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BY THE PEW RESEARCH CENTER FOR THE PEOPLE AND THE PRESS

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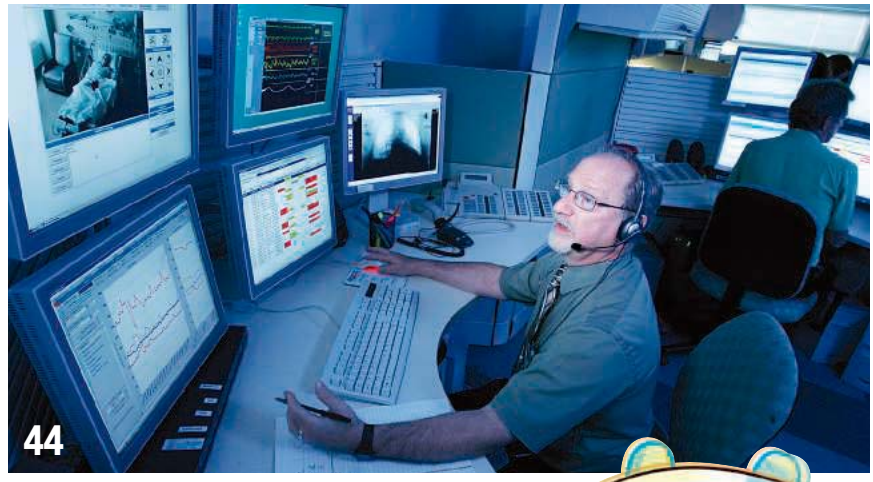

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Dig the Digest

As *Reader's Digest* celebrates its 1,000th issue, editor Jackie Leo talks to *U.S. News* about what keeps the magazine fresh after 83 years. She also provides highlights from this month's cover story, telling us what the future holds both in the short term (self-checkout at the supermarket) and decades away (flying cars).

www.usnews.com/digest

The Army's Armor

It used to be that a soldier's best friend was a rifle. But in America's current fight in Iraq, there is little question that a frontline trooper relies on his vest and helmet. Julian Barnes reports more insider Iraq news in our regular National Security Watch column.
www.usnews.com/armor

Colorectal Cancer

In our next installment of healthy living guides, *U.S. News* provides a help center on colorectal cancer, a widespread killer that doesn't have to be. While cancer of the large intestine is among the most common types, the good news is that there are high cure rates when it is detected early.
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Where Do I Find A Wired Hospital?

View the full list of America's 100 highest-tech hospitals, along with top vote getters in small and rural areas.
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Lexus ES330

Richard J. Newman finds an impressive engine but bland styling that fails to inspire.
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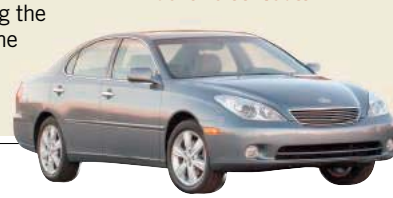

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America's Best Hospitals. Who's on top in cancer, heart, and pediatric care?
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Biz Buzz. Paul J. Lim catches you up on Main Street money worries and Wall Street business trends every day.
www.usnews.com/buzz

Whispers Poll. Court nominee John Roberts is winning early high marks. So how should Democrats handle him in the Senate confirmation hearings?
www.usnews.com/wwpoll

TOP: JASON GROW FOR *USN&WR*; MIDDLE ROW, FROM LEFT: LISETTE LE BON—SUPERSTOCK; ILLUSTRATION BY HARRY CAMPBELL FOR *USN&WR*; BOTTOM ROW, FROM LEFT: GAIL ALBERT-HALLIBAN; GUY SPANGENBERG—TOYOTA / LEXUS; ILLUSTRATION BY DAVID BAMUNDO FOR *USN&WR*

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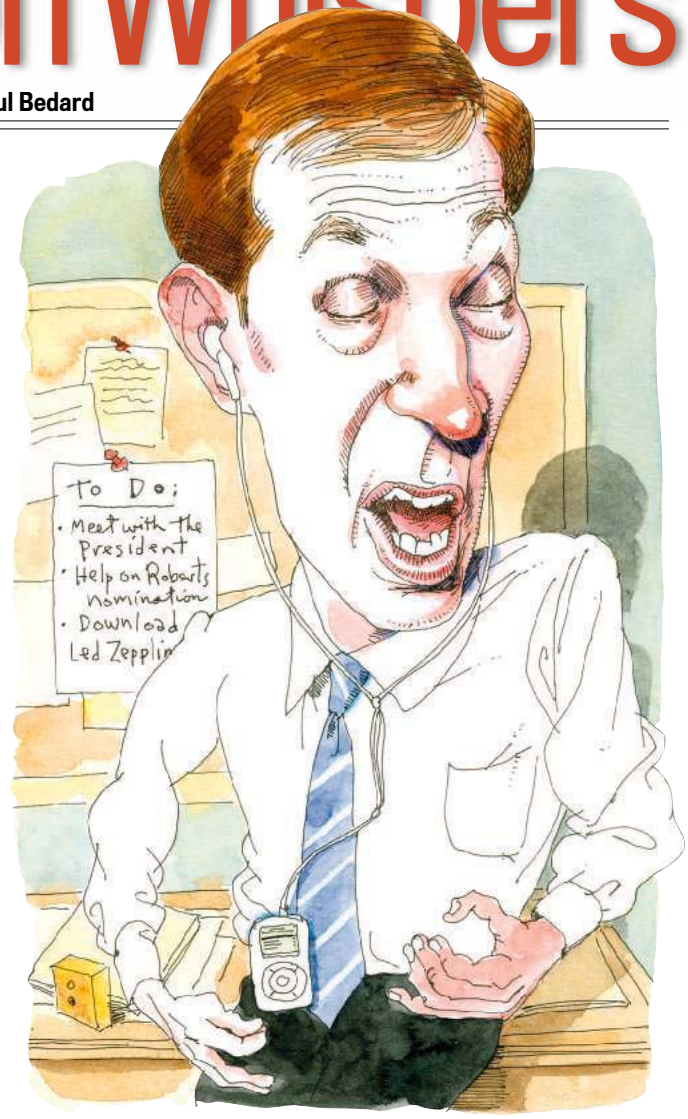
Washington Whispers

By Paul Bedard

Pols Rockin' Out—On iPod or 8-track

OK, so he's not the kind of guy we'd expect to see playing air guitar à la **Tom Cruise** in *Risky Business*, but that's not to take anything away from Deadhead **Ken Mehlman.** Yes, the same serious guy who is chairman of the Republican National Committee digs rock-and-roll. Just check out his brand new iPod. He's got a 20-gigabyte portable Apple and is filling it with a nearly complete collection of the Grateful Dead and Led Zeppelin. Who knew? But that's not all. Included in the 700 songs he has already downloaded are some from the Beatles, the Doobie Brothers, the Allman Brothers, Fleetwood Mac, Lynyrd Skynyrd, the Doors, the Stones, Pink Floyd, Jimi Hendrix, and even Ray Charles. "Listening to good tunes while I work out and run," he tells us, "is a great escape, and I try to do it every day." Insiders say he's a big downloader, using Apple's iTunes and keeping his iPod plugged in at work as he checks off items on his very long political to-do list.

Two blocks away on Capitol Hill, at Democratic Party HQ, Chairman **Howard Dean** isn't into iPods, but he's not lost musically, preferring Willie Nelson, the Beatles, Sheryl Crow, even rapper Wyclef Jean, an activist whose song "If I Was President" could be a Dean theme song. Dean's a Dead guy, too. He stays musically current thanks to all the CDs his kids leave in the car, though an aide concedes, "It's hard to get the newer artists on 8-track."



Yankee Lefty Might Pitch to the Right

Lefty pitcher **Al Leiter** is the toast of New York, now that he's left the Florida Marlins to help the Yankees in the pennant stretch. The Yanks think the 39-year-old with a winning record will help solidify a muddling rotation. But insiders say that's not the only reason he headed north. Republican tipsters say he's mulling a political bid in his adopted state or back home in New Jersey. GOP-ers say he has helped at recent Republican events and is up on current issues. He has even been featured as GOP "dude of the week" on the New Jersey Republican Party Web page. "Oh, he's one of us," says a Republican tipster: "A conservative."

Looking Inward For a Fed Head

Federal Reserve watchers got another clue last week about who might succeed **Alan Greenspan** when his 18-year stint as Fed chairman ends next January. **Ben Bernanke,** the former Fed governor just named **President Bush**'s top economic adviser, said he'll play a role in suggesting names to fill open Fed seats, but not Greenspan's. "I don't expect to be involved in the discussion of the chairmanship." Some took that as a suggestion that he's on the list of replacement candidates.

No Such Thing as Bad Publicity?

For many Hollywood stars, supporting People for the Ethical Treatment of Animals is a no-brainer. But come this week, some may be reconsidering. That's because the Foundation for Biomedical Research, which promotes "humane animal testing," is using *Variety*'s annual philanthropy edition to warn the stars about the case in North Carolina in which PETA workers stand accused of killing dozens of animals and tossing them in a dumpster. A front-page ad says, "Some people say there's no such thing as bad publicity." It refers to an inside ad that features **Alec Baldwin, Pamela Anderson,** and other stars on PETA's 25th Anniversary Honorary Committee and asks: "What is your publicist thinking?"

Clear Sailing for A Few War Vets

The old presidential yacht that has played host to many critical diplomatic events is now taking on an even higher cause. We hear

ILLUSTRATION BY JOE CIARDIELLO FOR *USN&WR*

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that the USS Sequoia is providing Potomac River cruises for injured Iraq and Afghanistan war vets being treated at Walter Reed Army Medical Center. "The soldiers really enjoy themselves," said Sequoia owner **Gary Silversmith.** But his tour is not just a quickie ride by the Alexandria, Va., waterfront. Silversmith has lined up politicians and NFL players to come along. Last week the pros included **Brian Mitchell,** the NFL's career leader in total yards; pro bowler **Ken Harvey;** ex-linebacker **Andre Collins;** journeyman linebacker **Keith Goganious;** and former Detroit Lion **Stan White.** All signed hats and photos. Democratic Sen. **Frank Lautenberg** of New Jersey and Louisiana Republican Sen. **David Vitter,** meanwhile, collected vets' complaints. One: Why aren't phone calls home from Iraq free?

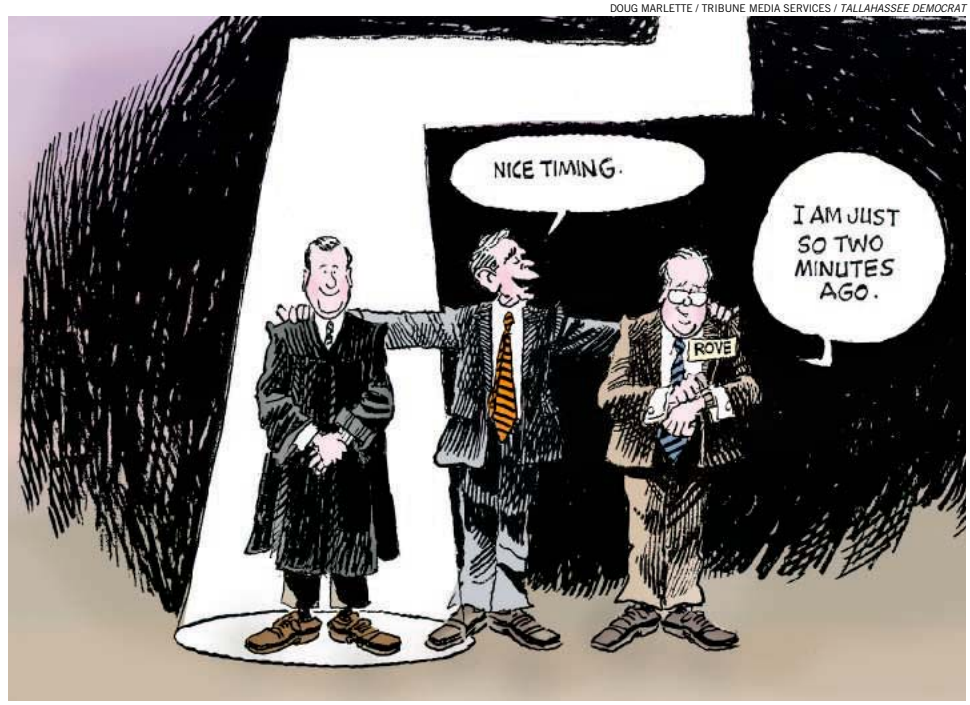
Must-Reading: Clinton, the Koran

Are we the only ones who find this odd? Among the books Iraqi Prime Minister **Ibrahim Jafari** keeps on his desk are the Koran and former **President Clinton**'s autobio, *My Life.* What's more, Bubba's book is filled with underlined passages. We learn this from our correspondent **Ilana Ozernoy,** who has interviewed Jafari several times in different offices, and every time the books were there. Naturally, she had to ask why Clinton's words were highlighted, figuring they held great meaning. Nope. "When I asked him about it, he said an aide had gone through and highlighted the graphs he wanted the PM to read."

Secrets of the First Doodlers

Ronald Reagan liked to draw horses. Ike preferred knives. LBJ put horns on heads. And Truman? "His few doodles appear woefully undeveloped—rough and haphazard," says **Paul Gilbert** of Basic Books. He knows because the publisher has collected doodles from 27 presidents and plans to bind them into a book. Of those we've seen, Reagan's look best, especially his pony. LBJ, who scribbled on White House stationery, drew the oddest: a three-headed girl.

DOUG MARLETTE / TRIBUNE MEDIA SERVICES / *TALLAHASSEE DEMOCRAT*



OUT LOUD

"He's good in every way, except he's not a woman."

Sandra Day O'Connor, retiring Supreme Court justice, on John Roberts, the man named to replace her

"You have to respect her. This is a first-class professional. And if Bill is 'first spouse,' it'll be one of the great moments."

Newt Gingrich, former House speaker, praising Sen. Hillary Rodham Clinton

"The beauty of daylight savings time is that it just makes everyone feel sunnier."

