following inclusion criteria.

The guideline contains systematically developed statements that include recommendations, strategies, or information to help physicians or other health care practitioners and patients make decisions about appropriate health care for specific clinical circumstances.

The guideline has been produced under the auspices of a medical specialty association, professional society, public or private organization, government agency at the Federal, state, or local level, or health care organization.

A systematic review of existing scientific evidence published in peer-reviewed journals was performed during the guideline's development. (A guideline is not excluded if corroborating documentation can be produced and verified detailing specific gaps in scientific evidence for some of the guideline's recommendations.)

The guideline is in English, is the most recent version, and was developed, reviewed, or revised within the last five years.

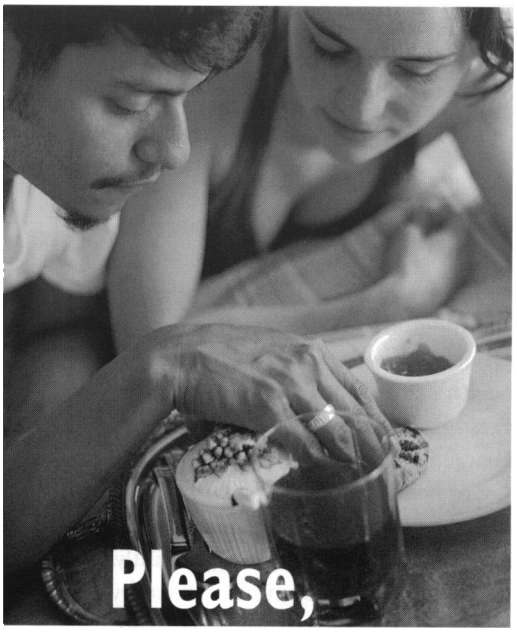
The NGC will receive guidelines on an ongoing basis. Organizations wishing to submit a guideline should contact: Vivian Coates, NGC Project Director, ECRI, 5200 Butler Pike, Plymouth Meeting PA 19462. ■

NONMEDICAL HEALTH LITERATURE CONSOLIDATED: www.chid.nih.gov

The Combined Health Information Data Base (CHID) is a free bibliographic database of more than 101,000 entries including teaching guides, audio- and videotapes, booklets, fact sheets, newsletter and journal articles, book chapters, and posters. The clearinghouse combines the resources of the National Institutes of Health, the Centers for Disease Control and Prevention, the National Institute of Dental Research, and other agencies of the Public Health Service.

The database does not duplicate existing medical literature databases. Rather, most materials indexed in CHID—such as brochures or newsletters produced by patient advocacy organizations or Federal health booklets—are not picked up by traditional cataloging and indexing services. Materials for Spanish-speaking people, migrant workers, people with low literacy skills, and children are also available in CHID. Links to the respective sources allow for quick access to the full text of available materials.

CHID includes information on AIDS education; Alzheimer's disease; arthritis and musculoskeletal and skin diseases; cancer; deafness and communication disorders; diabetes; digestive diseases; disease prevention; health promotion; epilepsy; kidney and urologic diseases; maternal and child health; medical genetics and rare disorders; oral health; prenatal smoking cessation; school health; and weight control. ■



Please, More Folate

Women who might become pregnant need 400 micrograms of folic acid per day to reduce their risk of having a child with neural tube defects, according to the latest report on Dietary Reference Intakes (DRIs) from the Institute of Medicine.

The report—the second in a new series by American and Canadian scientists—provides Recommended Dietary Allowances (RDAs) and other dietary reference values for B vitamins, of which folate is one, and choline. It says that all adult men and women need 400 micrograms of folate in their diets daily. Despite the fact that folic acid can be found in enriched bread, pasta, flour, crackers, breakfast cereal, rice, and many other foods in this country, many in the United States have not met the 400 microgram level, according to surveys completed before January 1998, when many foods began to be fortified with folic acid, a synthetic form of folate.

Neural tube defects such as spina bifida result from a disruption of the fetus's central nervous system in the first month of pregnancy, when many women do not realize they are pregnant. A common type of congenital malformation of the central nervous system, neural tube defects may appear as incomplete closure of the spinal column or even the absence of part of the brain. In the United States and Canada they occur in about one birth per 1000.

To reduce the risk of neural tube defects, women capable of becoming pregnant should consume 400 micrograms of folic acid daily from fortified foods, vitamin supplements, or a combination of the two, the report says. This is in addition to the naturally occurring folate they obtain from a varied diet. Whether such women can rely totally on the folate in food is uncertain from the research.

