‘Medical Errors’ Uproar: IOM’s Scary Report Is Badly Flawed; Key Data Are Stale, Veiled, and Skewed

Shocking!

Between 44,000 and 100,000 Americans die each year in hospitals as the result of medical errors.

This devastating finding was announced late last year by the conservative Institute of Medicine (IOM), an arm of the similarly conservative — and recondite — National Academy of Sciences (NAS), in Washington, D.C.

Congress and the President responded rapidly:

Senate hearings have already been held. Bills were introduced, and at least one has been passed and signed into law. President Clinton’s proposals and directives call for new federal and state offices to oversee patient safety, which, as the New York Times pointed out approvingly, “will now . . . be a federal and state responsibility,” as well as a medical one. Tens, and eventually hundreds of millions of dollars will be committed to these efforts.

“President Clinton’s proposals, or something similar, seem likely to become reality,” health care reporter Robert Pear wrote in the New York Times (Feb. 22), on Page 1. One reason, he explained, is “The issue has great appeal to consumers, and this is an election year.”

In a word, pandering.

Much of the public debate is about finger-pointing: How to find ways to report medical errors to government officials. This concern was heightened by news coverage last month of criminal charges against a New York City obstetrician, Allan Zarkin, M.D., who — bizarrely — had carved his initials into the belly of a woman whose baby he had just delivered.

The IOM report, entitled To Err Is Human, and its dire findings, thus have become a persisting source of public concern and policy debate. Surely, the data to back this indictment of America’s health care system must be rock solid!

Problem: They’re not.

Not at all! (See analysis, p.5.)

This, too, suggests that politics, rather than scientific understanding, is driving the headline scramble. It also raises our sense that, as has happened before, the medical care system, and particularly doctors, are being scapegoated in pursuit of others’ political agendas.

Let’s look at the evidence behind the IOM report, which was written by a committee chaired by business administration expert William C. Richardson, Ph.D., president and CEO of the W.R. Kellogg Foundation, in Battle Creek, Michigan. The report is 221 pages long, and contains hundreds of footnotes. In fact, however, the report’s scary findings are based on just two studies. Here’s what the report says, on Page 1:

Two large studies, one conducted in Colorado and Utah and the other in New York, found that adverse events occurred in 2.9% and 3.7% of hospitalizations, respectively. In Colorado and Utah hospitals, 8.8% of adverse events led to death, as compared to 13.6% in New York hospitals. In both these studies, over half of these adverse events resulted from medical errors and could have been prevented.

continued on page 4
Follow-up
VERIS’s Veracity Is Strained Again

No sooner had we closed last month’s issue, than we received another promotional piece from VERIS Research Information Service, headlined “The Role of the Antioxidants in Cancer Prevention and Treatment.” VERIS, you will recall, is a front for Cogins Nutrition and Health, a La Grange, Ill., company that makes beta-carotene and other antioxidants.

Contrary to Cogins and VERIS, there is precious little evidence to show that beta-carotene or other carotenoids prevent cancer. And, there is quite a bit of evidence that indicates, to the contrary, that they don’t.

The latest mailing piece, called a VERIS Research Summary, is 20 large pages with 122 footnotes. Way at the end is this summary:

The majority of animal and human epidemiologic studies, and some intervention trials, have demonstrated beneficial effects of antioxidants in preventing certain cancers. In contrast, most of the intervention trials that investigated the effects of a single substance, such as purified beta-carotene, did not show a protective effect.

Unlike the Page 1 headline, the summary back on page 16 makes no claim for carotenoids as a cure or treatment for cancer.

Nevertheless, Cogins and VERIS want you to continue to take beta-carotene and other carotenoid pills. If a single one of these substances won’t help, well then maybe combining a few or more of them — as nature does in fruits and vegetables — will. Since it will be a decade or so before any of these combinations is proven to be of value — if in fact one ever is — consumers have not much more than the seller’s hunch and its profit and loss projections to show that these pills are worthwhile.

We say: Wait for the evidence.

# # #

Blood Still Spilt: We reported last month that the fed and the nation’s blood bankers still are dumping, rather than saving and using, blood drawn from patients with the iron overload disease hemochromatosis.

These patients need to be bled (phlebotomized) regularly to reduce their iron levels. Their blood then is discarded — despite FDA’s finding that it is perfectly safe, and suitable for transfusion recipients.