Rep. Ed Markey, on changing the law

"Meeting the president, maybe this really speaks more to the worldwide acceptance of the flip-flop."

Meghan Cleary, a footware expert, on the controversy over members of the Northwestern University women's lacrosse team who wore flip-flops to the White House

Sources: *Washington Post, GQ, Los Angeles Times, Chicago Tribune*

The 40th Time Is the Charm

Sen. **Edward Kennedy** can be one of the Senate's blustering best, but we found him in a candid moment last week when he sized up his speech this week at the AFL-CIO convention in Chicago. "You're gonna miss a great speech there," he said with a chuckle. "Same one I've given for 40 years. It's going to be breathtaking."

With Matthew Benjamin and Suzi Parker

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To see the doodles of LBJ, Reagan, and Eisenhower: www.usnews.com/whispers

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Edited by Peter Cary

SAMANTHA REINDERS FOR *USN&WR*

WHITE HOUSE MOMENT

7:00 p.m., July 18, White House North Portico

President George Bush and first lady Laura greeted **Manmohan Singh,** the prime minister of India, as he arrived for a White House dinner last week. Singh and Bush reached an agreement that, if approved by Congress and other countries, will bring India closer to being recognized as a nuclear-armed nation.

Democrats Want to Avoid Same-old, Same-old

Senate Democrats will use a nomination hearing strategy that was cooked up well before John G. Roberts got the nod for the Supreme Court. The plan—to raise questions about Roberts's support for civil and human rights—was designed to avoid stereotypical attacks on antiabortion candidates, Democratic officials said. Sen. Edward Kennedy (this will be his 20th Supreme Court confirmation hearing), whose aides helped plan the strategy, concedes that Roberts's nomination is going well, but he cautions the GOP about overconfidence. He also says that despite her activism as both a feminist and antiabortion advocate, Roberts's wife should not be an issue at the hearing. "I admire her for it," Kennedy said of the personal and professional career of Jane Sullivan Roberts. Senate aides added that they don't expect outside groups to make the Catholicism of Roberts and his wife an issue either.

Bush's Short, Hot Summer Timetable

The president felt he was under a lot more deadline pressure than White House officials let on publicly in the run-up to his nomination of John G. Roberts to the Supreme Court. Bush's aides started with his desire to have a new justice confirmed for the court's fall term in October, then backed up the timetable, taking into account the Senate's summer recess and the expectation that confirmation hearings would take about four days and that votes in committee and on the floor would consume another two or three days. Their conclusion: It was do or die last week, Friday at the latest.

More Mystery in the Plame-Rove Affair

As the news turned to the president's Supreme Court nominee and the latest London attacks, congressional Democrats strove mightily to keep alive the issue of who in the White House leaked the identity of a covert CIA agent. To that end, they held a Democrats-only hearing, questioning former intelligence officers on the dangers posed by such a disclosure. Meanwhile, the case of who knew that Valerie Plame worked for the CIA and who told that to the press took a new turn when the *Wall Street Journal* reported that her name and role appeared in a classified State Department memo prepared in 2003 for then Secretary of State Colin Powell—a memo possibly seen by other White House officials. The paragraph containing Plame's name was marked "S" for Secret. While it has been disclosed that Bush deputy Karl Rove talked to two reporters about Plame—apparently without naming her—Rove's lawyer says his client saw the memo only when a prosecutor showed it to him.

Troublemakers, Right to the Bitter End

The Treasury Department has learned that four sons of Saddam Hussein's half brother have provided financial support—and even weapons and explosives—to groups that have attacked coalition forces. So Treasury put their names, and those of two more nephews, on a list that would freeze any assets they might have in the United States and urged the United Nations to do the same overseas. That's key, officials say, because the six nephews live in Iraq, Syria, Yemen, and Lebanon. ●

With Paul Bedard, Kenneth T. Walsh, and Danielle Knight

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The Week

By Lisa Stein

Target: London—Again

It could have been much worse. In a city already on edge, London was shaken by a series of four small explosions on its vast mass-transit system last Thursday. The near-miss attacks—on three subway cars and a double-decker bus—were a virtual copy of the deadly blasts two Thursdays earlier that killed at least 55 people. This time, fortunately, all four devices only partially detonated, leaving panicked commuters unharmed.

The city did its best to live up to its stiff-upper-lip tradition. "It makes you more vigilant," says Ian Redding, a London commuter. "But people just get on with their lives." Still, London was rattled. Authorities cast a huge dragnet for new suspects, and police killed a man wearing a large, padded coat as he ran toward a subway car. The man, who ignored commands to stop, fell to the ground and was shot multiple times. Police also released photos of four new bombing suspects, including one wearing a shirt with "New York" emblazoned on the front.

ON THE RUN. A photo (above) released by Scotland Yard of one of four men wanted for questioning in last week's attempted attacks on London's transit system; at right, emergency personnel are reflected in a window near a targeted double-decker bus.

At first, the incidents appeared to be a pale copycat strike—the kind that counterterrorism experts refer to as a weapon of mass *distraction*. The explosives, concealed in backpacks, were said to be homemade. Police were optimistic that they would be able to exploit the partially intact devices for forensic clues, such as fingerprints and DNA. But there were increasing signs that London was lucky to escape relatively unscathed and that the two waves of attacks were connected. "This operation was carried out with the same professionalism and confidence, with the difference that the devices didn't explode" fully, says Charles Shoebridge, a London security analyst.

The hunt for the masterminds of the first wave of bombings, meanwhile, goes on. Revelations that at least two of the four suicide bombers spent time in Pakistan last year—where they may have met with radicals—sparked a crackdown on jihadist organizations there. Since the July 7 bombings, Pakistani authorities have arrested nearly 400 Islamists, many of them tied to violent groups focused on Kashmir. Making the investigation even tougher is the informal nature of the region's jihadist networks, in which militants from various groups, including al Qaeda, mix easily.

At the top of the Pakistan most-wanted list is Haroon Rashid Aswat, a 31-year-old militant from the same English town, Dewsbury, as Mohammed Sidique Khan, the oldest of the four suicide bombers. Investigators have tied Aswat to the bombers through phone logs. An aide to London's most notorious jihadist imam, the hook-handed Abu Hamza al Masri, Aswat scouted land in Oregon for a possible jihadist training camp six years ago, law enforcement officials say. Despite reports that Pakistani police have arrested Aswat, U.S. officials are skeptical, with one saying there is "no independent corroboration" of his capture.

In London, most people continued their daily commute, but warily. "If you see someone who looks Muslim with a backpack, you can't help but wonder," says Lisa Karady, a 17-year-old student. Adds Karolina Swiecka, another student: "I am not really worried today. Next Thursday, perhaps." *–Kevin Whitelaw and David E. Kaplan with Thomas K. Grose in London and Aamir Latif in Pakistan*

The Patriot Act Gets a Second Act

Just hours after last week's failed London attacks, the House renewed the U.S.A. Patriot Act. Lawmakers OK'd the measure—which gives the feds more power in terrorism probes—by a 257-to-171 margin; 43 Democrats joined Republicans. Legislators made some provisions in the post-9/11 law permanent and extended two of the most controversial for 10 years: One allows investigators to get "roving wiretaps" to bug calls and Internet traffic from any venue; another permits the feds to scour business, library, and medical records. In an attempt to assuage critics, who say the law steps on privacy rights, the House package requires the FBI director to sign off on records searches. The bill sets a minimum 20-year jail term for mass-transit attacks; 30 years for strikes on vehicles ferrying nuclear material, and life—with the possibility of death—if anyone is killed in such attacks.

● *The Senate is considering versions that, among other things, could give the FBI expanded powers to subpoena records without the approval of a judge or grand jury.*

Iraq's Forces: Ready—or Not

Some 171,300 Iraqi police officers and soldiers have been equipped and trained, says a Pentagon report to Congress last week. But a serious question remains: How well can those cops and soldiers

FROM LEFT: METROPOLITAN POLICE / AP; ADRIAN DENNIS—AFP / GETTY IMAGES

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SPOTLIGHT

Mojo in Motor City?

DETROIT—Major League Baseball's All-Star Game last month ignited some hope in Detroit, the perpetually sullied city that has for three decades promised to clean up its act. The midsummer classic drew glowing attention, something the city has seen precious little of recently. But while an estimated 100,000-plus tourists and suburbanites briefly wandered the freshly scrubbed streets, Detroit has been hemorrhaging residents at a rate of 1,000 a month in the past year. They are fleeing a city where the feds monitor a troubled police department and housing commission. At least 700 police and fire department layoffs are pending to help plug a $300 million budget deficit, and the city faces state takeover if it can't pay its bills. This all leaves Mayor Kwame Kilpatrick, 35, in quite a bind as he heads into the August 2 mayoral primary. The "hip-hop mayor" badly trails Freman Hendrix, 54, a former deputy mayor, polls show. His Honor will probably survive the nonpartisan primary, but the November 8 election could be trouble.

FABRIZIO CONSTANINI—*THE NEW YORK TIMES*

Mayor Kwame Kilpatrick hits the streets of Detroit to campaign.

Scandal-scarred. It should come as absolutely no surprise, of course, that Kilpatrick is in such a jam, given the number of self-administered black eyes on his watch. Among them: the leasing of a Lincoln Navigator on the city's dime—cost: $25,000—and the use of a city-issued credit card for extravagant purchases. Kilpatrick, however, did make good on campaign pledges to revive housing starts and get rid of rundown buildings all over the city. "The race is still his to lose," says veteran Detroit political consultant Sam Riddle. "He is a native son, but there is no doubt it is an administration on the ropes."

While its politics simmer, the city's cockeyed charisma, a blend of post-industrial hipness and gritty history, keeps it from being written off completely. But as for a wholesale comeback, "we're still waiting," says Eric Lupher of the Citizens Research Council of Michigan. "There have been plenty of big cities that have fallen and gotten back up. But I don't think any have fallen as hard as Detroit." *–Steve Miller*

fight? The real answer was relegated to a classified annex that the military refuses to discuss in detail. But the Pentagon acknowledged that about half the police and a third of the soldiers are not yet ready to fight the insurgency, even with the help of American units. Although the military says the remainder of the police and soldiers can fight with American forces' help, Lt. Gen. Walter Sharp, the Pentagon's director of strategic plans and policy, admits that only a slice of the Iraqi force can operate independently. "We are alongside them, helping them," he said. "You should not minimize this as far as Iraqi security forces' bravery or capability."

● *Left unanswered: When might Iraqi troops be able to stand on their own—and American forces sent home?*

Hey, Is It Hot Enough for You?

Can you believe this miserable, suffocating heat? Last week, 21 deaths in the Phoenix area were blamed on a stifling heat wave engulfing the Southwest—and spreading. The mercury in the desert city rose to a record 116 degrees during a four-week span from June 19 to July 20 when maximum temps dipped below 108 degrees on only two days, says Tony Haffer, the National Weather Service's meteorologist in charge in Phoenix. He says most residents sought refuge in air-conditioned homes and offices, but the less fortunate—mostly the homeless—died, as did a toddler left in a car. In Denver, oven-hot temps hit a record 105 degrees; it was so sweltering that zoo officials sprayed down animals and fed some popsicles. It was even steamier in Las Vegas, says Craig Schmidt, a meteorologist in the National Weather Service's western region headquarters; residents there baked in temps that shot up to a record 117 degrees, the hottest since 1942. The best way to beat the heat, says Will Humble of Arizona's Department of Health Services: Stay out of the sun, drink lots of fluids—at least 2 quarts a day—exercise outdoors only between 5 a.m. and 8 a.m., and do *not* leave children or animals in cars, which can become 135-degree steam boxes in minutes. Monsoons are supposedly moving in, promising some relief in the Southwest.

● *The bad news: The relief will likely be fleeting. So brace yourselves—it's gonna be a long, hot summer.*

The Dawning of a New, Longer Day

Ever wish that the light of day could last just a little bit

ETHAN MILLER—GETTY IMAGES

STAY COOL. Ashley Barberio-Kitts (left), 18, and her sister, Chelsea, 15, eat ice cream in front of a fan to keep cool in broiling Las Vegas.

Suffering From Abdominal Pain?...

Each year in the United States:

- Hospital Emergency Departments receive almost 6 million visits from patients complaining of stomach and abdominal pain.
- 50% of 700,000 patients with suspected appendicitis do not display typical symptoms — pain in the lower right abdomen and fever.
- Over 100,000 patients with appendicitis are not diagnosed in time, and suffer a perforated appendix.
- Over 95,000 patients who have their appendix removed have a normal appendix.

Sources: National Center for Health Statistics, 1995; 2003 PIBD; 2003 MedPAR; http://www.rsna.com.

Learn more about appendicitis, other causes of abdominal pain, and new and exciting methods that could help to insure an accurate diagnosis.

appendicitisinfo.com

NeutroSpec™ [Technetium (99m Tc) fanolesomab] contains both murine antibodies and sodium hydrosulfite, each of which has been known to induce allergic reactions, including anaphylaxis. The most frequently observed adverse events seen in clinical studies were flushing and dyspnea.

See accompanying brief summary of prescribing information.

Sponsored by NeutroSpec™ imaging agent, indicated for the diagnosis of equivocal appendicitis.

NeutroSpec™
Find it. Define it.™

[Technetium (99m Tc) fanolesomab]

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NEUTROSPEC™

Kit for the Preparation of Technetium (99m Tc) fanolesomab
Diagnostic Radiopharmaceutical
For intravenous use only
Rx ONLY
CONTAINS SODIUM HYDROSULFITE

Before prescribing, see complete prescribing information. The following is a brief summary.

DESCRIPTION

NeutroSpec™ [Kit for the Preparation of Technetium (99m Tc) fanolesomab] is a radiodiagnostic agent consisting of a murine IgM monoclonal antibody, formulated to be labeled with technetium Tc 99m. NeutroSpec™ [Technetium (99m Tc) fanolesomab] is an *in vivo* diagnostic radiopharmaceutical that can be visualized by nuclear medicine instrumentation.

INDICATIONS AND USAGE

NeutroSpec™ [Technetium (99m Tc) fanolesomab] is indicated for scintigraphic imaging of patients with equivocal signs of appendicitis who are five years of age or older.