Research has also shown that consumption of folate and vitamin B6 can reduce elevated levels of homocysteine in the blood, and some studies have linked lower homocysteine concentrations with a decreased risk of cardiovascular disease. But there is conflicting evidence about whether increasing folate or B6 intake leads directly to a lower incidence of vascular and heart disease. Likewise, data showing that increased folate may protect against colorectal cancer do not provide conclusive evidence of a benefit, the report says.

In addition to folate, the report recommends individual intakes for thiamin, riboflavin, niacin, vitamins B6 and B12, pantothenic acid, biotin, and choline. Where possible, it also specifies intake levels above which health problems might occur. Except for folate, recommended intakes for these vitamins have not changed substantially since the last group of recommendations was published in the United States in 1989 and in Canada in 1990. Most Americans and Canadians already meet their requirements for these vitamins through their diet.

The report points out that although most Americans and Canadians get sufficient amounts of vitamin B12 in their food, between 10% and 30% of older adults have lost the ability to adequately absorb the naturally occurring form of B12 found in food. People older than age 50 should meet most of their recommended intake with synthetic B12 from fortified foods or vitamin supplements.

The report was funded by the Department of Health and Human Services, the National Institutes of Health, the Centers for Disease Control and Prevention, Health Canada, the Institute of Medicine, and the Dietary Reference Intakes Corporate Donors Fund. Contributors to the fund include Roche Vitamins, Inc., Mead Johnson Nutrition Group, Daiichi Fine Chemicals, Inc., Kemin Foods, Inc., M&M Mars, Weider Nutrition Group, and Natural Source Vitamin E Association.

Since 1941, Recommended Dietary Allowances have been set periodically by the National Academy of Sciences. Five additional reports—on antioxidants, trace elements, electrolytes and water, macronutrients, and other food components—will follow.

Pre-publication copies of Dietary Reference Intakes for Thiamin, Riboflavin, Niacin, Vitamin B6, Folate, Vitamin B12, Pantothenic Acid, Biotin, and Choline *are available from the National Academy Press, 2101 Constitution Ave. NW, Washington DC 20418; tel. 202-334-3313 or 800-624-6242; for $40 (prepaid) plus shipping charges of $4 for the first copy and 50 cents for each additional copy.* ■

Major Access Barriers Identified in 10-State Health Insurance Study

For many people who have health problems or who are approaching the age of retirement, coverage through the individual health insurance market may be priced out of reach or may be denied altogether, according to a new study prepared by the Alpha Center for the Kaiser Family Foundation. Information in the report is based on population surveys, insurer filings with states, and interviews with independent insurance agents; rates cited in the report were for 1998.

Understanding Individual Health Insurance Markets documents rates, regulations, and policies in 10 states: California, Florida, Iowa, Louisiana, Montana, North Dakota, New York, Pennsylvania, Utah, and Washington. These states were selected to represent varying geographic regions, market sizes, urban-rural populations, and state regulations with regard to the individual insurance market. The health plans reviewed in each state were limited to those that sold more than $500,000 in coverage in 1995.

Denial of coverage. The study found that coverage is often denied to people with health problems. Six of the ten states studied—California, Florida, Louisiana, Montana, North Dakota, and Pennsylvania—allow insurers to deny coverage to applicants with a history of such health problems as rheumatoid arthritis, chronic headaches, kidney stones, angina, heart disease, or stroke.

The study found that people with HIV/AIDS, in particular, face unique insurance challenges when trying to obtain coverage through the individual insurance market. Although five of the ten states studied—California, Iowa, New York, North Dakota, and Washington—require that HIV/ AIDS be treated the same as other conditions, the remaining five allow insurers to limit coverage. Where permitted by law, health plans may impose lifetime caps on coverage ranging from $10,000 to $25,000 for people with HIV/AIDS. Some states also limit prescription drug benefits. For example, in California many insurers limit prescription coverage to $2500 per year even though the newest drug therapies available for HIV/AIDS can cost up to $10,000 annually.

Premiums. Premiums vary significantly based on the age of the applicant. Premiums charged to a 60-year-old may be two to four times the premium charged to a 25-year-old. Nine out of the ten states—all except New York, the only state with community rating—allow insurers to base premiums on the applicant's age. For example, in Washington State, a healthy 25-year-old who buys insurance independently would pay $57 per month for one HMO policy, while a healthy 60-year-old would pay $205 for the same policy.

Insurers often increase premiums or add riders for people with preexisting health conditions or risk factors. These increases, called "rate-ups," can range from 20% to 80% above the base rate, depending on the applicant's medical history. For example, someone who has a history of heart disease may face a premium increase or be denied coverage altogether. Seven out of the ten states—all but New York, North Dakota, and Washington—allow insurers to set premiums based on the applicant's health status. New York's community rating ensures that people are charged the same rate regardless of age or health status.