Blood banks have been slow to obtain a temporary waiver from FDA that would allow them to put this blood into the blood supply — relieving shortages — rather than continuing to throw it away.

A journalist in Brookwood, Alabama, David Reach, who has hemochromatosis, e-mailed us this report on his own, thus-far futile effort to see that his blood is put to good use. This is his account, which we have edited:

“I found out that I have hemochromatosis when I was 40, six years ago. I was told by my doctor that it was good blood, but the American Red Cross (ARC) would not use it.

“From the first time I was drawn off, I could not stand to see it thrown away.

“I just let it go [however], until I saw a TV news story last December. It said that [this] was good blood, and, if used, could wipe out the nation’s blood shortage in a day. That just floored me. The reporter said the ARC would not use it because it was given for the wrong reasons.

“I could not believe what I heard. I started searching the internet for Hemochromatosis, trying to find out if there was anything on the net that resembled what I had heard on TV, or just any reason why the Red Cross would not use this blood.

“I stumbled onto the American Hemochromatosis Society trying to find someone to talk to. I hit the join button hoping to get a person who could tell me more. This is when I found out about the FDA decision [that the blood is okay]. Sandra Thomas of the Society encouraged me to go to the nearest Red Cross donor center and try and give blood, to see if they were able to take it. If not, I could suggest they ask for a variance from the FDA.

“When I went to the Red Cross, they were still not authorized to take my blood, and did not know what the variance was. After that, I went to a nearby Red Cross office. The gentleman there was very helpful in trying to find out something about this. He put me in touch with one of the main ARC doctors in Birmingham, Ala. . . . He said it was something they had discussed, but had not acted on. He asked me to get back in touch with him in a week.

“After a week I e-mailed him twice before getting a response. It was short and sweet, citing safety concerns. He was not prepared to make the change. After I e-mailed him a third time, he said he would continue to work on this issue, but would not make a decision until he was comfortable that he had all the necessary data.

“That’s where we stand.”

—David Reach (IronMan)

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In its newsletter Vital STATS (Jan.), the conservative Statistical Assessment Service (SAS), a nonprofit organization, has a feature article on “the worst science of the century.” It awards a Dishonorable Mention to Silent Spring, Rachel Carson’s 1962 book on the menace of DDT, and what it calls the “demonization of DDT.”

Vital STATS is small potatoes, except that it is sent, free, to science writers, and SAS is rated as a standard source for reporters by the American Association for the Advancement of Science. Vital STATS is claiming the high ground of truth and accuracy in an important, world-wide conflict between developers and environmentalists. The stakes, thus, are high. And few contemporary journalists remember the antecedents.

In the left column, below, is the STATS item in its entirety. In the right column is our comment.

**Vital STATS**

Rachel Carson’s book, Silent Spring, drew attention to the dangers of the pesticide DDT, including the damage it did to the peregrine falcon population. It was also argued that the pesticide merely produced insects with increased resistance to it. DDT has since been blamed for increasing the risk of breast cancer among women. As a result, use of DDT has been banned or discouraged all over the world.

But it seems that bans on hunting, not DDT, have led to the revival of the peregrine falcon population, and long-term studies have shown DDT not to have the carcinogenic properties claimed. Even worse, because the most effective means of killing mosquitoes has been made unacceptable, malaria continues to kill 2.7 million people a year. Ecuador, which decided to increase the use of DDT in 1993, has seen a 60 percent drop in new malaria cases since then. Bolivia, Paraguay and Peru, which stopped spraying the same year, have seen an increase in new cases of more than 90 percent. DDT was not a panacea, but it saved lives.

It wasn’t Rachel Carson who brought DDT’s depredation of peregrine falcons to wide public attention. It was us, in this Aug. 9, ’70 cover story in the New York Times Magazine. The DDT ban was based on rock solid biological data.

**PROBE**

Rachel Carson didn’t mention peregrines in Silent Spring, as a simple check of the index would have revealed.

No one ever claimed that DDT didn’t kill insects. It does. But as WHO and UNICEF discovered and reported in the 1960s, repeated use does lead to the emergence of DDT-resistant strains of mosquitoes and other insects. That’s why these agencies’ campaign to eradicate malaria in Latin America failed.

The dubious claim that DDT causes breast cancer has been largely dismissed. But it is worth noting that in 1972, when peregrines, eagles, and ospreys were plummeting in numbers due to DDT’s use on crops, the only legal justification Congress had for banning it in the U.S. was danger to humans, not to birds.