CONTRAINDICATIONS

NeutroSpec™ should not be administered to patients who are hypersensitive to any murine proteins or other component of the product.

WARNINGS

Hypersensitivity Reactions

Allergic reactions, including anaphylaxis, can occur in patients who receive murine antibodies such as fanolesomab.

Cenolate™ Ascorbic Acid, USP injection (diluent) contains sodium hydrosulfite, a sulfite that may cause allergic reactions, including anaphylaxis. Serious hypersensitivity reactions were not observed in the 523 patients who received NeutroSpec™ in the clinical studies. Emergency resuscitation personnel and equipment for the treatment of hypersensitivity reactions should be immediately available during administration of this agent.

PRECAUTIONS

Repeat Administration

NeutroSpec™ has not been studied in repeat administration to patients. Murine monoclonal antibodies are frequently immunogenic. The development of human anti-mouse antibodies (HAMA) can alter the pharmacokinetics, biodistribution, safety, and imaging performance properties of the administered agent.

Use in Patients with Neutropenia

The biodistribution and the imaging performance of NeutroSpec™ in neutropenic patients have not been studied. NeutroSpec™ induces transient neutropenia and a downward shift in white blood cell counts. (See **ADVERSE REACTIONS Laboratory Values**.) The safety and effectiveness of NeutroSpec™ in patients with neutropenia have not been established.

General Use and Handling

NeutroSpec™ [Technetium (99m Tc) fanolesomab], like other radioactive medical products, must be handled with care and appropriate safety measures should be used to minimize radiation exposure to clinical personnel. Care should also be taken to minimize radiation exposure to the patient consistent with proper patient management.

Radiopharmaceuticals should be used by or under the control of personnel who are qualified by specific training and experience in the safe use and handling of radionuclides, and whose experience and training have been approved by the appropriate governmental agency authorized to license the use of radionuclides.

Information for patients

Murine monoclonal antibodies such as fanolesomab are foreign proteins and their administration can induce hypersensitivity reactions. Patients should be informed that the use of this product could affect their future use of other murine based products, and should be advised to discuss prior use of murine antibody based products with their health care provider.

To minimize the radiation-absorbed dose to the bladder, adequate hydration should be encouraged to permit frequent voiding during the first few hours after injection. To help protect themselves and others in their environment, patients should take the following precautions for 12 hours after injection. Whenever possible, a toilet should be used, rather than a urinal and the toilet should be flushed several times after each use. Spilled urine should be cleaned up completely. After each voiding or fecal elimination, patients should thoroughly wash their hands. If blood, urine or feces soil clothing, the clothing should be washed separately.

ADVERSE REACTIONS

The data described below reflect exposure to NeutroSpec™ in 523 patients and normal volunteers receiving a mean antibody dose of 121 µg (33–250 µg) and a mean radioactive dose of 15 mCi (1-33 mCi). The median patient age was 35 years (5-91 years); 53% of patients were women and 61% of patients were Caucasians.

Two patients enrolled in studies of post surgical infection or abscess had serious adverse events associated with fatality (hypotension and worsening of sepsis). Underlying medical conditions may have also contributed to the fatality and the relationship of the fatality to NeutroSpec™ cannot be determined.

Overall, 49 adverse events occurred in 37 (7%) of the 523 patients exposed to NeutroSpec™. Four of these events were classified as severe (hypotension, worsening of sepsis, chest pressure and decreased SaO_2, pain). The most frequently reported adverse events were flushing (n=10, 2%) and dyspnea (n=5, 1%). Other less common adverse events (< 1%) included syncope, dizziness, hypotension, chest pressure, paresthesia, nausea, injection site burning/erythema, pain, and headache.

Because clinical trials are conducted under widely varying controlled conditions, adverse reaction rates observed in clinical trials of a drug cannot be directly compared with rates in the clinical trials of another drug, and may not reflect the rates observed in practice. The adverse reaction information from clinical trials does, however, provide a basis for identifying the adverse events that appear to be related to drug use and for approximating rates.

Laboratory Test Values

NeutroSpec™ induced transient decreases in neutrophil counts in a study of 10 healthy volunteers. Neutrophil counts began to decrease within 3 to 5 minutes post-injection and returned to pre-injection values within four hours. Downward shifts in neutrophil counts have been observed in 18% of patients (28/151). Three of 284 patients were observed to develop transient elevations of AST and ALT after NeutroSpec™ administration.

Immunogenicity

The incidence of antibody development in patients receiving NeutroSpec™ has not been adequately determined because the assay was not directly quantitative and its ability to detect low titers could not be assured. Human anti-mouse antibody (HAMA) response following a single NeutroSpec™ administration was evaluated in a total of 54 patients 3-16 weeks post injection. None of the patients had a positive HAMA response. In 30 healthy volunteers who were exposed to two administrations of fanolesomab separated by two weeks, fanolesomab induced HAMA response in five volunteers.

Immunogenicity data are highly dependent on the sensitivity and specificity of the assay. Additionally, the observed incidence of antibody positivity in an assay may be influenced by several factors, including sample handling, timing of sample collection, concomitant medications, and underlying disease. For these reasons, comparison of the incidence of antibodies to NeutroSpec™ with the incidence of antibodies to other products may be misleading.

NeutroSpec™ is manufactured for Palatin Technologies, Inc., Cranbury, NJ 08512 by Ben Venue Laboratories, Inc., Bedford, OH 44146.
U.S. Patent 6,066,309
U.S. License Number 1588

Cenolate™ (Ascorbic Acid Injection, USP) is manufactured for Palatin Technologies, Inc. by Hospira, Inc.,Chicago, IL 60064.

Distributed by:
Mallinckrodt Inc.
St. Louis, MO 63134

NeutroSpec™ is a trademark of Palatin Technologies, Inc.
Cenolate™ is a trademark of Hospira, Inc.

Rx Only

longer? Well, your wish is about to come true. House and Senate negotiators last week agreed to extend daylight-saving time by four weeks, starting the second Sunday of March and continuing through the first Sunday of November. Studies show that longer days cut the crime rate and number of fatal traffic accidents, and there will be a review to determine energy saved.
● *Plus, says cosponsor Rep. Fred Upton, "Kids across the nation will soon rejoice with extended daylight on Halloween night that will allow for an additional hour of trick-or-treating."*

CORBIS BETTMANN

A FAREWELL TO ARMS. Ret. Gen. William Westmoreland—who commanded the American troops during the Vietnam War, the longest and the only war America lost—died last week at 91.

Death of a Salesman

Long before microwaveables, there was the trusty TV dinner, a frozen meal in a tin-foil tray that boomer parents would pop in the oven when they were too tired, too busy, too lazy, or too incompetent to cook. TV dinners debuted in late 1953 after Gerry Thomas, then a salesman for C. A. Swanson & Sons, hatched the idea. The first "Swanson TV Dinner"—turkey with cornbread stuffing and gravy, sweet potatoes, and buttered peas—sold for 98 cents and could be cooked in 25 minutes at 425 degrees. TV Dinners went like hotcakes from the get-go, novelty and marketing trumping taste. Five-star meals they weren't. But they were trendy and cool and easy—and they heralded a brave new world in which women were freed from the kitchen and kids were freed from the table. In a 1999 interview with the Associated Press, Thomas credited marketing for the phenomenal success, noting that he capitalized on the then booming popularity of TV by putting a television screen and knobs on the package. Alas, not everyone was a fan. Thomas said Swanson received "hate mail from men who wanted their wives to cook from scratch, like their mothers did."
● *Last week, Thomas—who not surprisingly became marketing director—died at 83 in Paradise Valley, Ariz., leaving behind a taste for life frozen in time.*

PEOPLE

A First Ladies' Man

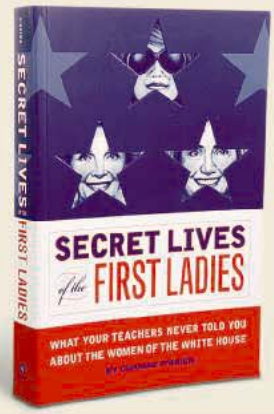
Maybe people don't know much about 13th President Millard Fillmore, but they know even less about his wife, Abigail, who met the future commander in chief when he was an 18-year-old student in the schoolroom where she taught. There are plenty of other juicy tidbits in the new *Secret Lives of the First Ladies* ($17) by **Cormac O'Brien**, who also wrote *Secret Lives of the U.S. Presidents*. He chronicles all of the gals, from the first George's Martha to the current George's Laura.

There's speculation about how Laura Bush's pro-choice views may sway her husband. How much of an impact does she have on the president?
If she does, it's private. She's not a force in the administration. It's a first ladyship very much like the early ones, where she hangs back.

How common has it been for first ladies to disagree with their husbands?
Way back to James Polk's wife, Sarah. She was known for debating with him. It was not quite scandalous then, but unusual. Then Pat Nixon and Betty Ford openly discussed opinions that weren't [the same as] their husbands'. There was that *60 Minutes* interview with Betty about marijuana and abortion. He thought that interview cost him 10 million votes.

Is there a trait the first ladies have shared?
I think misery. And a real fear of losing identities and privacy. Jane Pierce fainted when her husband, Franklin, won; Bess Truman wept. Margaret Taylor, Zachary Taylor's wife, prayed every day during his campaign that he'd lose.

Who was the most unusual first lady?
Ida McKinley was an odd one and had a tragic story. She was absent throughout the campaign because she was ill, and then she appeared at the inaugural ball all dressed up and immediately passed out. Turns out she had epilepsy, so she stayed in bed most of the time knitting thousands of pairs of slippers. When they were at dinner, she would have seizures, and William had a habit of draping a handkerchief over her head.



Any first ladies you're obsessed with?
Frances Cleveland became a revelation for me. She was the youngest first lady and exceptionally beautiful. When she married Grover, the notorious bachelor, she became a tabloid media sensation. During one slow summer, a bunch of reporters decided to make up a story that she'd stopped wearing the bustle.

What's a bustle?
It's a frame that extended a woman's rear end.

Right.
So once this was reported, it killed the bustle. Everyone stopped wearing them—and eventually Frances did, too. *–Vicky Hallett*

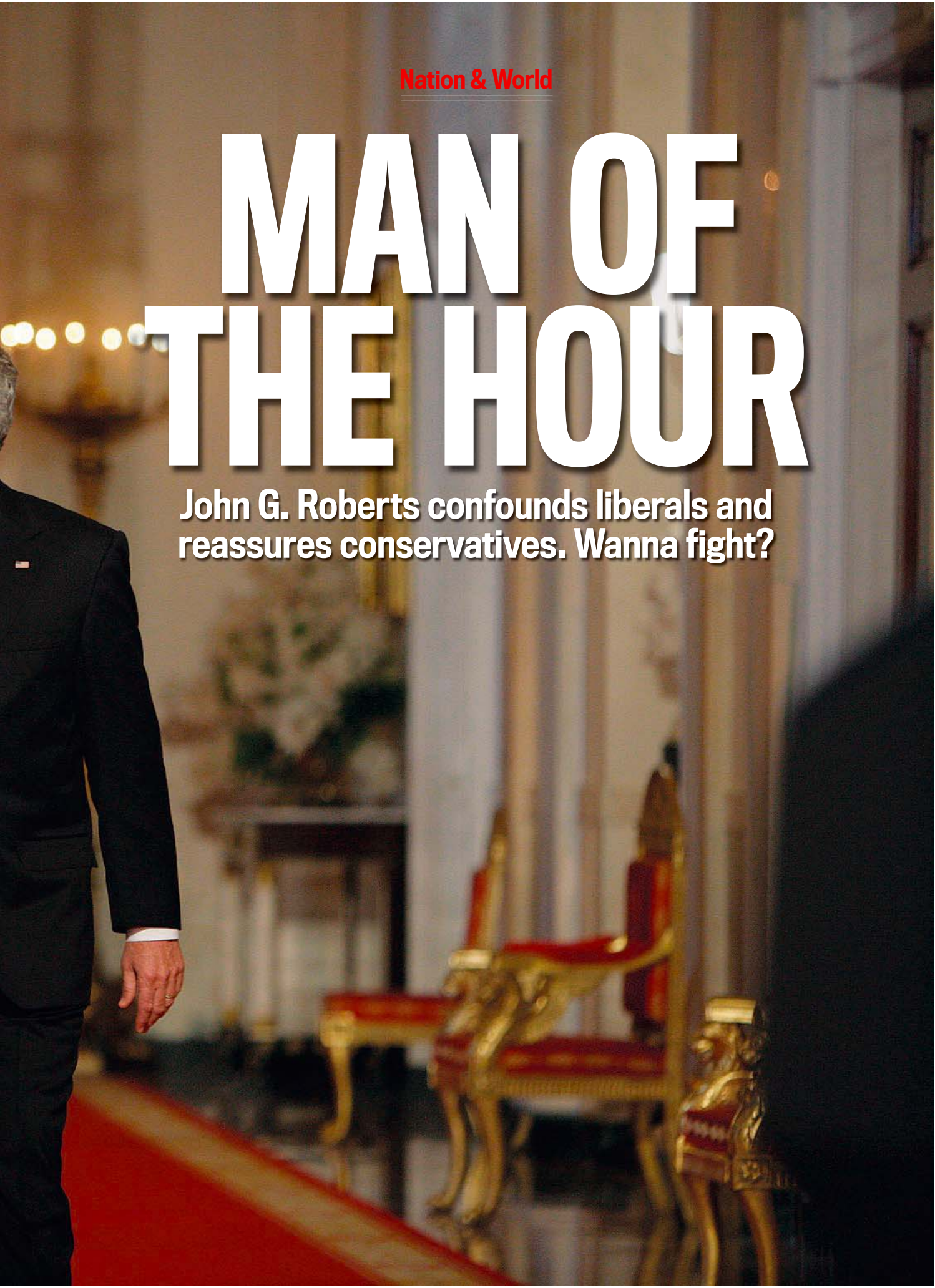
FROM LEFT: LAUREN BECK; CHARLIE ARCHAMBAULT FOR *USN&WR*

Judge John G. Roberts and President Bush on their way to the introduction

JIM LO SCALZO FOR *USN&WR*

MAN OF THE HOUR

John G. Roberts confounds liberals and reassures conservatives. Wanna fight?