In a state without community rating, premiums can vary significantly. In California, for example, a healthy 25-year-old would be charged about $89 per month for a policy through one of the Preferred Provider Organizations (PPOs) in the state, while a healthy 60-year-old woman would pay $250, close to three times as much. If she had high blood pressure, her base premium would increase by 25%. She might have to purchase additional coverage (known as a "rider") to cover prescription drugs, which range in cost from $8 to $27 per month.

The study comes at a time when the number of Americans without health insurance continues to grow, and policy makers are considering raising the age of Medicare eligibility to 67, which could require more older Americans to turn to the individual insurance market for coverage. At the same time, the President is proposing an early Medicare buy-in for the younger than 65 population to help address the insurance access problems faced by many pre-Medicare uninsured people.

Copies of the study are available by calling the Kaiser Family Foundation's publication request line at 800-656-4533. (Ask for #1376.) ■

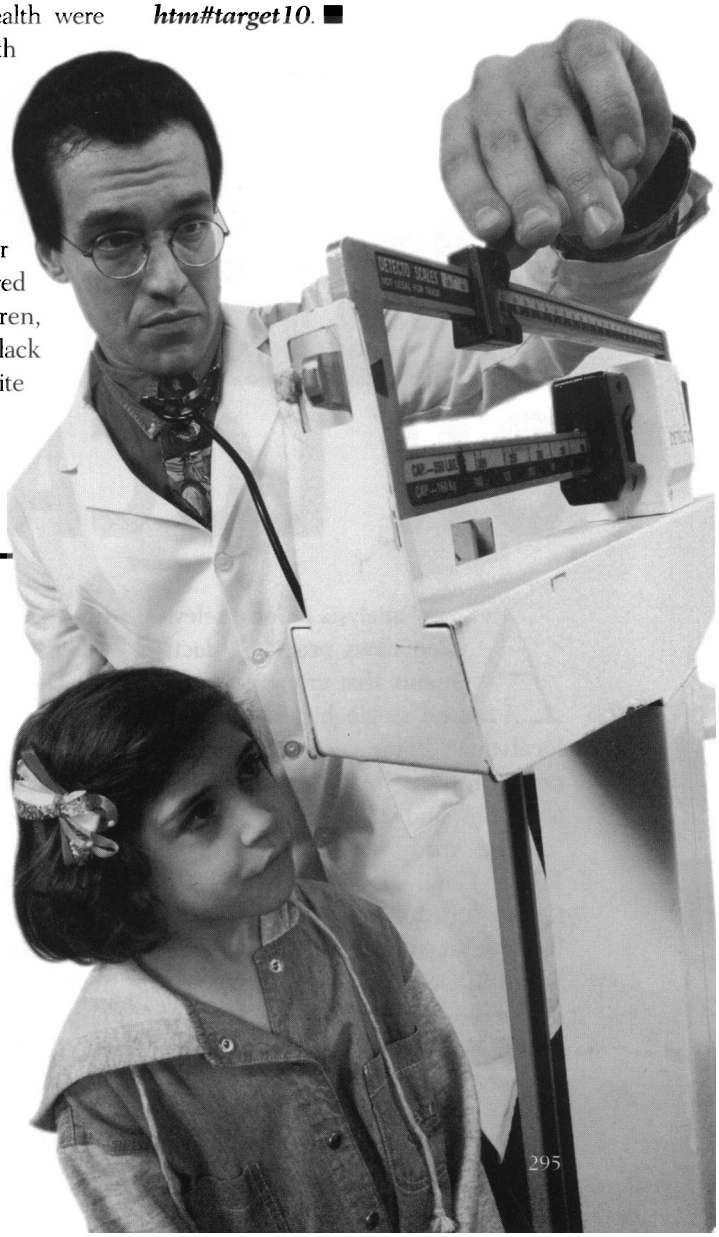
Millions of American Children Still Uninsured and Facing BARRIERS TO CARE

In a new sourcebook of data about children's health, the Agency for Health Care Policy and Research (AHCPR) reveals that in 1996, nearly 11 million American children were uninsured. The data highlight findings from AHCPR's 1996 Medical Expenditure Panel Survey (MEPS). Significant findings on children's health included in the chartbook are:

- In 1996, approximately 90% of all uninsured children lived in households with at least one working adult.
- Over half (52.8%) of children insured through Medicaid lived in households with at least one working adult.
- At least 3.3 million American children younger than age 13, and more than 1 million ages 13 and older, were eligible for Medicaid but not enrolled.
- Of families who said they did not receive needed health care, 60% said they did not get care because they could not afford it.
- Children ages 13-17 were nearly three times less likely to have a usual source of health care than children ages 5 and younger.
- Although children in fair or poor health were as likely as children in excellent health to be covered by some form of health insurance, 41.8% of children in fair or poor health were covered by a public health insurance program while only 15.1% of children in excellent health had public insurance.
- Hispanic children were more likely than black or white children to be uninsured (27.7% of Hispanic children, compared with 17.6% of black children and 12.3% of white children).
- Hispanic children were more likely than black or white children to be in fair or poor health (7.8% of Hispanic children, compared with 4.2% of black children and 2.9% of white children).