We’ve covered peregrines conservation for 30 years, and we’ve never heard the birds’ decline blamed on hunting, or their resurgence attributed to a ban on hunting. This judgment is consistent with a major review article on the peregrine’s recovery in the New York Times (Feb. 15). What is more, federal and other researchers demonstrated — fulfilling Koch’s Postulates — that DDT caused these birds’ decline.

Present-day DDT bans do not — and need not — prohibit indoor spraying of DDT, which is the only way DDT can control malaria. (The anopheles mosquitoes that carry malaria, fortunately, bite only at night. They then alight to rest on the indoor walls of their victims’ homes, where the DDT kills them. They thus can’t transmit their first bite victim’s infected blood to anyone else.)

Used in this way, DDT has little environmental impact. The problem is, the mosquitoes soon become resistant to it, so that other insecticides are needed.

Last year the Nobel Prize-winning Physicians for Social Responsibility, in Washington, D.C., summed these matters up:

**DDT is no longer an appropriate tool in the fight against malaria.** [It] poses a threat to the environment and, potentially, public health . . . In wildlife, DDT and its metabolites have been linked with reproductive failures . . . . [S]ome mosquito populations have grown increasingly resistant to DDT over the years, reducing its longer-term effectiveness as an anti-malarial tool . . .

The statisticians at Vital STATS and elsewhere are correct that a lot of bad science gets translated into ill-informed policy and public opinion. By the same token, however, statisticians who comment on these matters can retain their credibility only if they do their homework — and get the other data right. Vital STATS in this case failed to do so.

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Credit Where Due

It wasn’t Rachel Carson who brought DDT’s depredation of peregrine falcons to wide public attention. It was us, in this Aug. 9, ’70 cover story in the New York Times Magazine. The DDT ban was based on rock solid biological data.
Error...
continued from page 1

Extrapolating these estimates to all U.S. hospital admissions, the IOM panel says, this comes to 44,000 deaths annually (based on Colorado and Utah), or "as high as 98,000 deaths," based on the New York study.

Western Data Are Fresher

The New York data, from what is called the Harvard Medical Practice Study, come from two Harvard physicians, Lucian L. Leape, M.D., and Troyen A. Brennan, M.D. (who also is a public health specialist and a lawyer) and several associates. It was published in the New England Journal of Medicine (NEJM) in 1991—Feb. 7 of that year, to be precise. But this was not fresh information even back then. The hospital records upon which the Harvard study was based came from 1984, sixteen years ago.

The findings provoked little controversy when they were published. Only two letters to the editor about the reports appeared in the NEJM in the next six months. Neither breathed fire.

Leape and Brennan subsequently raised their estimate of "iatrogenic injury" to 180,000 deaths per annum. Leape was also a member of the IOM panel.

The Colorado-Utah study is more recent, and might be considered to be more "fresh" data. Thomas and colleagues used data from Colorado and Utah hospitals (see chart, left). Their last words, unavailable to the public 'til now, should give pause. While much of the public debate has focused on whether and how to report individual health care providers' errors and mistakes, Thomas and his colleagues say that "many errors in medicine are likely the result of system failures rather than just one practitioner committing an error" (emphasis added). Improving health care systems thus might offer "exciting opportunities to improve patient safety."

In thirty years of medical reporting, we'd never heard of it. We doubt that many doctors, reporters or public health pundits have either.

Fiscal Costs Highlighted

The published Inquiry paper, however, is on the fiscal "costs of medical injuries." It does not discuss the scary morbidity and mortality findings, or the extrapolation to 44,000 annual deaths in the U.S. that are purportedly based on them.

This information is cited in the IOM report as "forthcoming in March," in a second publication, identified as Medical Care. This journal is similarly obscure. It took us ten days and thirty phone calls to find it in time to cover it here. It was published on February 28—long after everybody in Washington had made up his or her mind about it, based on the IOM report summary and news accounts.

There is this additional problem: The Colorado-Utah data also are stale. They were collected in 1992, and hence are eight years old!

The first author is ex-Harvard internist Eric J. Thomas, M.D., who is now in Houston. Brennan, again, is a co-author, and the study is a replay of the one in New York. But: significantly lower levels of disability and death were found in Colorado and Utah hospitals (see chart, left). The authors do not use the phrases "medical error" or "medical mistake" in their discussion. They report only adverse events and negligent ones.