By Liz Halloran, Dan Gilgoff, Bret Schulte, and Terence Samuel

It was the coming cataclysm—a political death match over President Bush's first nomination to the Supreme Court and the next chapter in the nation's overheated culture wars. On one side, conservatives massed to avenge an 18-year-old grudge over Robert Bork's failed nomination and rein in a court that, in their eyes, has usurped the role of Congress in making law. On the other side, liberals expecting a right-wing nominee threatened a political Armageddon with one of their last remaining powers: the Senate filibuster.

But then, *poof,* less than 24 hours after the president named Judge John G. Roberts, a respected Washington insider, the anticipated high-stakes brawl wilted like an Ohio tourist in Washington's searing summer heat.

The fight, it seemed, was over before it began.

Though abortion-rights groups came out swinging, the mood on Capitol Hill, where Roberts made courtesy visits in the days following his nomination, was downright agreeable. Even liberal lions like Ted Kennedy, whose devastating attack on Bork minutes after he was nominated set the course for his rejection, announced on the Senate floor that he would not "prejudge" Roberts, adding: "I will not decide whether to support or oppose him based on any single issue."

By week's end, Senate Democrats admitted they'd be hard pressed to filibuster Roberts's nomination. Conservative groups canceled teleconference strategy sessions, saying they were unnecessary. Even liberal activists reluctantly acknowledged the deftness of Bush's choice: a brilliant, low-key 50-year-old lawyer with solid conservative credentials, an independent streak, and, perhaps most important, a negligible paper trail from two short years on the U.S. Court of Appeals in Washington. "If there's nothing new out there," said a Democratic strategist, "he's going to get confirmed."

"Those who know him say he is extremely conservative. [But] he doesn't make speeches. He doesn't write articles."

Prof. Herman Schwartz, American University

"Nuclear option" unlikely. Born in Buffalo and raised in Indiana, Roberts, the son of a steel plant manager, seems far less a lightning rod for the left than other judges on the president's short list. "We're seemingly off to a smooth start," says Sen. Mary Landrieu, a Louisiana Democrat. Though much could change prior to his expected confirmation hearings before the Senate Judiciary Committee in September, the Harvard-educated lawyer and married father of two adopted children is clearly on course to replace retiring Justice Sandra Day O'Connor. "He looks very good going into this process," says Nebraska Sen. Ben Nelson, a Democrat and one of the "Gang of 14" senators who brokered a deal in late May to avoid the "nuclear option" that would have ended the right to filibuster judicial nominees. Roberts, who has argued 39 cases before the Supreme Court, is already benefiting from that deal, which calmed emotions on Capitol Hill, since some of the Gang have decreed that his nomination does not constitute an "extraordinary circumstance" that would put a Democratic filibuster back on the table.

Though Roberts has given the opposition little to shoot at, his record shows him to be a solid conservative. He clerked for Chief Justice William Rehnquist and has served in two previous Republican administrations. There is little doubt that in replacing O'Connor, a centrist who was often the key swing vote in high-profile cases, he would push the court firmly to the right. So Democrats say that, nice a guy as he is, Roberts can look forward to some aggressive questioning during the hearings. "People are looking forward to getting into his record and having a robust nomination process," says Arkansas Sen. Mark Pryor. "Nonetheless, people are impressed by him so far."

And the American public, almost always game for some good political theater, can still expect quite a show during televised Senate hearings. Starting with Kennedy and ranking minority member Patrick Leahy of Vermont, Democrats on the Judiciary Committee will press Roberts to answer questions about his position on abortion and about the court briefs he wrote for the Reagan and first Bush administrations. New York's Charles Schumer, a reliable liberal flame-thrower, wants Roberts to produce documents from his stints as principal deputy solicitor gen-

JIM LO SCALZO FOR *USN&WR*

The nominee meeting with Republican senators before a gaggle of photographers

eral and associate White House counsel —a request the president is likely to resist vigorously. Cue the fireworks.

While Democrats insist they need more information, religious conservatives are satisfied with what they know. Despite Roberts's limited judicial record, they believe he is "strict constructionist," if not an "originalist" like Justices Antonin Scalia and Clarence Thomas. "I don't think there's any evidence that he's going to be another [Justice David] Souter," said James Dobson, the founder of Focus on the Family. A little-known state-court judge from New Hampshire, Souter came to Washington with a thin record and turned out to be a bitter disappointment to the right after his nomination by President Bush's father. "We know a lot about Judge Roberts from his life, from his record, and from the things that he stood for," says Dobson. "This is a man who we could get very excited about."

Roberts's record on abortion, however, appears somewhat ambiguous. In a 1991 brief for the first Bush administration, he wrote that *Roe v. Wade* was "wrongly decided and should be overruled." But in his 2003 appeals court confirmation hearing, Roberts said the brief was written in his role as "an advocate for a client," adding that he believed the legal right to abortion "is the settled law of the land . . . . There's nothing in my personal views that would prevent me from fully and faithfully applying that precedent."

The ambiguity means that conservatives, to some extent, "are being asked to take a leap of faith," says Manuel Miranda, who heads a coalition of conservative activists, but that leap has been eased by the White House staff, which made phone calls to assure conservative religious groups before Bush introduced Roberts. Ted Haggard, the president of the National Association of Evangelicals, says he was told by a White House aide that Roberts "would have respect for precedent,

but that precedent would not have the same weight as the Constitution itself," perhaps signaling the nominee's stance on *Roe*.

Support from religious activists stems largely from reports of Roberts's faithful Catholicism and his wife's activism with the antiabortion group Feminists for Life of America. On a conference call among prominent conservative activists after the president's announcement, the initial concerns were about Roberts's religious affiliation, according to one participant.

Because his record of judicial decision making is so brief, speculation has abounded about how Roberts might fit in when the court opens its new term on October 3. "Those who know him say he is extremely conservative," says American University law Prof. Herman Schwartz, author of *Right Wing Justice: The Conservative Campaign to Take Over the Courts*. "[But] he doesn't make speeches. He doesn't write articles."

In addition to the footnote calling for *Roe* to be overturned, Roberts, as principal deputy solicitor general, also argued that the antiabortion group Operation Rescue did not engage in a conspiracy to prevent women from receiving abortions by blockading clinics. As a Supreme Court justice, says Peter Irons, a University of California–San Diego political science professor, "it's pretty clear that he would be caught between his personal views, which I'm sure are pro-life, and his respect for precedent." Roberts's stance wouldn't swing a court that currently supports Roe by a 6-to-3 margin, but it could affect decisions on the procedure opponents call "partial-birth" abortion, parental consent laws, and assisted suicide.

LA LUMIERE HIGH SCHOOL

BACK THEN. Roberts in a high school chemistry class

Colleagues familiar with his legal philosophy say Roberts is guided by a firm belief in the limits of federal power. "I see the comparability [with O'Connor] being the strongest on federalism," says Douglas Kmiec, a Pepperdine University law professor. In what's now known as the "Arroyo Toad Case," Roberts pushed the D.C. Circuit Court to review a decision that protected a species of toad in California from commercial devel-

The President's Shrewd Surprise

Washington's self-styled cognoscenti predicted that President Bush would name a woman to the Supreme Court, or a Hispanic, or someone who would throw red meat to his conservative base. Wrong, wrong, and wrong again. Bush loves to confound the capital's insiders, and he did it once more in choosing John G. Roberts. "The beltway still hasn't figured President Bush out," says Ed Gillespie, a White House adviser on the confirmation strategy.

Bush could still pick a woman or a Hispanic if another vacancy occurs, and he considered at least one of each before settling on Roberts, according to Republican strategists. But the president decided that Roberts offered an appealing mix of legal substance and political armor.

In his final interview with Roberts, Bush was particularly impressed with the judge's intellect and humility, which the president expects will shine through at Senate hearings. This, White House aides say, gives Roberts an edge over previous conservative nominees, such as the aloof Clarence Thomas and the imperious Robert Bork. Bush was well aware that if Roberts doesn't appear to be a threatening or polarizing figure, Democrats who go after him will seem petulant or out of the mainstream. To that end, Bush placed a premium on choosing a conservative without an extensive or controversial trail of writings and speeches that can be dissected and attacked by critics. "He is a confirmable conservative," Ken Duberstein, former White House chief of staff for President Ronald Reagan, told *U.S. News*. "The liberals have a real problem here because to attack somebody with his Establishment credentials makes it look like they will oppose anybody and everybody."

LARRY DOWNING—REUTERS

Roberts (behind Bush) and other judges

Charmed. Bush, who believes in a personal style of diplomacy in both foreign and domestic affairs, also saw in Roberts a charming advocate who could smooth over differences with Democrats and who might even be persuasive, privately, among the more liberal members of the high court. Bush, who sees a similar affability in himself, thinks Roberts has the potential to spruce up the Republican Party's image and add to Bush's own reputation for making smart personnel picks.

So far, his bet on Roberts is paying off. Only a week ago, a bitter donnybrook was foreseen. It could still come. But more likely is that the president has charted a crafty course that will quickly move a conservative onto the high court without the pitched battle that could hurt his other priorities, such as Social Security overhaul and winning more public and congressional support for the war in Iraq. *–Kenneth T. Walsh*

When it comes to bad cholesterol–

Ask your doctor if lower is better.

Getting high cholesterol down is important.

Doctors know lowering high cholesterol is important for everyone. But for some people, it's even more important. In fact, a panel of medical experts recently proposed updated guidelines suggesting many patients aim for an even lower cholesterol goal than before.*

Working with your doctor is key to helping you reach your cholesterol goal.

If, after all you've tried—including diet and exercise—your doctor believes you need to get your bad cholesterol even lower, ask whether CRESTOR might help.

Aim lower.

CRESTOR may make the difference you need. In fact, the 10-mg dose of CRESTOR, along with diet, can lower bad cholesterol by as much as 52% (vs 7% with placebo). That means your LDL-C—the bad cholesterol—could go down about half. Your results may vary.

Is CRESTOR right for you?

That's another conversation you need to have with your doctor. Your doctor will decide the best course of treatment for you after assessing your particular needs.

Get more information about CRESTOR.

To learn more about CRESTOR, or if you are without prescription coverage and can't afford your medication, AstraZeneca may be able to help. Call 800-CRESTOR or visit CRESTOR.com.

Here is important safety information about CRESTOR you need to know.

CRESTOR is prescribed along with diet for lowering high cholesterol and has not been determined to prevent heart disease, heart attacks, or strokes. CRESTOR is not right for everyone, including women who are nursing, pregnant, or who may become pregnant, or anyone with liver problems. Your doctor will do blood tests before and during treatment with CRESTOR to monitor your liver function. Unexplained muscle pain and weakness could be a sign of a rare but serious side effect and should be reported to your doctor right away. The 40-mg dose of CRESTOR is only for patients who do not reach goal on 20 mg. Be sure to tell your doctor if you are taking any medications. Side effects occur infrequently and include muscle aches, constipation, weakness, abdominal pain, and nausea. They are usually mild and tend to go away.

If your doctor says, "lower is better," aim lower with CRESTOR.

CRESTOR®
rosuvastatin calcium

*Adult Treatment Panel (ATP) III, Update, 2004

Please read the important Product Information about CRESTOR on the adjacent page and discuss it with your doctor.

AstraZeneca

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Please read this summary carefully and then ask your doctor about CRESTOR. No advertisement can provide all the information needed to determine if a drug is right for you.
This advertisement does not take the place of careful discussions with your doctor. Only your doctor has the training to weigh the risks and benefits of a prescription drug.