The sourcebook is divided into three sections: children's health status, access to care, and health insurance status.

Copies of Children's Health 1996 *(Pub. No. 98-0008) are available through the AHCPR Publications Clearinghouse, Children's Health 1996, PO Box 8547, Silver Spring MD 20907; tel. 800-358-9295; website* ***www.meps.ahcpr.gov/publicat.htm#target10.*** ■

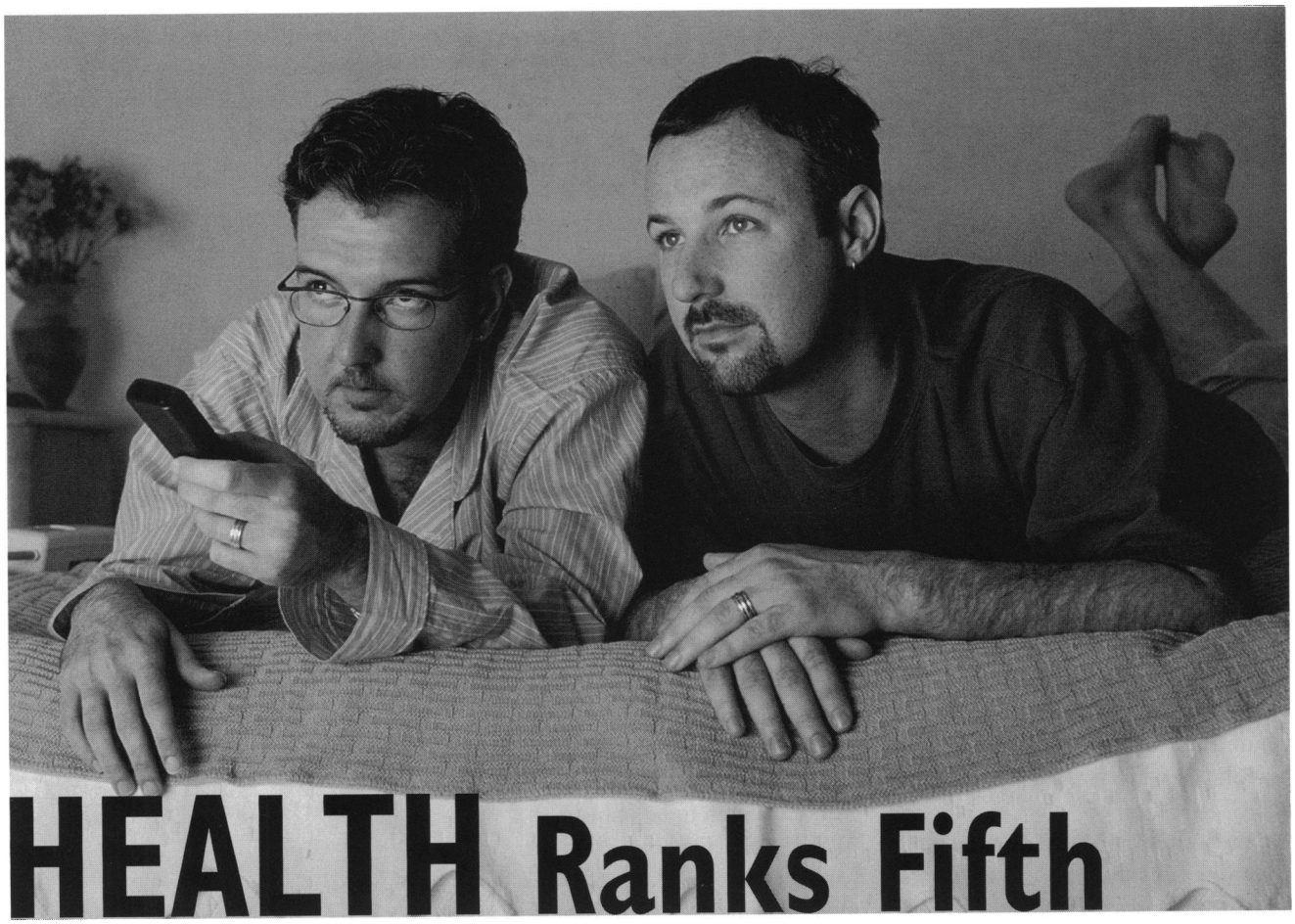


UPCOMING SYMPOSIUM

The Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) will sponsor a Symposium on Statistical Methods on January 28-29, 1999, in Atlanta, Georgia.