Their last words, unavailable to the public 'til now, should give pause. While much of the public debate has focused on whether and how to report individual health care providers' errors and mistakes, Thomas and his colleagues say that "many errors in medicine are likely the result of system failures rather than just one practitioner committing an error" (emphasis added). Improving health care systems thus might offer "exciting opportunities to improve patient safety."

In other words, the investigators upon whom the IOM committee based their recommendations ended up with a proposal that is diametrically opposed to the finger-pointing that the IOM report, the President, Congress, and the press have indulged in.

Has the public been served by this policy debate? ■

This coverage continues on following page ➔
Findings Are Wildly Exaggerated

Our media colleagues grossly exaggerated the severity of the "medical error" problem, in part because the IOM exaggerates it in its report. So, too, do the authors of the key sources — whose conclusions are not wholly supported by their own data.

This is hard to understand, since one senior author of the Harvard study — the only published source of the dire estimates of deaths due to medical "errors" — was a member of the IOM committee that wrote the report. He might have corrected the report's exaggeration had he chosen to do so.

In a typical headline on the findings, the New York Times (Feb. 22) uses the words "medical mistakes." Others use the phrase "medical errors." The IOM report, referring to the alleged "13.6% of adverse events [that] led to death" in New York hospitals, claims, "Over half of these adverse effects resulted from medical errors and could have been prevented."

This is an incorrect interpretation of the Harvard study.

The Harvard authors do say at one point that "Most adverse events are preventable . . . particularly those due to error or negligence." But elsewhere their own data belie this assertion, since "error" is not an endpoint in the study, and negligence is implicated in only 28% of adverse events, i.e., a minority, not a majority.

The terms "error" and "medical error" are not defined outcomes in the Harvard study. The defined outcomes are adverse event and negligence.

"We defined an adverse event as an injury that was caused by medical management (rather than the underlying disease), and that prolonged hospitalization, produced a disability at the time of discharge, or both," the authors wrote.

"We defined negligence as care that fell below the standard expected of physicians in their community."

Charts Reviewed

The Harvard researchers read — reviewed — 30,121 randomly selected medical charts from patients hospitalized in New York State in 1984. They found adverse events in 3.7% of them. But of that 3.7%, only about a quarter, or "1%" as the authors write, were due to negligence. So, even if all negligent care were prevented, only a quarter of the adverse events could have been prevented — not the "half" claimed by the authors and the IOM.

Here's how the authors say it:

"We estimated that 3.7% of the patients . . . suffered adverse events, whereas the adverse events due to negligence was 1%."

Of that 1%, half died.

It is worth noting that the Harvard study is confusing and difficult to follow. It was published in two parts, and it also is worth noting that the first, more concise part, with Troyen Brennan as the lead author, does not contain the words "medical error." The second, more diffuse part, with Lucian Leape as the top author, does use the words "physicians' errors."

These refer to intermediate judgments by the medical reviewers who looked at the 30,000 patient charts. But only half (58%) of these errors were rated adverse events in the authors' final analysis, and only about one-quarter (28%) were identified as negligent, as noted above.

The Law Is Invoked

Citing tort law, the authors say: "Error is not the same as negligence . . . . The presence of error is a necessary but not sufficient condition of the determination of negligence."

Contrary to the tenor of the IOM report, and the news bulletins based on it, what is more, the Harvard Study authors say explicitly, that "adverse effects do not, of course, necessarily signal poor-quality care."

They also wrote:

"The judgments of [the] physicians [who reviewed the charts] that an adverse event led to death also require a note of caution. Many patients who died after an adverse event had very serious underlying disease, and several [?] surely had shortened life expectancies independent of their iatrogenic injury."

Amplifying this, they add:

"Many of the adverse events we identified were neither preventable nor predictable, given the current state of medical knowledge." Many such errors, therefore, "are unavoidable and therefore not negligent."

Old Folks at Higher Risk

A high proportion of the "errors" and adverse events occurred in elderly patients with multiple illnesses, who "are more than seven times as likely to have a complication as those without such conditions." Because of their frailty, the Harvard authors qualify their description of the fatal adverse events as "at least in part . . . a result of adverse events" (emphasis added).

In other words, an unknown number of these patients were already sick enough that they could have been knocked over with a feather.