BRIEF SUMMARY: For full Prescribing Information, see package insert. **INDICATIONS AND USAGE** CRESTOR is indicated: 1. as an adjunct to diet to reduce elevated total-C, LDL-C, ApoB, nonHDL-C, and TG levels and to increase HDL-C in patients with primary hypercholesterolemia (heterozygous familial and nonfamilial) and mixed dyslipidemia (Fredrickson Type IIa and IIb); 2. as an adjunct to diet for the treatment of patients with elevated serum TG levels (Fredrickson Type IV); 3. to reduce LDL-C, total-C, and ApoB in patients with homozygous familial hypercholesterolemia as an adjunct to other lipid-lowering treatments (e.g., LDL apheresis) or if such treatments are unavailable. **CONTRAINDICATIONS** CRESTOR is contraindicated in patients with a known hypersensitivity to any component of this product. Rosuvastatin is contraindicated in patients with active liver disease or with unexplained persistent elevations of serum transaminases (see WARNINGS, Liver Enzymes). **Pregnancy and Lactation** Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. ROSUVASTATIN SHOULD BE ADMINISTERED TO WOMEN OF CHILDBEARING AGE ONLY WHEN SUCH PATIENTS ARE HIGHLY UNLIKELY TO CONCEIVE AND HAVE BEEN INFORMED OF THE POTENTIAL HAZARDS. If the patient becomes pregnant while taking this drug, therapy should be discontinued immediately and the patient apprised of the potential hazard to the fetus. **WARNINGS Liver Enzymes** HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. The incidence of persistent elevations (>3 times the upper limit of normal [ULN] occurring on 2 or more consecutive occasions) in serum transaminases in fixed dose studies was 0.4, 0, 0, and 0.1% in patients who received rosuvastatin 5, 10, 20, and 40 mg, respectively. In most cases, the elevations were transient and resolved or improved on continued therapy or after a brief interruption in therapy. There were two cases of jaundice, for which a relationship to rosuvastatin therapy could not be determined, which resolved after discontinuation of therapy. There were no cases of liver failure or irreversible liver disease in these trials. **It is recommended that liver function tests be performed before and at 12 weeks following both the initiation of therapy and any elevation of dose, and periodically (e.g., semiannually) thereafter.** Liver enzyme changes generally occur in the first 3 months of treatment with rosuvastatin. Patients who develop increased transaminase levels should be monitored until the abnormalities have resolved. Should an increase in ALT or AST of >3 times ULN persist, reduction of dose or withdrawal of rosuvastatin is recommended. Rosuvastatin should be used with caution in patients who consume substantial quantities of alcohol and/or have a history of liver disease (see CLINICAL PHARMACOLOGY, Special Populations, Hepatic Insufficiency). Active liver disease or unexplained persistent transaminase elevations are contraindications to the use of rosuvastatin (see CONTRAINDICATIONS). **Myopathy/Rhabdomyolysis Rare cases of rhabdomyolysis with acute renal failure secondary to myoglobinuria have been reported with rosuvastatin and with other drugs in this class.** Uncomplicated myalgia has been reported in rosuvastatin-treated patients (see ADVERSE REACTIONS). Creatine kinase (CK) elevations (>10 times upper limit of normal) occurred in 0.2% to 0.4% of patients taking rosuvastatin at doses up to 40 mg in clinical studies. Treatment-related myopathy, defined as muscle aches or muscle weakness in conjunction with increases in CK values >10 times upper limit of normal, was reported in up to 0.1% of patients taking rosuvastatin doses of up to 40 mg in clinical studies. In clinical trials, the incidence of myopathy and rhabdomyolysis increased at doses of rosuvastatin above the recommended dosage range (5 to 40 mg). In post-marketing experience, effects on skeletal muscle, e.g. uncomplicated myalgia, myopathy and, rarely, rhabdomyolysis have been reported in patients treated with HMG-CoA reductase inhibitors including rosuvastatin. As with other HMG-CoA reductase inhibitors, reports of rhabdomyolysis with rosuvastatin are rare, but higher at the highest marketed dose (40 mg). Factors that may predispose patients to myopathy with HMG-CoA reductase inhibitors include advanced age (≥65 years), hypothyroidism, and renal insufficiency. Consequently: 1. Rosuvastatin should be prescribed with caution in patients with predisposing factors for myopathy, such as, renal impairment (see DOSAGE AND ADMINISTRATION), advanced age, and inadequately treated hypothyroidism. 2. Patients should be advised to promptly report unexplained muscle pain, tenderness, or weakness, particularly if accompanied by malaise or fever. Rosuvastatin therapy should be discontinued if markedly elevated CK levels occur or myopathy is diagnosed or suspected. 3. The 40 mg dose of rosuvastatin is reserved only for those patients who have not achieved their LDL-C goal utilizing the 20 mg dose of rosuvastatin once daily (see DOSAGE AND ADMINISTRATION). 4. The risk of myopathy during treatment with rosuvastatin may be increased with concurrent administration of other lipid-lowering therapies or cyclosporine, (see CLINICAL PHARMACOLOGY, Drug Interactions, PRECAUTIONS, Drug Interactions, and DOSAGE AND ADMINISTRATION). **The benefit of further alterations in lipid levels by the combined use of rosuvastatin with fibrates or niacin should be carefully weighed against the potential risks of this combination. Combination therapy with rosuvastatin and gemfibrozil should generally be avoided. (See DOSAGE AND ADMINISTRATION and PRECAUTIONS, Drug Interactions).** 5. **The risk of myopathy during treatment with rosuvastatin may be increased in circumstances which increase rosuvastatin drug levels (see CLINICAL PHARMACOLOGY, Special Populations, Race and Renal Insufficiency, and PRECAUTIONS, General).** 6. **Rosuvastatin therapy should also be temporarily withheld in any patient with an acute, serious condition suggestive of myopathy or predisposing to the development of renal failure secondary to rhabdomyolysis (e.g., sepsis, hypotension, dehydration, major surgery, trauma, severe metabolic, endocrine, and electrolyte disorders, or uncontrolled seizures).** **PRECAUTIONS General** Before instituting therapy with rosuvastatin, an attempt should be made to control hypercholesterolemia with appropriate diet and exercise, weight reduction in obese patients, and treatment of underlying medical problems (see INDICATIONS AND USAGE). Administration of rosuvastatin 20 mg to patients with severe renal impairment (CL_{cr} <30 mL/min/1.73 m^2) resulted in a 3-fold increase in plasma concentrations of rosuvastatin compared with healthy volunteers (see WARNINGS, Myopathy/ Rhabdomyolysis and DOSAGE AND ADMINISTRATION). The result of a large pharmacokinetic study conducted in the US demonstrated an approximate 2-fold elevation in median exposure in Asian subjects (having either Filipino, Chinese, Japanese, Korean, Vietnamese or Asian-Indian origin) compared with a Caucasian control group. This increase should be considered when making rosuvastatin dosing decisions for Asian patients. (See WARNINGS, Myopathy/ Rhabdomyolysis; CLINICAL PHARMACOLOGY, Special Populations, Race, and DOSAGE AND ADMINISTRATION.) **Information for Patients** Patients should be advised to report promptly unexplained muscle pain, tenderness, or weakness, particularly if accompanied by malaise or fever. When taking rosuvastatin with an aluminum and magnesium hydroxide combination antacid, the antacid should be taken at least 2 hours after rosuvastatin administration (see CLINICAL PHARMACOLOGY, Drug Interactions). **Laboratory Tests** In the rosuvastatin clinical trial program, dipstick-positive proteinuria and microscopic hematuria were observed among rosuvastatin-treated patients, predominantly in patients dosed above the recommended dose range (i.e., 80 mg). However, this finding was more frequent in patients taking rosuvastatin 40 mg, when compared to lower doses of rosuvastatin or comparator statins, though it was generally transient and was not associated with worsening renal function. Although the clinical significance of this finding is unknown, a dose reduction should be considered for patients on rosuvastatin 40 mg therapy with unexplained persistent proteinuria during routine urinalysis testing. **Drug Interactions Cyclosporine:** When rosuvastatin 10 mg was coadministered with cyclosporine in cardiac transplant patients, rosuvastatin mean C_{max} and mean AUC were increased 11-fold and 7-fold, respectively, compared with healthy volunteers. These increases are considered to be clinically significant and require special consideration in the dosing of rosuvastatin to patients taking concomitant cyclosporine (see WARNINGS, Myopathy/Rhabdomyolysis, and DOSAGE AND ADMINISTRATION). **Warfarin:** Coadministration of rosuvastatin to patients on stable warfarin therapy resulted in clinically significant rises in INR (>4, baseline 2-3). In patients taking coumarin anticoagulants and rosuvastatin concomitantly, INR should be determined before starting rosuvastatin and frequently enough during early therapy to ensure that no significant alteration of INR occurs. Once a stable INR time has been documented, INR can be monitored at the intervals usually recommended for patients on coumarin anticoagulants. If the dose of rosuvastatin is changed, the same procedure should be repeated. Rosuvastatin therapy has not been associated with bleeding or with changes in INR in patients not taking anticoagulants. **Gemfibrozil:** Coadministration of a single rosuvastatin dose to healthy volunteers on gemfibrozil (600 mg twice daily) resulted in a 2.2- and 1.9-fold, respectively, increase in mean C_{max} and mean AUC of rosuvastatin (see DOSAGE AND ADMINISTRATION). **Endocrine Function** Although clinical studies have shown that rosuvastatin alone does not reduce basal plasma cortisol concentration or impair adrenal reserve, caution should be exercised if any HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered concomitantly with drugs that may decrease the levels or activity of endogenous steroid hormones such as ketoconazole, spironolactone, and cimetidine. **CNS Toxicity** CNS vascular lesions, characterized by perivascular hemorrhages, edema, and mononuclear cell infiltration of perivascular spaces, have been observed in dogs treated with several other members of this drug class. A chemically similar drug in this class produced dose-dependent optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in dogs, at a dose that produced plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose. Edema, hemorrhage, and partial necrosis in the interstitium of the choroid plexus was observed in a female dog sacrificed moribund at day 24 at 90 mg/kg/day by oral gavage (systemic exposures 100 times the human exposure at 40 mg/day based on AUC comparisons). Corneal opacity was seen in dogs treated for 52 weeks at 6 mg/kg/day by oral gavage (systemic exposures 20 times the human exposure at 40 mg/day based on AUC comparisons). Cataracts were seen in dogs treated for 12 weeks by oral gavage at 30 mg/kg/day (systemic exposures 60 times the human exposure at 40 mg/day based on AUC comparisons). Retinal dysplasia and retinal loss were seen in dogs treated for 4 weeks by oral gavage at 90 mg/kg/day (systemic exposures 100 times the human exposure at 40 mg/day based on AUC). Doses ≤30 mg/kg/day (systemic exposures ≤60 times the human exposure at 40 mg/day based on AUC comparisons) following treatment up to one year, did not reveal retinal findings. **Carcinogenesis, Mutagenesis, Impairment of Fertility** In a 104-week carcinogenicity study in rats at dose levels of 2, 20, 60, or 80 mg/kg/day by oral gavage, the incidence of uterine stromal polyps was significantly increased in females at 80 mg/kg/day at

CRESTOR®
rosuvastatin calcium

systemic exposure 20 times the human exposure at 40 mg/day based on AUC. Increased incidence of polyps was not seen at lower doses. In a 107-week carcinogenicity study in mice given 10, 60, 200 mg/kg/day by oral gavage, an increased incidence of hepatocellular adenoma/carcinoma was observed at 200 mg/kg/day at systemic exposures 20 times human exposure at 40 mg/day based on AUC. An increased incidence of hepatocellular tumors was not seen at lower doses. Rosuvastatin was not mutagenic or clastogenic with or without metabolic activation in the Ames test with *Salmonella typhimurium* and *Escherichia coli,* the mouse lymphoma assay, and the chromosomal aberration assay in Chinese hamster lung cells. Rosuvastatin was negative in the *in vivo* mouse micronucleus test. In rat fertility studies with oral gavage doses of 5, 15, 50 mg/kg/day, males were treated for 9 weeks prior to and throughout mating and females were treated 2 weeks prior to mating and throughout mating until gestation day 7. No adverse effect on fertility was observed at 50 mg/kg/day (systemic exposures up to 10 times human exposure at 40 mg/day based on AUC comparisons). In testicles of dogs treated with rosuvastatin at 30 mg/kg/day for one month, spermatidic giant cells were seen. Spermatidic giant cells were observed in monkeys after 6-month treatment at 30 mg/kg/day in addition to vacuolation of seminiferous tubular epithelium. Exposures in the dog were 20 times and in the monkey 10 times human exposure at 40 mg/day based on body surface area comparisons. Similar findings have been seen with other drugs in this class. **Pregnancy** ***Pregnancy Category X*** See CONTRAINDICATIONS. Rosuvastatin may cause fetal harm when administered to a pregnant woman. Rosuvastatin is contraindicated in women who are or may become pregnant. Safety in pregnant women has not been established. There are no adequate and well-controlled studies of rosuvastatin in pregnant women. Rosuvastatin crosses the placenta and is found in fetal tissue and amniotic fluid at 3% and 20%, respectively, of the maternal plasma concentration following a single 25 mg/kg oral gavage dose on gestation day 16 in rats. A higher fetal tissue distribution (25% maternal plasma concentration) was observed in rabbits after a single oral gavage dose of 1 mg/kg on gestation day 18. If this drug is administered to a woman with reproductive potential, the patient should be apprised of the potential hazard to a fetus. In female rats given oral gavage doses of 5, 15, 50 mg/kg/day rosuvastatin before mating and continuing through day 7 postcoitus results in decreased fetal body weight (female pups) and delayed ossification at the high dose (systemic exposures 10 times human exposure at 40 mg/day based on AUC comparisons). In pregnant rats given oral gavage doses of 2, 20, 50 mg/kg/day from gestation day 7 through lactation day 21 (weaning), decreased pup survival occurred in groups given 50 mg/kg/day, systemic exposures ≥12 times human exposure at 40 mg/day based on body surface area comparisons. In pregnant rabbits given oral gavage doses of 0.3, 1, 3 mg/kg/day from gestation day 6 to lactation day 18 (weaning), exposures equivalent to human exposure at 40 mg/day based on body surface area comparisons, decreased fetal viability and maternal mortality was observed. Rosuvastatin was not teratogenic in rats at ≤25 mg/kg/day or in rabbits ≤3 mg/kg/day (systemic exposures equivalent to human exposure at 40 mg/day based on AUC or body surface comparison, respectively). **Nursing Mothers** It is not known whether rosuvastatin is excreted in human milk. Studies in lactating rats have demonstrated that rosuvastatin is secreted into breast milk at levels 3 times higher than that obtained in the plasma following oral gavage dosing. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from rosuvastatin, a decision should be made whether to discontinue nursing or administration of rosuvastatin taking into account the importance of the drug to the lactating woman. **Pediatric Use** The safety and effectiveness in pediatric patients have not been established. Treatment experience with rosuvastatin in a pediatric population is limited to 8 patients with homozygous FH. None of these patients was below 8 years of age. **Geriatric Use** Of the 10,275 patients in clinical studies with rosuvastatin, 3,159 (31%) were 65 years and older, and 698 (6.8%) were 75 years and older. The overall frequency of adverse events and types of adverse events were similar in patients above and below 65 years of age. (See WARNINGS, Myopathy/Rhabdomyolysis.) The efficacy of rosuvastatin in the geriatric population (≥65 years of age) was comparable to the efficacy observed in the non-elderly. **ADVERSE REACTIONS** Rosuvastatin is generally well tolerated. Adverse reactions have usually been mild and transient. In clinical studies of 10,275 patients, 3.7% were discontinued due to adverse experiences attributable to rosuvastatin. The most frequent adverse events thought to be related to rosuvastatin were myalgia, constipation, asthenia, abdominal pain, and nausea. **Clinical Adverse Experiences** Adverse experiences, regardless of causality assessment, reported in ≥2% of patients in placebo-controlled clinical studies of rosuvastatin are shown in Table 1; discontinuations due to adverse events in these studies of up to 12 weeks duration occurred in 3% of patients on rosuvastatin and 5% on placebo.