The theme for the symposium is "Emerging Statistical Issues in Public Health for the 21st Century." A short course entitled "Privacy, Confidentiality, and the Protection of Health Data—A Statistical Perspective" will be offered on January 27, 1999, in conjunction with the symposium. Both the symposium and short course are open to the public.

Registration and abstract information and forms or additional information regarding the scientific content of the Symposium can be obtained from Bradford A. Myers, 1999 CDC and ATSDR Symposium on Statistical Methods, 1600 Clifton Rd. NE, MS-D01, Atlanta GA 30333; tel. 404-639-3806; fax 404-639-4463, e-mail <bam6@cdc.gov>. ■



HEALTH Ranks Fifth ON LOCAL TV NEWS

A new analysis of local television news programs documents that crime is indeed the single biggest topic of local news coverage and that most crime reports focus on murders, shootings, and other violent crime.

The study, conducted by the Kaiser Family Foundation and the Center for Media and Public Affairs, found that the five most common topics in local TV news coverage are crime (20% of news items), weather (11%), accidents and disasters (9%), human interest stories (7%) and health stories (7%), with all other topics ranking below the top five.

The report, *Assessing Local Television News Coverage of Health Issues*, analyzed more than 17,000 local news broadcasts covering a three-month period. During that time, the number of violent crime stories (2035) was almost double the number of all health stories (1265), three times the number of foreign news reports (630), and four times the number of education reports (501).

The study also found that in a typical 30-minute newscast, commercials (eight minutes), crime (four minutes) and sports (four minutes) accounted for more than half the air time. Typical weather coverage lasted about three minutes, while health and accident and disaster coverage lasted about two minutes per topic. All other topics averaged one minute or less.

"Local TV news wouldn't cover crime as much as it does if the public didn't reward such coverage with high ratings" says Drew Altman, PhD, President of the Kaiser Family Foundation. "But does anyone seriously believe that crime is twice as impor-

tant as any other issue that the public needs to learn about from local television news?" Adds Robert Lichter, PhD, President of the Center for Media and Public Affairs, "If it bleeds it leads on the local news, regardless of the reality of falling crime rates."

Assessing Local News Coverage of Health Issues is a comprehensive look at the content of local television news broadcasts in 13 U.S. markets. The study, which analyzes nightly newscasts during the last three months of 1996, was conducted primarily to better understand how health issues are covered by local television news shows. The study also compares the content of local television news shows with that of network news broadcasts during the same three-month period.

The network news agenda differed substantially from that of local news, with foreign news coverage accounting for the largest number of news items, followed by health stories, 1996 campaign coverage, business and the economy, and social issues. Crime finished sixth on the network news agenda.

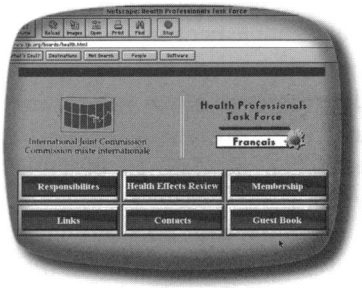
Local television health coverage. When local television covered health issues, it focused a majority (60%) of its health stories on causes and treatments of disease. The diseases that attracted the heaviest coverage were foodborne illnesses (15% of all local disease stories) and cancer (12% of all local disease stories). The second most common subjects of health items were environmental/lifestyle health issues, such as diet and exercise (21% of local health coverage). Stories about the health care industry and health insurance ranked a distant third, accounting for 5% of health coverage, followed by legal health issues (4%), HIV/AIDS (3%), and reproductive health and abortion issues (2%). Stories about the two major government health insurance programs, Medicaid and Medicare, made up 1% of local health news stories. An anchorperson or reporter without a specified beat, not a health reporter, reported 94% of local health news stories.

Network news health coverage. Although health items were more common on network news programs than on local programs, the three networks covered health much like local news. Stories about causes and treatments of disease accounted for more than half (51%) of network health stories, the largest number (16%) of which were about cancer. Environmental/lifestyle health issues, the second most common topic among network news health stories, accounted for 28% of all health items. Local and network health news also mirrored each other in terms of the type of health information they provided to viewers. Almost three-quarters of local health stories (74%) and more than two-thirds (69%) of network health news focused on providing consumer news—"news you can use"—such as items on how to choose an HMO or the latest approach to preventing heart disease.

Health policy coverage, such as stories on health care legislation at the state level or the Medicare debate, accounted for about one-fourth of local (23%) and network (28%) health stories.