This coverage continues on following page →
Doctors are not — should not — be blamed for the risk factors in the health care system. A different, non-judgmental approach will be needed to fix the problems it suffers.

This is the view of systems expert Robert A. Frosch, Ph.D., of the John F. Kennedy School of Government, in Cambridge, Mass. Frosch, a theoretical physicist, has developed and run major systems for NASA, the Navy, and industry — and he is familiar with efforts to diagnose and heal the health care delivery system. A systems approach is required, he says.

Medical care and hospitals are sometimes compared, unfavorably, to air transport and other major systems, Frosch told PROBE by phone. Airlines are organized to do highly routine work in a highly reliable way. Medicine, to the contrary, still is craft work. The health care system, such as it is, is not set up to manage the craft work that doctors do.

Given the present lack of a systems approach, Frosch says, "It's a marvelous thing that they keep the error rate as low as it is!" One thing the air transport industry has, and that health care lacks, is a non-punitive way of keeping track of "near-miss" events, through which participants can report incidents that might have ended in disaster, but didn't. These alerts are important in fine-tuning a system. To get these needed data, Frosch explained, it is necessary for workers to be able to respond without fear of retribution.

**Problems Need to be Found**

With these data coming in, or in hand, the next step is to study problems from the point of view of an industrial flow system. It's necessary to find out where the system is error-prone, and then find ways to fix it, Frosch said.

In many systems, including air travel, even the low man (or woman) on the totem pole is encouraged to ask difficult and searching questions about the process. Organizations with a high degree of reliability encourage this. But not in health care.

Would a nurse ask a doctor if the prescription he or she has just written is correct?

Under present circumstances, Frosch says, the answer is no. Comparing medical care to the space program, which also is a complex and high-risk system, Frosch added:

"What's needed by the medical system is a searching self-examination by people who think about the kinds of data flow, processing, and checking that NASA thinks about for a space launch!"

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**Epidemiologist Says, Go Slow!**

PROBE is not alone in its concern that too much action on so-called medical errors is built on too flimsy a research base.

Epidemiologist John Bailar, III, M.D., at the University of Chicago, told us by phone that he's concerned, too.

"I think there's need for a great deal more study of this situation before we start doing things that may have substantial effect with regard to cost, delay in the delivery of very important developments, or the assigning of blame to the wrong person or the wrong institution," he said. "The fact is, we're swimming in a sea of ignorance about this. While I'm convinced there's a problem, I don't know the dimensions or the shape of that problem!"

**Good Work Seen**

Bailar told PROBE he'd read substantial portions of the IOM report, and found that a lot of good work went into it. But, he said:

"A lot of it rests on a fairly shaky foundation."

The Chicago epidemiologist noted that you can find and record lots of errors, if you define "error" expansively on the one hand, and apply the definition *ex post facto*.

Modern medical modalities are extremely complex, and involve many care-givers, working under stress, in situations where action has to be taken quickly — often on the basis of inadequate information, he noted.

"It's possible to say after the fact that someone should have done something different," Bailar explained. "I have a lot of trouble with that kind of after-the-fact analysis."

He would like to see the whole issue restudied, in order to look at the evidence in some other, hopefully more useful ways.

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**Sloppy Editing? Or Spin?**

**REFERENCES**


IOM's key page of sources seems impressive (above). But closer inspection reveals repetitions of one source (arrows). This could have been avoided by use of standard abbreviations. Report authors and editors knew this correct usage, because they employed it on the following page below.

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**This coverage continues on following page →**
Dad Fights to Save Diabetic Daughter

By Stephen Barrett, M.D.*

Several times a year, I encounter cases in which separated or divorced parents battle about whether their children's health care should be administered by an "alternative" practitioner. One such case has provided me with a unique glimpse of naturopathy in action.

Mahri Morrow, now nine years old, lives in Portland, Oregon, a city in which naturopaths cluster. She was raised primarily by her mother, who is generally averse to standard medical care.

Her father, Charles, states that Mahri was not taken to a medical doctor until she was nearly eight, and had developed severe symptoms of insulin-dependent diabetes mellitus (IDDM). She had received two tetanus shots (three are recommended) but no other immunizations. She had never been treated with an antibiotic, even though some of the respiratory infections she suffered were probably bacterial in origin.