Table 1. Adverse Events in Placebo-Controlled Studies

Adverse event	Rosuvastatin N=744	Placebo N=382
Pharyngitis	9.0	7.6
Headache	5.5	5.0
Diarrhea	3.4	2.9
Dyspepsia	3.4	3.1
Nausea	3.4	3.1
Myalgia	2.8	1.3
Asthenia	2.7	2.6
Back pain	2.6	2.4
Flu syndrome	2.3	1.8
Urinary tract infection	2.3	1.6
Rhinitis	2.2	2.1
Sinusitis	2.0	1.8

In addition, the following adverse events were reported, regardless of causality assessment, in ≥1% of 10,275 patients treated with rosuvastatin in clinical studies. The events in *italics* occurred in ≥2% of these patients. **Body as a Whole:** *Abdominal pain, accidental injury, chest pain, infection, pain,* pelvic pain, and neck pain. **Cardiovascular System:** *Hypertension,* angina pectoris, vasodilatation, and palpitation. **Digestive System:** *Constipation, gastroenteritis,* vomiting, flatulence, periodontal abscess, and gastritis. **Endocrine:** Diabetes mellitus. **Hemic and Lymphatic System:** Anemia and ecchymosis. **Metabolic and Nutritional Disorders:** *Peripheral edema.* **Musculoskeletal System:** *Arthritis, arthralgia,* and pathological fracture. **Nervous System:** *Dizziness, insomnia, hypertonia, paresthesia, depression,* anxiety, vertigo, and neuralgia. **Respiratory System:** *Bronchitis, cough increased,* dyspnea, pneumonia, and asthma. **Skin and Appendages:** *Rash* and pruritus. **Laboratory Abnormalities:** In the rosuvastatin clinical trial program, dipstick-positive proteinuria and microscopic hematuria were observed among rosuvastatin-treated patients, predominantly in patients dosed above the recommended dose range (i.e., 80 mg). However, this finding was more frequent in patients taking rosuvastatin 40 mg, when compared to lower doses of rosuvastatin or comparator statins, though it was generally transient and was not associated with worsening renal function. (See PRECAUTIONS, Laboratory Tests.) Other abnormal laboratory values reported were elevated creatinine phosphokinase, transaminases, hyperglycemia, glutamyl transpeptidase, alkaline phosphatase, bilirubin, and thyroid function abnormalities. Other adverse events reported less frequently than 1% in the rosuvastatin clinical study program, regardless of causality assessment, included arrhythmia, hepatitis, hypersensitivity reactions (i.e., face edema, thrombocytopenia, leukopenia, vesiculobullous rash, urticaria, and angioedema), kidney failure, syncope, myasthenia, myositis, pancreatitis, photosensitivity reaction, myopathy, and rhabdomyolysis. **Postmarketing Experience** In addition to the events reported above, as with other drugs in this class, the following event has been reported during post-marketing experience with CRESTOR, regardless of causality assessment: very rare cases of jaundice. **OVERDOSAGE** There is no specific treatment in the event of overdose. In the event of overdose, the patient should be treated symptomatically and supportive measures instituted as required. Hemodialysis does not significantly enhance clearance of rosuvastatin. **DOSAGE AND ADMINISTRATION** The patient should be placed on a standard cholesterol-lowering diet before receiving CRESTOR and should continue on this diet during treatment. CRESTOR can be administered as a single dose at any time of day, with or without food. **Hypercholesterolemia (Heterozygous Familial and Nonfamilial) and Mixed Dyslipidemia (Fredrickson Type IIa and IIb)** The dose range for CRESTOR is 5 to 40 mg once daily. Therapy with CRESTOR should be individualized according to goal of therapy and response. The usual recommended starting dose of CRESTOR is 10 mg once daily. However, initiation of therapy with 5 mg once daily should be considered for patients requiring less aggressive LDL-C reductions, who have predisposing factors for myopathy, and as noted below for special populations such as patients taking cyclosporine, Asian patients, and patients with severe renal insufficiency (see CLINICAL PHARMACOLOGY, Race, and Renal Insufficiency, and Drug Interactions. For patients with marked hypercholesterolemia (LDL-C >190 mg/dL) and aggressive lipid targets, a 20-mg starting dose may be considered. After initiation and/or upon titration of CRESTOR, lipid levels should be analyzed within 2 to 4 weeks and dosage adjusted accordingly. **The 40-mg dose of CRESTOR is reserved only for those patients who have not achieved their LDL-C goal utilizing the 20 mg dose of CRESTOR once daily (see WARNINGS, Myopathy/ Rhabdomyolysis). When initiating statin therapy or switching from another statin therapy, the appropriate CRESTOR starting dose should first be utilized, and only then titrated according to the patient's individualized goal of therapy. Homozygous Familial Hypercholesterolemia** The recommended starting dose of CRESTOR is 20 mg once daily in patients with homozygous FH. The maximum recommended daily dose is 40 mg. CRESTOR should be used in these patients as an adjunct to other lipid-lowering treatments (e.g., LDL apheresis) or if such treatments are unavailable. Response to therapy should be estimated from pre-apheresis LDL-C levels. **Dosage in Asian Patients** Initiation of CRESTOR therapy with 5 mg once daily should be considered for Asian patients. The potential for increased systemic exposures relative to Caucasians is relevant when considering escalation of dose in cases where hypercholesterolemia is not adequately controlled at doses of 5, 10, or 20 mg once daily. (See WARNINGS, Myopathy/ Rhabdomyolysis, CLINICAL PHARMACOLOGY, Special Populations, Race, and PRECAUTIONS, General). **Dosage in Patients Taking Cyclosporine** In patients taking cyclosporine, therapy should be limited to CRESTOR 5 mg once daily (see WARNINGS, Myopathy/Rhabdomyolysis, and PRECAUTIONS, Drug Interactions). **Concomitant Lipid-Lowering Therapy** The effect of CRESTOR on LDL-C and total-C may be enhanced when used in combination with a bile acid binding resin. If CRESTOR is used in combination with gemfibrozil, the dose of CRESTOR should be limited to 10 mg once daily (see WARNINGS, Myopathy/Rhabdomyolysis, and PRECAUTIONS, Drug Interactions). **Dosage in Patients With Renal Insufficiency** No modification of dosage is necessary for patients with mild to moderate renal insufficiency. For patients with severe renal impairment (CL_{cr} <30 mL/min/1.73 m^2) not on hemodialysis, dosing of CRESTOR should be started at 5 mg once daily and not to exceed 10 mg once daily (see PRECAUTIONS, General, and CLINICAL PHARMACOLOGY, Special Populations, Renal Insufficiency).

NOTE: This summary provides important information about CRESTOR. For more information, please ask your doctor or health care professional about the full Prescribing Information and discuss it with them.

Rx only

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opment, arguing that the amphibian was not protected by the Endangered Species Act because it, "for reasons of its own, lives its entire life in California." The matter, he wrote, was thus beyond the reach of the federal government. That same philosophy of limited federal power could affect future court rulings on school prayer and public displays of religious symbols. "I think he'd take a more accommodating position," says Kmiec, "toward religion and public life."

Business groups say they're reassured by Roberts's hands-off judicial philosophy and history of defending major corporate clients. Advocating on behalf of Toyota in 2002 while a partner at the Washington firm Hogan & Hartson, Roberts won a Supreme Court case by arguing that the Americans with Disabilities Act didn't protect a woman suffering from carpal tunnel syndrome. He also filed a brief supporting the West Virginia coal industry's practice of mountaintop removal in a lawsuit brought by citizens who claimed the practice damaged their homes. Tom Donohue, the president of the U.S. Chamber of Commerce, issued a statement hailing Roberts as "well respected."

PROTEST. Antiabortion demonstrators stand silently in front of the Supreme Court building in Washington.

Backed tribunals. Roberts's legal history on business matters, however, cannot be easily categorized. "Lawyers from firms like [Hogan & Hartson] . . . represent their clients' interests," says Irons, "regardless of what side they're on." A top lawyer at the prestigious white-shoe firm for more than a dozen years, Roberts also argued successfully on behalf of a preservation group fighting to curb development in the Lake Tahoe area.

Roberts's unswerving support for Bush administration policy may provide one of his toughest challenges on Capitol Hill. In July, he joined in the unanimous decision to allow military tribunals for terrorism suspects held at the U.S. Naval Base at Guantánamo Bay, Cuba. Roberts also wrote a dissent arguing that Vice President Dick Cheney's energy task force records should be kept secret, an opinion upheld by the Supreme Court. Still, he is far from predictable. According to a review posted on the website of Goldstein & Howe, a Supreme Court litigation firm, Roberts agreed with liberal members of the court nearly as often as he sided with conservatives. So just exactly what type of justice Roberts would be is an open question. "The crystal ball," says Irons, "is a little cloudy." Which should keep things interesting—throughout the summer and into the fall. ●

A Full Plate for the Fall

Should Judge John G. Roberts be confirmed by the Senate in time for the upcoming Supreme Court term, he will join a court that's already facing a challenging fall docket of hot-button social issues. Among the cases to be heard:

Ayotte v. Planned Parenthood of Northern New England. The court's first major abortion-rights case in five years will review a New Hampshire law prohibiting abortions for minors whose parents have not been notified. The law allows for exceptions if an abortion would prevent a mother's death and if a judge says the minor is mature enough to make such a decision. The case doesn't threaten to overturn *Roe v. Wade,* but the ruling might signal how the court will weigh other restrictions on abortion.

Gonzales v. Oregon. The Bush administration has challenged Oregon's Death With Dignity Act, a law allowing physician-assisted suicide. The Justice Department has said doctors have no "legitimate medical purpose" in prescribing federally controlled drugs to help terminally ill patients commit suicide.

Rumsfeld v. FAIR. The court will decide whether the government can withhold federal money from colleges that restrict military recruiting on campus. Colleges argue that the military's ban on openly gay men and women violates their own nondiscrimination policies. The government says that by limiting the military's access, colleges have hampered recruiting, particularly at law schools.

House v. Bell. A Tennessee death penalty case will help determine the standards of proof that must be met for a prisoner to be granted a new trial. The case centers on DNA evidence that was not available when Paul House was convicted two decades ago; his lawyers say it proves he is innocent.
–Silla Brush

KRISANNE JOHNSON FOR *USN&WR*

By Michael Barone

Bush Bashing Fizzles

THIS SUMMER, ONE BIG STORY IS REPLACED by another—the London bombings July 7, the speculation that Karl Rove illegally named a covert cia agent, the nomination of John Roberts to the Supreme Court, more London bombings last week. But beneath the hubbub, we can see the playing out of another, less reported story: the collapse of the attempts by liberal Democrats and their sympathizers in the mainstream media—the *New York Times,* etc., etc.—to delegitimize yet another Republican administration.

This project has been ongoing for more than 30 years. Richard Nixon, by obstructing investigation of the Watergate burglary, unwittingly colluded in the successful attempt to besmirch his administration. Less than two years after carrying 49 states, he was compelled to resign. The attempt to delegitimize the Reagan administration seemed at the time reasonably successful. Reagan was widely dismissed as a lightweight ideologue, and the rejection of his nomination of Robert Bork to the Supreme Court in 1987 contributed to the impression that his years in office were, to take the title of a book by a first-rate journalist, "the Reagan detour." As time went on, as the Berlin Wall fell and Bill Clinton proclaimed that the era of big government was over, it became clear that Reagan was a successful transformational president—something the mainstream media grudgingly admitted when he died in 2004 after a decade out of public view.

You think they'd learn. But for the past five years, the same folks have been trying to undermine the presidency of George W. Bush. The Supreme Court's decision in *Bush v. Gore* was denounced as an outrage, and Democrats noted, accurately, that Bush did not win a plurality of the popular vote in 2000. The nation rallied to his support after September 11, but Democrats held up his judicial and other nominations even if they had to violate Senate tradition to do so. Coverage of Bush during the 2004 campaign was heavily negative; for months the mainstream media mostly ignored the swift boat vets' charges against John Kerry and broadcast accusations against Bush based on forged documents eight weeks before the election. News of economic recovery in 2003 and 2004 was pitched far more negatively than it had been when Bill Clinton was president in 1995 and 1996.

Now the unsupported charges that "Bush lied" about weapons of mass destruction in Iraq have been rekindled via criticism of Karl Rove. A key witness for the Democrats and mainstream media was former diplomat Joseph Wilson. Unfortunately for his advocates, he turned out to be a liar. A year after his famous article appeared in the *New York Times* in July 2003 accusing Bush of "twisting" intelligence, the Senate Intelligence Committee, in a bipartisan report, concluded that Wilson lied when he said his wife had nothing to do with his dispatch to Niger and Chairman Pat Roberts said that his report bolstered rather than refuted the case that Saddam Hussein's Iraq sought to buy uranium in Africa. So despite the continuing credulousness of much of the press, it appears inconceivable at this point that Karl Rove will be charged with violating the law prohibiting disclosure of the names of undercover agents. The case against Rove—ballyhooed by recent *Time* and *Newsweek* cover stories that paid little heed to the discrediting of Wilson—seems likely to end not with a bang but a whimper.

Court intrigue. So, too, with the political left's determination to defeat Bush's first nominee to the Supreme Court. Democrats, with much help from the press, argued successfully in 1987 that Robert Bork was out of the mainstream and in 1991 brought up spectacular charges that cast a pall on Justice Clarence Thomas. They seem almost certain not to have such success against the obviously highly qualified John Roberts. They may try to argue that Roberts is "out of the mainstream." But the vote on Roberts's nomination to the appeals court was 14 to 3 in the judiciary committee. Who is in the mainstream now?

The bombings and attempted bombings in London have brought home to the American public that we face implacable enemies unwilling to be appeased by even the most emollient diplomacy. Yet, mainstream media coverage of Iraq has been mostly negative. But mainstream media no longer have a monopoly; Americans have other sources in talk radio, Fox News, and the blogosphere. Bush's presidency is still regarded as illegitimate by perhaps 20 percent of the electorate. But among the rest, the attempt to delegitimize him seems to be collapsing. ●

Attempts by the left and the liberal media to undermine the president are running out of steam.

SAMANTHA REINDERS FOR *USN&WR*

No heat: Bush's court choice may be an uncontroversial pick.

Reagan National is just a stone's throw from the Capitol.

A REALLY CAPITOL IDEA?