The study was based on content analysis of weekday evening newscasts from 13 cities around the country (Seattle, San Francisco, Los Angeles, Phoenix, Denver, Houston, Minneapolis, Chicago, St. Louis, Atlanta, Baltimore, Philadelphia, and New York) during October, November, and December 1996. The national evening newscasts from the ABC, CBS, and NBC networks during the same time period were also analyzed.

A copy of the report may be obtained by calling the Kaiser Family Foundation's publication request line at 800-656-4533. (Ask for document #1374.) ■



Newsletter Summarizes Health and Environment Research

The International Joint Commission's (IC) Health Professionals Task Force, formed in 1995, produces a quarterly newsletter entitled *Health Effects Review.*

The newsletter (one page, double-sided) summarizes current research initiatives in the area of human health and the environment. It is written for health professionals to serve as a quick reference to current research. Recent issues have covered the topics of radionuclides, airborne particulate matter, and neurobehavioral effects from PCBs.

The newsletter can be found on the Web at www.ijc.org/boards/health.html under the "Report" icon. ■

POLICY STATEMENT

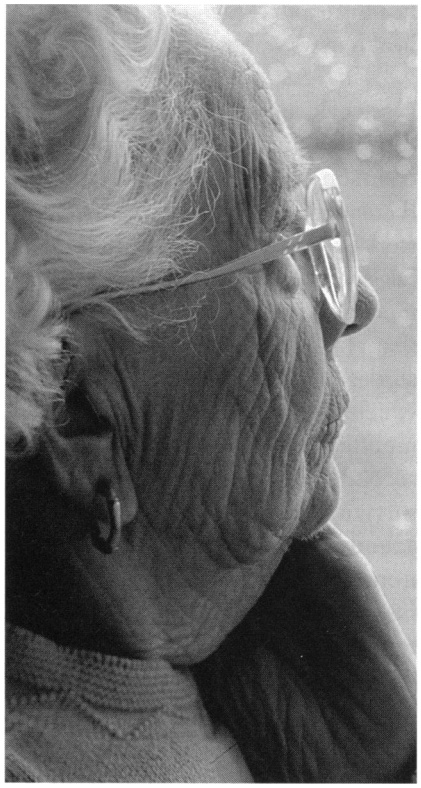
Nursing Colleges Point to Needed Skills for END-OF-LIFE CARE

Undergraduate nursing students should not only be skilled at addressing the physical, psychological, social, and spiritual needs of patients at the end of life but should have the ability to implement an overall plan for improved end-of-life care within today's complex health system, says a major new document by the American Association of Colleges of Nursing (AACN).

Moreover, with such care likely to be given by a variety of health professionals, it is essential that nursing and other health professions students be prepared for end-of-life practice with an interdisciplinary approach, the document urges.

The document, *Peaceful Death*, is the outcome of a two-day invitational roundtable conference sponsored by AACN in Washington DC in November 1997 and supported by a grant from the Robert Wood Johnson Foundation. Participants included practitioners, researchers, educators, health care ethicists, and other experts from academia and clinical settings.

Peaceful Death notes that "educational preparation for end-of-life care has been inconsistent at best, and sometimes neglected within nursing curricula." The report incorporates the roundtable's two major products—a statement detailing End-of-Life Competencies, or skills, that every undergraduate nurse should attain and recommendations for including these skills in the content of nursing curricula.



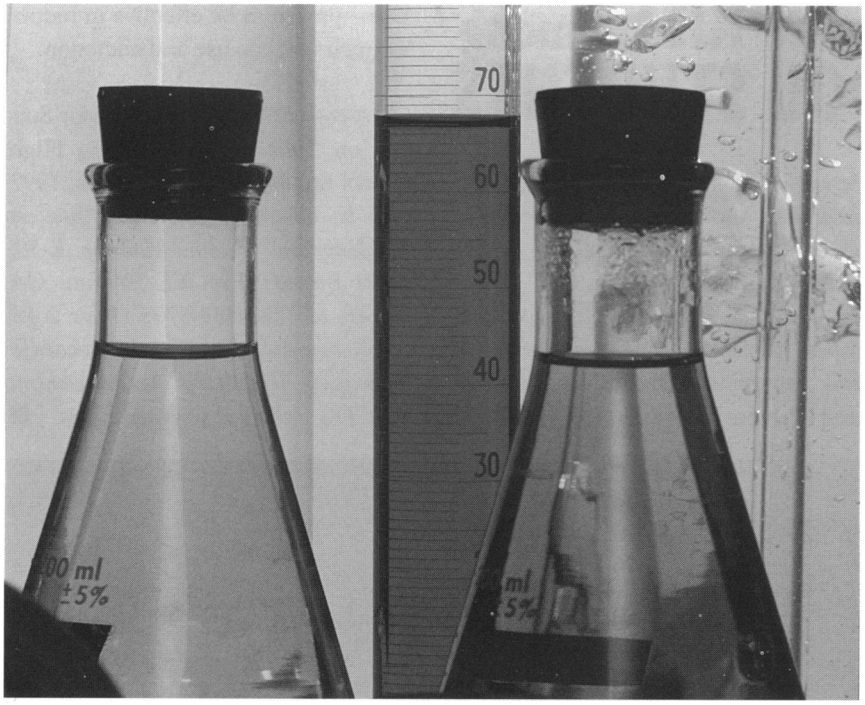
"Because nurses spend more time with patients and their families than do any other health professionals, they are in the most immediate position to provide care, comfort, and counseling at the end of life when critical decisions must be reached and compassionate and often highly specialized care provided," says AACN President Andrea R. Lindell, RN DNSc. "The roundtable's range of expert nurses—representing such areas as pain management, palliative care, and care involving such major sources of morbidity as AIDS, cancer, and kidney disease—illustrates the complexity of concerns that RNs must address in responding comprehensively to end-of-life needs of patients and their families."