**Records Are Poor**

Mahri's records indicate that, at various times, she was treated by at least nine naturopaths. Their treatment notes are skimpy and contain little or no rationale related to the products prescribed. Several claimed that Mahri is allergic to dairy products, sugar, wheat, and various other foods — even though she exhibits no adverse reactions to these foods.

Although episodes of "chest congestion," "chronic cough," "vaginitis," "urinary burning" and "asthma" are noted in Mahri's records, there were no indications that these problems were adequately diagnosed or appropriately treated. Episodes of cough and "chest congestion," for example, were treated with homeopathic remedies. No homeopathic product has ever been proven effective against any disease.

Three of the naturopaths used a Vegatest device to diagnose "allergies" to sugar and many other foods, and recommended severe dietary restrictions, even though the child had not reacted adversely to any of the foods. The first of at least eight such tests was performed when Mahri was four months old. The Vegatest is a quack device claimed to measure disturbances in the body's flow of "electro-magnetic energy" along "acupuncture meridians." It actually reflects the amount of moisture on the skin, and how hard the practitioner presses a probe against the patient's fingers or toes. The Food and Drug Administration, which has banned importation of these devices, considers them to pose a "significant risk" because they are used to make nonexistent diagnoses. In order to use such a device, a practitioner must be dishonest, delusional, or both.

**Therapy Was Unorthodox**

Throughout most of her life, Mahri has been treated with dietary supplements, herbal products, and/or homeopathic products. The recommended treatments for both actual and nonexistent conditions included regimens of up to 50 pills a day, plus Chinese herbal teas, whether she is apparently healthy or not. The teas and many of the products contain multiple ingredients, placing her at risk for unpredictable adverse interactions. Some of the supplements were prescribed in potentially toxic doses. One treatment regimen included eating several cloves of garlic daily — enough to cause bad breath, which can pose some social risk. Another included daily dosage of 6 grams of vitamin C, which is 133 times the recommended dietary allowance for a child her age.

The inappropriate diagnoses and excessive numbers of prescribed pills may convey to Mahri the idea that she is chronically ill, which could undermine her self-esteem. The irrational dietary restrictions could subject her to teasing by her peers and place her at risk for the development of an eating disorder.

Although the nine naturopaths do not constitute a random sample, their unscientific practices were consistent with typical naturopathic writings.

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**How the Times Sees the Story**

Nothing better illustrates the difference between the New York Times and PROBE than our contrasting coverage of the IOM report. The Times has been all over this story — on Page 1, the editorial page, and more recently, in its science section. There, the newspaper of record rolled out its big gun, internist and medical correspondent Lawrence K. Altman, M.D., for a behind-the-scenes analysis in his "Doctor's World" column.

Here's Larry's lead (Feb. 29):

Doctors have amputated the wrong leg, killed patients with overdoses of medications and committed other serious errors for centuries. So why only now is a United States president calling for the first national plan to reduce such errors?

The reasons behind the new concern are as complex as medicine itself and as varied as recent changes in society, including medical advances, greater complexity of care, increasing challenge to medical authority and new techniques to pinpoint sources of errors in the maze of systems that doctors and hospital staffs use every day.

Altman is appropriately skeptical in his first paragraph on the continued on following page...
Cancer Society Hires PR Firms That Plug Cigs

Our colleagues at the Cancer Letter, Kirstin and Paul Goldberg, report that the American Cancer Society (ACS) has been using two public relations firms that also represent cigarette companies. This violates ACS's own rules, a spokesman conceded to the Goldbergs.

One company, Shandwick International, was fired by ACS after they learned that Shandwick also worked for R.J. Reynolds. Shandwick had helped ACS rewrite the National Cancer Act.

No sooner was Shandwick gone, than Cancer Letter (Jan. 28) reported that Edelman Public Relations — which represents health-related products as well as the ACS — also is promoting Brown & Williamson's KOOL Green championship auto racing team. B&W makes KOOL cigarettes. The ACS promised to drop Edelman after Cancer Letter reported its work for B&W and other cigarette makers.

Story...

continued from previous page

question, Why now? But in his second, wordy paragraph he buys the IOM's critique hook, line, and sinker.

He and a half dozen other writers and editors at the Times have the ability to examine the IOM report, and decide whether it makes sense — which it doesn't.

Instead, in fine Times style, Larry is set to work to justify — at great length — a story that is simply not there! — D.R.Z.

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