The feds are allowing private planes back at Washington's Reagan National Airport. Not everyone's exactly thrilled

By Angie C. Marek

Ronald Reagan Washington National Airport is less than five miles from the White House and the Capitol, so pols and lobbyists love it. But the Secret Service has been trying to get the facility shuttered for years. Joe Petro, a retired agent who protected Ronald Reagan, says agents recommended closing the airport after the 1983 embassy bombing in Lebanon. "We came to the conclusion," he said, "that was the only way to . . . protect downtown Washington."

But National lives on, thanks to the support of all those congressmen and K Street types who rely on its close-in convenience. Not even 9/11 could change that. National was closed to commercial aviation following the attacks, but it reopened just a few weeks later. General aviation planes—privately owned aircraft and corporate jets—remain largely shut out of National, but that's about to change. Last week, the Transportation Security Administration finalized security procedures that will allow the smaller planes back into National as soon as October. The rules have sparked a brisk debate between general aviation supporters, who think the rules are draconian, and critics who think it's ludicrous to allow more planes into an area that has experienced several recent aviation scares. The dispute highlights several broader concerns about the safety and security of general aviation in a post-9/11 world.

Violated. The smaller planes have been kept out of National partly as a result of pressure from the Secret Service, which also pushed successfully for creation of a general aviation no-fly zone that extends 15 miles around the Washington Monument. The Federal Aviation Administration reports that planes have violated the restricted airspace above and around Washington 2,200 times since 9/11. When a confused pilot in a Cessna strayed deep into the forbidden airspace in May, security officials scrambled two F-16s and evacuated thousands from the Capitol.

For some, it seems a strange time to be loosening restrictions. "You're just begging for more incidents," says Democratic Sen. Mark Dayton of Minnesota, who closed his Capitol Hill office because of worries about terrorism last fall. But general aviation has well-connected advocates. Jim Coyne, president of the National Air Transportation Association, a group representing charter carriers, says he has personally met with 150 members of the House and Senate to discuss the situation at National. In December 2003, as part of a broader bill, Congress called for a plan to reopen the airport to private planes.

The plan that emerged last week will restrict National's general aviation traffic to 336 flights a week, compared with roughly 660 flights a week before 9/11. Planes headed for National must first touch down at one of 12 "gateway" airports nationwide, where TSA officials will scrutinize all the aircraft's cargo and carry-on baggage, as well as the passengers themselves. Each plane will carry an armed law enforcement official trained by the TSA. "It's like putting three deadbolt locks" on the private planes, says Randall Larsen, director of the Institute for Homeland Security.

But some hope that's just the beginning. West Virginia Sen. Jay Rockefeller, the top Democrat on the Senate aviation subcommittee, says the 200,000 general aviation aircraft nationwide "have virtually no protocol for security." Larsen says some of these planes—like the Gulfstream 5—can "carry far more [powerful] explosives than Timothy McVeigh used" in the Oklahoma City bombing. Such planes can fly into the United States directly from international airports. "If I were a terrorist and wanted to bring a nuclear weapon into this country," says Larsen, "I'd throw it in the back of a Gulfstream 5 and fly to the U.S. from the Middle East or Africa."

Industry officials say they've increased voluntary surveillance of private planes since 9/11, creating an 800 number for pilots to report suspicious events. And TSA Acting Deputy Administrator Tom Blank says the Department of Homeland Security "does not currently believe that GA airports, facilities, and aircraft pose a significant, immediate threat." But a February report issued jointly by the FBI and the DHS said intelligence indicated terrorists were considering using the "largely unregulated" general aviation planes in the United States for attacks. In Washington, that's an increasingly sobering thought. ●

JEFFREY MACMILLAN FOR *USN&WR*

Special Report

PLAN OF ATTACK

The Pentagon has a secret new strategy for taking on terrorists—and taking them down

STEVE HEBERT—POLARIS

U.S. Army Special Forces troops, working with Iraqi National Guard soldiers, raid a suspected hideout of insurgents in Mosul.

By Linda Robinson

ON MARCH 3, WITH LITTLE FANFARE, Secretary of Defense Donald Rumsfeld and the chairman of the Joint Chiefs of Staff, Gen. Richard Myers, signed a comprehensive new plan for the war on terrorism. Senior defense officials briefed *U.S. News* on the contents of the still-secret document, which is to be released soon in an unclassified form. Officially titled the "National Military Strategic Plan for the War on Terrorism," the document is the culmination of 18 months of work and is a significant evolution from the approach adopted after the 9/11 attacks, which was to focus on capturing or killing the top al Qaeda leaders. For the first time since then, Pentagon officials say, they have a strategy that examines the nature of the anti-terror war in depth, lays out a detailed road map for prosecuting it, and establishes a score card to determine where and whether progress is being made.

The origins of the new plan lie in an October 2003 "snowflake," as Rumsfeld's numerous memoranda to his staff are called. Was the United States really winning the war on terrorism, Rumsfeld asked his commanders, and how could we know if more terrorists were being killed or captured than were being recruited into the ranks? Douglas Feith, the Pentagon's under secretary for policy, was told, along with the deputy director for the war on terrorism for the Joint Chiefs of Staff, Brig. Gen. Robert Caslen, to find answers to the questions. "We sat down as a result of the secretary's snowflake," Feith recalled, "and said, 'How do we want to state some fundamental propositions about the war?' "

The initial result was a 70-page draft report, which subsequently went through over 40 revisions as it was shared with Rumsfeld's inner circle, then a larger group, called the senior-level review group ("Slurg," in Pentagon-speak), and then regional commanders and other agencies. The president was briefed on the report last January and presented with recommendations for presidential-level initiatives to be included in a governmentwide review of counterterrorism policy, which is still being conducted by the National Security Council. In March, the final 25-page report, plus 13 annexes, was signed and became formal Pentagon policy. Key features of the new plan:

- The terrorist threat against the United States is now defined as "Islamist extremism"—not just al Qaeda. The Pentagon document identifies the "primary enemy" as "extremist Sunni and Shia movements that exploit Islam for political ends" and that form part of a "global web of enemy networks." Recognizing that al Qaeda's influence has spread, the United States is now targeting some two dozen groups—a significant change from the early focus on just al Qaeda and its leadership.
- The new approach emphasizes "encouraging" and "enabling" foreign partners, especially in countries where the United States is not at war. Concluding that the conflict cannot be fought by military means alone—or by the United States acting alone—the new Pentagon plan outlines a multipronged strategy that targets eight pressure points and outlines six methods for attacking terrorist networks.
- The Pentagon will use a new set of metrics twice a year to measure its progress in the war against terrorism. Commanders are to report, for example, on successes in locating and dismantling terrorist safe havens, financial assets, communications networks, and planning cells for each of the target groups.
- The Pentagon's Special Operations Command is designated in the new plan as the global "synchronizer" in the war on terrorism for all the military commands and is responsible for designing a new global counterterrorism campaign plan and conducting preparatory reconnaissance missions against ter-

GOING AFTER OSAMA BIN LADEN IS STILL PART OF THE PLAN, BUT THE

FROM LEFT: DARREN MCCOLLESTER—GETTY IMAGES; STEVE HEBERT—POLARIS

GETTING REAL. An Afghan detainee (left) awaits questioning. At Fort Bragg, N.C., training to take down a terrorist group's safe haven.

rorist organizations around the world.

● Under a draft national security presidential decision directive, expected to be approved next month, the White House would have greater flexibility to resolve turf battles in the government's overall counterterrorism effort.

The new Pentagon directive, General Caslen told *U.S. News*, has unified the military behind one counterterrorism plan for the first time: "Prior to the release of this document, everybody had their own idea of what the enemy was. Therefore, everybody had their own idea of how to fight it. We had different ideas among the services, among the commands, among the different agencies. Heck, we even had different ideas among the different organizations within this building."

Defining the enemy in precise terms was one of the first big hurdles in producing the new strategy document. "Since 9/11," Caslen said, "the relationships and interdependencies among like-minded terrorist groups have become clearer, and we assess [that] there are nearly two dozen terrorist groups with varying degrees of interaction with and/or interdependency on al Qaeda." But some officials were leery of painting the adversary with too broad a brush for fear of alienating the mainstream Muslims the new strategy defines as pivotal allies. "It's important that we point out that it's not a religious or cultural clash," Caslen says. "It is a war to preserve ordinary people's ability to live as they choose."

The final product reflects changes of profound significance, Pentagon officials say. First, the enemy is now defined more broadly than just al Qaeda. Second, the Pentagon has now officially moved away from what has been widely seen as a unilateral American approach. "It's not a military project alone," Feith explained, "and the United States cannot do it by itself alone."

Going global. The new strategy, for the first time, formally directs military commanders to go after a list of eight pressure points at which terrorist groups could be vulnerable: ideological support, weapons, funds, communications and movement, safe havens, foot soldiers, access to targets, and leadership. Each U.S.

PENTAGON IS FOCUSING ON MORE THAN JUST AL QAEDA'S TOP LEADERS.

geographic command is to follow a systematic approach, first collecting intelligence on any of the two dozen target groups that are operating in its area of responsibility and then developing a plan to attack all eight nodes for each of those groups.

Going after high-value targets like Osama bin Laden and Abu Musab Zarqawi, his emir in Iraq, is still a big part of the strategy but only a part. Three less direct approaches will now receive much greater emphasis: helping partner nations confront terrorism, going after supporters of terrorist organizations, and helping the State Department-led campaign to reduce the ideological appeal of terrorism. The latter category includes such things as military-provided humanitarian aid. U.S. aid to tsunami victims, for example, dramatically swung Asian public opinion from a negative to a positive view of America. Despite fears that the U.S. military is waging a duplicitous propaganda war, many military officials say that "information operations" are an inevitable dimension of warfare and must play a role, along with the State Department's public-diplomacy efforts. One particular area of emphasis: educating soldiers in religious and cultural sensitivities. Caslen showed a reporter two photographs as examples of what not to do—one of marines bivouacked inside Fallujah's Khulafah Rashid mosque after driving out insurgents, another of a soldier's rosary dangling from a tank barrel.

For a Pentagon that has been seen as primarily championing pre-emptive attacks against terrorist threats, the new strategy's enthusiastic embrace of foreign partners is a real sea change. Feith describes the reasons for it. "How do you fight an enemy that is present in numerous countries with whom you're not at war?" he asked. "The answer, in many cases, is we're going to have to rely on the governments of the countries where the terrorists are present. We can't do it ourselves, because you're talking about actions on the sovereign territory of other countries. . . . We need to have countries willing to cooperate with us and capable of doing the things they need to do to serve our common interests."

For whatever opposition they encounter, Pentagon brass know they must now rely more than ever on foreign partners; the insurgency in Iraq and the continuing violence in Afghanistan have stretched U.S. forces, simply precluding go-it-alone missions. Attempting to make a virtue out of a necessity, Washington has developed some promising relationships with countries that were previously wary or reluctant allies. The special operations commander for the Middle East and South Asia recounted several cases to *U.S. News* in which his forces, which traditionally work beneath the radar, have scored successes in Pakistan, Yemen, Africa, and Saudi Arabia. In a rare interview, the Jordanian special operations commander said that his men are training Iraqi counterterrorism forces at three bases in Jordan, staffing a hospital in the Iraqi city of Fallujah, and sealing the Iraqi-Jordanian border against insurgents. "We have the most secure

ABID KATIB—GETTY IMAGES

UNDERCOVER. A Saudi soldier in Mecca. The kingdom is cooperating with U.S. counterterrorism efforts but keeping it quiet.

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border with Iraq of any of its neighbors," Brig. Gen. Jamal al Shawabkeh said.

The head of U.S. Army special operations forces, Lt. Gen. Philip Kensinger, says such partnerships need to be developed around the world. "If you don't take a holistic approach to this . . . you press on one area, and you get a bulge someplace else." He described how he saw his troops fitting into the new strategy: "What my forces have got to be able to do is work around the world, continue to train and work with host-nation forces and U.S. forces and other U.S. agencies to try to establish a global intel database so that that little piece of information that you may get out of some little area, say, in Rwanda, provides the key to a cell someplace else around the world."

The new Pentagon strategy gives several new responsibilities to the Special Operations Command, which oversees all American special operations forces. "One of the earlier criticisms of the war on terror," says General Caslen, was "that we had no one to look at this from a global perspective." Now Special Operations Command has that role. Annex C of the

DOMINIQUE DERDA—FRANCE 2 / CORBIS

HELPING HAND. In Niger, U.S. Special Forces training locals in "Operation Flintlock"

A Few Real Good Friends

Pakistan's President Pervez Musharraf may have banned the U.S. military from chasing down al Qaeda within his country's borders, but U.S. Special Forces teams are training his elite special operations forces to do the job. In sharing this information with *U.S. News*, Brig. Gen. Francis Kearney, the new commander of special operations forces in the Central Command region covering the Middle East, South Asia, and Horn of Africa, sought to illustrate the kind of partnerships that the U.S. military has been able to forge with countries often seen as skittish or recalcitrant.

Pakistan is a case in point. The main impediment to its cooperation was, in Kearney's view, the long break in military ties with Washington until the 9/11 attacks. "It's all about staying the course," Kearney says, "building a relationship."

Like Pakistan, the Horn of Africa is another area of terrorist activity. In Ethiopia and Kenya, U.S. special operations soldiers are conducting exercises dubbed Nectar Bend and Noble Piper to help train local forces in counterterrorism and border-control skills. In Yemen, where radical Islamists move through the wide-open border with Saudi Arabia, Yemeni troops have graduated from training with U.S. operators to knocking down insurgent bases on their own. Twice in recent months, their elite troops, led by the Yemeni ruler's son, have interrupted counterterrorism training with the Americans to launch real operations. The country is a valuable partner because it is right across the Gulf of Aden from Somalia where, Kearney says, "we believe there are [terrorist] training camps and a regular network of folks moving back and forth."

Partners. Exercises run by the European Command have brought a growing group of West African countries into the counterterrorism fold, including Algeria, Morocco, Mauritania, Niger, Mali, Chad, and Nigeria. Saudi Arabia keeps its military cooperation on a low profile, but officials say the country has acted on leads from Iraq to round up al Qaeda militants at home and shared its own leads on Saudi troublemakers. Pakistan and Saudi Arabia have captured more high-level al Qaeda members than the United States, which in turn has helped paint increasingly detailed pictures of the terrorist network. Other officials remain skeptical, saying the Saudis have been selective and have continued to fund a huge worldwide Wahhabist movement that generates more jihadists than they pick up.