Among its recommendations, the document calls for nurses to promote the provision of comfort care to the dying "as an active, desirable, and important skill, and an integral component of nursing care." Although nurses should respect the patient's views and wishes during care at the end of life, RNs should recognize their own attitudes, values, and expectations about death and the "individual, cultural, and spiritual diversity" existing in these beliefs and customs, the AACN document urges.

Moreover, nurses should use state-of-the-art traditional and complementary approaches to manage pain, anxiety, and other symptoms in patients at the end of life while at the same time, assisting patients, families, colleagues, and themselves to cope with suffering, grief, loss, and bereavement. In addition, the experts call for nurses to use legal and ethical principles in analyzing complex issues surrounding end-of-life care.

Acknowledging that few nursing schools will offer a separate course in end-of-life care, the AACN document recommends several ways that nursing educators can incorporate these issues into existing curricula. For example, students in health assessment courses should be taught to use standardized tools, such as numeric rating scales, to quantify pain, breathlessness, and other common symptoms at the end of life.

A copy of Peaceful Death *is available online at AACN's website at* ***www.aacn.nche.edu*** *or from AACN, 1 Dupont Circle, Suite 530, Washington DC 20036; tel. 202-463-6930.* ■



WHO Leads Assessment of Chemicals that Disrupt Hormonal Activities

A rapidly growing body of scientific evidence has shown that a number of substances interfere with the normal functions of the body governed by the endocrine system and thus have the potential to cause adverse health effects. *(See related article, PHR 1996;111:298-313.)*

One of the most dramatic consequences of such hormonal interferences could be the decrease in sperm count and quality recently reported in a number of countries. Indications for an increase in the incidence of some hormonally sensitive carcinomas, including female breast cancers as well as testicular and prostate cancers, could also be linked to the effects of these chemicals, called "endocrine disruptors." In addition, there are indications that exposure to these chemicals could alter physical and mental development in children.

Endocrine disruptors will now be under the permanent scrutiny of a Steering Group of scientific experts, which met for the first time in Washington DC in March 1998, at the Pan American Health Organization, which is also the regional office of the World Health Organization (WHO) for the Americas.

The meeting was jointly convened by the International Program on Chemical Safety (IPCS) and the Organization for Economic Co-operation and Development (OECD). The scientific experts who make up the Steering Group will participate in the development of a global inventory of research on endocrine-disrupting chemicals and an international assessment of the "state of the science" on these substances under the auspices of the IPCS.

Endocrine disruptors include natural and synthetic hormones; pesticides; monomers and additives used in the plastic industry; organometals; and detergent components; among other chemicals. They may interfere with hormones at various levels, including synthesis, storage, release, and transport. Target organs potentially affected include the male and female reproductive systems, the central nervous system, the thyroid gland, and the immune system.

The endocrine system is complex by nature, and multiple-organ interactions and effects are common. The establishment of a dose-response relationship, to determine what dose of a given substance is needed to compromise a functioning biological system, is a complicated task, because humans are often exposed to mixtures of chemicals. Even endogenous hormones, produced by the body, can interact with the endocrine system, making the situation all the more complex.

A resolution on "persistent organic pollutants" was adopted in May 1997 by the World Health Assembly. It called upon the Director-General of WHO to "take the necessary steps to reinforce WHO leadership in undertaking risk assessment as a basis for tackling high-priority problems as they emerge, and in promoting and coordinating related research, for example, on potential endocrine-related health effects of exposure to chemicals and on the possible links with cancer and reproductive, neurological and immunological disorders." ■

Tobacco Use Continues to RISE Among U.S. HIGH SCHOOL STUDENTS

The overall prevalence of smoking among high school students climbed by nearly a third between 1991 and 1997, with even sharper increases among African American students, according to a study by the Centers for Disease Control and Prevention (CDC).

The 1997 Youth Risk Behavior Survey measured cigarette, smokeless tobacco, and cigar use among more than 16,000 U.S. students in grades 9 through 12. Nearly half (48%) of male students and more than a third of female students reported using cigarettes, cigars, or smokeless tobacco within the month prior to being surveyed.

Almost 40% of white students, 34% of Hispanic students, and 23% of African American students reported using cigarette, smokeless tobacco, or cigars within the month prior to being surveyed. Alarmingly, these numbers show that the consistent decline in smoking once seen among young African Americans has reversed sharply in recent years, increasing by an estimated 80% between 1991 (13%) and 1997 (23%).

Smokeless tobacco use was much higher among male (16%) than female (fewer than 2%) students. White male students (21%) were significantly more likely to use smokeless tobacco products than African American or Hispanic male and female high school students.

The study also found the popularity of cigars to be high among high school students, with cigar use surpassing smokeless tobacco use. About one in five students (22%) reported having used cigars in the previous month—about three in ten male students and about one in ten female students.

Through its Research to Classrooms projects, CDC has identified two programs—Life Skills Training and Project Towards No Tobacco Use—proven to be effective in reducing teen tobacco use and addiction.

A copy of Youth Risk Behavior Survey on Tobacco Use Among High School Students—United States, 1997 *may be obtained from the Office on Smoking and Health, Mailstop K-50, 4770 Buford Hwy. NE, Atlanta GA 30341; tel. 770-488-5705 (Press 2 for publications); e-mail <tobaccoinfo @cdc.gov>. The study is also available on the CDC website at* **www.cdc.gov.** ■

SURPRISE!
Stogies Are Bad for You, Too

Out of fashion for decades, cigars—enhanced by the cachet of cigar-smoking celebrities—have become a status symbol once again. Cigar bars have appeared around the country, and vending humidors are now available in some places. In 1996, people in the United States smoked 4.4 billion cigars, 10 million more than in 1993.

According to the National Oral Health Information Clearinghouse (NOHIC), many cigar smokers mistakenly assume they are not at risk for diseases caused by cigarette smoking because they don't inhale or smoke only occasionally. In response, the public health community is trying to get out the facts.

The health effects of cigar smoking are the focus of one of the eight chapters making up the National Cancer Institute's new monograph titled *Cigars: Health Effects and Trends*. Additional topics include past and recent trends in cigar smoking, the toxic and carcinogenic compounds found in cigar smoke, the addictive potential of cigar smoking, marketing and advertising of cigars, and policies regulating taxation, labeling, and sale of cigars.

Among the facts cited by NOHIC:

- Cancers of the mouth, larynx, and esophagus are more common among cigar smokers than among nonsmokers.
- Cigar constituents enter the bloodstream directly through the mucosal lining of the mouth, so smokers are at risk even if they don't inhale.
- Cigar ingredients can include as many as 23 poisons and 43 carcinogens.
- Regular cigars can generate seven times as much tar, eleven times as much carbon monoxide, and four times as much nicotine as cigarettes.
- Abrasive particles in the cigar's outer wrapping can erode teeth.
- Cigar smoke promotes periodontal disease.

Ominously, the monograph also cites studies showing that one in four teenagers report having smoked at least one cigar within a year's time.

Copies of the NCI monograph are available: call 800-4-CANCER or go to the NCI website at ***rex.nci.nih.gov****; click on "Public," then "Prevention."*■

DHHS Announces Organ Transplant Regulation

Currently, allocation of scarce organs is based on accidents of geography, not on common medical criteria. The Department of Health and Human Services (DHHS) has established a new regulation to decrease geographic disparities.

The new rule calls on the Organ Procurement and Transplantation Network (OPTN), the private sector system created by the National Organ Transplant Act of 1984, to develop revised organ allocation policies that will reduce the current geographic disparities in the amount of time patients wait for an organ. The rule also calls on the OPTN to develop uniform criteria for determining a patient's medical status and eligibility for placement on a waiting list.

In 1996, some 20,000 Americans—about 55 each day—received organ transplants. Unfortunately, demand outstrips supply: more than 55,000 people are on the transplant waiting list nationwide and some 4000 people—10 every day—die while awaiting a donated organ.

More information on this issue is available at ***www.hrsa.dhhs.gov/osp/dot.***■