In Asia, Malaysia has become newly cooperative, and since 9/11 U.S. forces have conducted annual counterterrorism exercises in the Philippines to help fight its Abu Sayyaf Group. Gen. Mike Hindmarsh, the Australian special operations commander, declines to discuss his forces' role in Afghanistan and Iraq but outlines the extensive cooperation it has in the region with Asian neighbors and the United States.

One of the best counterterrorism allies the United States has is Jordan, but it was so wary of a backlash at home that it kept its role hidden during the Iraq war. The chief of Jordan's special operations command, Brig. Gen. Jamal al Shawabkeh, in a rare interview, talked about his forces' training of Iraqi special operations units. Jordan's special forces were modeled on the U.S. Green Berets, who have helped train them since their founding in 1963. "We have the very same organization," Jamal says. King Abdullah, who once led Jordan's commandos, sends them as instructors to countries where American forces may be less welcome. *–L.R.*

new Pentagon plan directs the Special Operations Command to draft a global campaign plan that will detail the new counterterrorism operations to be launched and to "synchronize" the counterterrorism plans of the five geographic military commands. In an interview with *U.S. News*, Gen. Doug Brown, the head of the Special Operations Command, or SOCOM, said his command was selected for the new mission "because, quite frankly, we are a global command. We've always been oriented around the world." In June, Brown convened a meeting of special operations forces from 59 foreign countries in Tampa, where SOCOM is based.

Traditionally, the geographic commands have been reluctant to yield to SOCOM on counterterrorism issues, but that's no longer an option. While Brown's command is now in charge of the planning effort in the war on terrorism, it will lead actual operations only when directed to do so by the president or Rumsfeld. Which is certainly a distinct possibility—Rumsfeld has expanded the authority of SOCOM in a number of key areas since Brown took command last year. "Most of them were in his purview," Brown said of the new areas of authority, "and we got them quickly."

One such authority granted in the new strategy is for special operations forces to conduct "operational preparation of the environment"—more Pentagon-speak for gathering information in trouble spots around the world to prepare for possible missions. "It's becoming familiar with the area in

ROOTING OUT TERROR

These are some of the principal military exercises that the Department of Defense is sponsoring in 2005 to foster cooperation, train U.S. and foreign troops, and improve regional security and counterterrorism capabilities. The principal host country is named; other countries may also participate.

SOUTHERN COMMAND

NEW HORIZONS (*Central America and Caribbean*): Annual cooperation and security exercises in Panama, Haiti, El Salvador, Nicaragua, Dominica, Antigua, and elsewhere.

UNITAS (*South America*): Annual naval exercise to increase regional maritime cooperation among South American countries.

PLAN COLOMBIA (*Colombia*): Counternarcotics and counterterrorism to fight Colombian narcoterrorist group FARC and others; also aimed at reducing potential for terrorists to seek safe havens in the region's ungoverned areas.

U.S. MILITARY REGIONAL COMMANDS

SOUTHERN COMMAND
Covers Central and South America and the Caribbean
TROOPS: 1,200

EUROPEAN COMMAND
Covers Europe, Russia, and Western Africa
TROOPS: 100,000

CENTRAL COMMAND
Covers Middle East, Horn of Africa, South and Central Asia
TROOPS: 17,000-25,000

PACIFIC COMMAND
Covers Southeast and North Asia
TROOPS: 300,000

EUROPEAN COMMAND (also covers Western Africa)

FLINTLOCK (*Saharan Morocco, Algeria, Chad, Niger, Tunisia, Senegal, Mali, Mauritania, Nigeria*): 1,000 U.S. troops, including 700 special operations forces, trained 3,000 African soldiers in airborne operations, border patrol, and marksmanship to fight, among other things, terrorist threats, including al Qaeda-linked groups. One quarter of foreign militants in Iraq come from Africa.

TRANS SAHARAN COUNTERTERRORISM INITIATIVE(*Saharan Morocco, Algeria, Chad, Niger, Tunisia, Senegal, Mali, Mauritania, Nigeria*): A $500 million, five-year program to train battalions of 500 soldiers and equip them with trucks, radios, and global positioning devices to track terrorists. After 9/11, the first stage began with U.S. 10th Special Forces Group training and equipping six companies of 150 soldiers.

which you might have to work," explains Thomas O'Connell, the Pentagon's assistant secretary for special operations and low-intensity conflict. "It's nonhostile recon. It's not intrusive. Others without a military background may view it as saber rattling, but it's as far from that as you can get." In the 1980s, O'Connell said, special operations forces spent lots of time preparing to respond to hijackings, kidnappings, and takeovers of embassies. To do that, they visited embassies and airports and examined possible helicopter landing zones and assault routes. In 1991, O'Connell said, the preparations paid off in the rescue of U.S. Embassy personnel in Somalia: "If one marine in that contingent hadn't just been in [as part of a survey team] and known that the embassy had switched, they would have assaulted the wrong compound."

Taking charge. While the new Pentagon strategy may have resolved some internal turf battles, other issues must await the conclusion of the National Security Council's review of counterterrorism policy. The Pentagon is floating one proposal that is sure to cause a stir in Congress and, probably, the State Department. Feith says there are good reasons to consider remaking the entire apparatus for aid and training for foreign troops, police, and other security forces. It was set up during the Cold War, he says, "more

EUROPEAN COMMAND

GEORGIA TRAIN & EQUIP: Since May 2002, U.S. Special Forces and U.S. Marines have trained 2,600 soldiers and support staff to fight transnational terrorist cells from Chechnya and Uzbekistan.

SORBET ROYAL (*East Mediterranean*): NATO's maritime effort to fight international terrorism. In October 2001, eight NATO ships contacted 1,000 vessels to search for terrorists.

IMMEDIATE RESPONSE (*Bulgaria*): Bilateral training with U.S. forces; U.S. European Command tests its rapid deployment.

TRIAL HAMMER (*Germany, France*): April 2005. NATO's first demonstration of its joint signals intelligence capability.

SPECIAL OPERATIONS COMMAND

HQ: Tampa; TROOPS: 51,000
Acts as "synchronizer" of regional commands' counterterrorism plans; writes global campaign plan; prioritizes deployments; conducts global "operational preparation of the environment;" carries out counterterror ops with special operations and other forces as directed; FY06 budget $6.5 billion

PACIFIC COMMAND

BALIKATAN (*Philippines*): Annual exercise to improve joint combat readiness, shore up Philippine defenses, and confront terrorist groups such as Abu Sayyaf and Jemaah Islamiya. The United States conducts some 20 exercises annually with the Philippines. In 2005, Balikatan included 300 American and 650 Philippine forces; Thailand, Singapore, and other Asian countries also have participated.

COBRA GOLD (*Thailand*): Some 400 U.S. Special Forces, Rangers, and Marines trained with the Royal Thai Army's Special Warfare Command Center staff, Special Task Force, and Rangers to instruct Thai forces in combat and counterterrorism skills. Long-standing military ties increased after 9/11 as intelligence showed growing links between Southeast Asian Islamist radicals and al Qaeda.

TALISMAN SABER (*Australia*): 11,000 U.S. and Australian forces joined in June's exercise for security, counterterrorism, and humanitarian scenarios in Asia. Force-on-force and live-fire exercises were carried out on land and sea. Australian forces have participated in both Afghanistan and Iraq coalitions.

FOAL EAGLE (*South Korea*): 17,000 U.S.-based troops and 7,000 based in South Korea conducted the weeklong exercise in March 2005 along with South Korea's military to deter North Korean aggression and increase regional security cooperation.

CENTRAL COMMAND

EBONY FLAME (*Djibouti*): Al Qaeda and other terrorist groups have used the Horn of Africa for safe haven and transit. Americans train and patrol with Djiboutian forces to help secure their borders with Somalia, believed to hold al Qaeda training camps.

NOBLE PIPER (*Kenya*): U.S. Special Forces 3rd Group trained with Kenyan Rangers; joint sea patrols with the U.S. Navy were conducted to stop al Qaeda from crossing the Gulf of Aden.

EAGER TIGER and **EAGER LIGHT** (*Jordan*): The primary U.S. joint exercises with Jordan in 2005 focus on counterterrorism, border security, and expanding Jordan's role as a center for regional cooperation.

EARNEST LEADER (*Saudi Arabia*): Annual exercise with Royal Saudi Land Forces and Third U.S. Army to practice command and control of coalition operations and to foster regional security and peacekeeping.

INSPIRED VENTURE, GAMBIT, SIREN, UNION (*Pakistan*): Exercises, including sea patrols and air-assault training, held in tribal provinces, where al Qaeda leaders are believed to hide.

Sources: Joint Chiefs of Staff, *GlobalSecurity.org, centcom.mil, eucom.mil, pacom.mil, southcom.mil, socom.mil*, and news reports

REPORTING: LINDA ROBINSON GRAPHIC BY ROD LITTLE AND STEPHEN ROUNTREE

FINBARR O'REILLY—REUTERS

MOVING OUT. In Mali, U.S. military experts are working with soldiers from nine West African nations to combat a group with ties to al Qaeda.

for building relationships and less for developing capabilities for partners to contribute to our military purposes." He cites the headache encountered when the Pentagon proposed to train and equip the Georgian Army in Central Asia after 9/11. "We had to tap five or six different pots of money," Feith says, "and it took over half a year."

Changing the system won't be easy. Congress has a long history of attaching all kinds of conditions to foreign aid. While the State Department administers most foreign security programs, its capability is small, and the Pentagon is restricted in training police forces abroad. A senior administration official declined to comment on the substance of the Pentagon strategy because it is still classified but said that it had been "invaluable to our governmentwide strategic thinking." At the White House, the official said, the National Security Council has focused its approach on "an ever growing number of willing partners . . . to address violent extremists operating within their borders."

Getting along. While there may be consensus on the broad approach, the devil will be in the hard bargaining over "who's in charge." The most important document to come out of the National Security Council review will be a new presidential directive that reconciles the conflicts among four counterterrorism directives. Two are from the Clinton era; two were signed by President Bush. Clinton's Presidential Decision Directive 39, signed in 1995, for example, gives the State Department the lead role in counterterrorism efforts abroad, but after 9/11, President Bush gave the CIA the lead for disrupting terrorist networks overseas. National Security Presidential Directive 9, signed on Oct. 25, 2001, directs the Pentagon to prepare military plans for eliminating terrorist sanctuaries. Similar overlapping jurisdictions exist for the Justice Department, the Department of Homeland Security, and the new intelligence entities created since 9/11. Since many planks of the Pentagon's new strategy require it to work with these other agencies, resolving these intramural issues will be essential.

Officials say that the Pentagon has proposed that the new National Security Presidential Directive include a mechanism that would allow the president to delegate a particular task in a particular region to whichever entity he deemed best suited to execute it. Would such an approach end the chronic turf warfare that cripples the Washington bureaucracy? Americans are disheartened, according to a July Gallup Poll, in which only 34 percent believe the United States is winning the war on terror. Some commentators note that it has already lasted longer than America's participation in World War II. A more apt analogy, however, may be the Cold War, which was another long, largely nonmilitary struggle. "The president has said this will be a generational struggle," said a senior official involved in the National Security Council review. "We need to make the same kind of commitment." ●

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All the News

By Megan Barnett

Most auto manufacturers spend lots of time and money figuring out who their customers are and how to reach them. Nissan knows that online is where to find them. Go to *Oprah.com,* and there's an ad for the Quest minivan. At *Forbes.com,* look for an ad for the Infiniti, Nissan's high-end sedan. Nissan America's online advertising spending is up 40 percent over last year, and it isn't about to slow down. "In the future, online advertising is going to grow rapidly, and it's likely that TV is going to be affected most," says John Rinek, director of media and agency management for Nissan. "We need to redirect our resources into areas that are paying off for us, such as online."

The online world is rapidly changing for advertisers—and for the media industry that depends on them for its livelihood. Long gone are the days when ad buyers handed over wads of cash for banner ads with the hopes of getting a few clicks. Now, the technology for delivering and measuring Internet ads is sophisticated and more powerful, allowing advertisers to be smarter and more demanding. This fact is not going unnoticed by print publishers and television executives, who are keenly aware that as their audiences are moving online, so are their advertisers. "Advertisers' expectations are greater now, and so is their involvement and knowledge of what they want their online advertising to be," says Peter Green, senior vice president of ad sales for *Weather.com,* the online arm of the Weather Channel.

To catch up, the media are in a feverish scramble to buy Internet properties and launch online initiatives that provide more Web pages that they hope will attract more viewers and, hence, more ads.

Last week Rupert Murdoch's News Corp. agreed to pay $580 million for Intermix Media, owner of the popular community website *Myspace.com,* which had 17.7 million visitors in June. The announcement came just days after News Corp. formed its Fox Interactive Media unit. The *Washington Post* recently launched dual home pages for its local and global audiences, which it hopes will increase advertising. And Yahoo! and Google, which are driven by advertising revenues, last week reported record quarterly earnings that indicated their growth shows no sign of slowing. Yahoo!'s revenues rose 51 percent from last year to $1.3 billion, and Google's revenues soared 98 percent to $1.4 billion.

> Newspapers, radio, TV, and magazines are scrambling to boost their Web presence.

Yet even as online advertising surges, it remains a tiny portion of total ad spending—3.6 percent, or $9.6 billion, in 2004, according to research firm eMarketer. It's expected to grow to 4.6 percent, or $12.9 billion, in 2005. Although Web commerce has been around for over a decade now, it is still a new environment for the advertising industry. Pricing is uncertain, and advertisers are still trying to determine how to best target their audience. The biggest spenders online are not yet the biggest old-media advertisers like Procter & Gamble and Pfizer. In May, according to TNS Media Intelligence, Internet phone pioneer Vonage spent the most online, serving up ads with an estimated value of $30.1 million. *LowerMyBills.com* came in second at $21.3 million, followed by Verizon at $19.5 million.

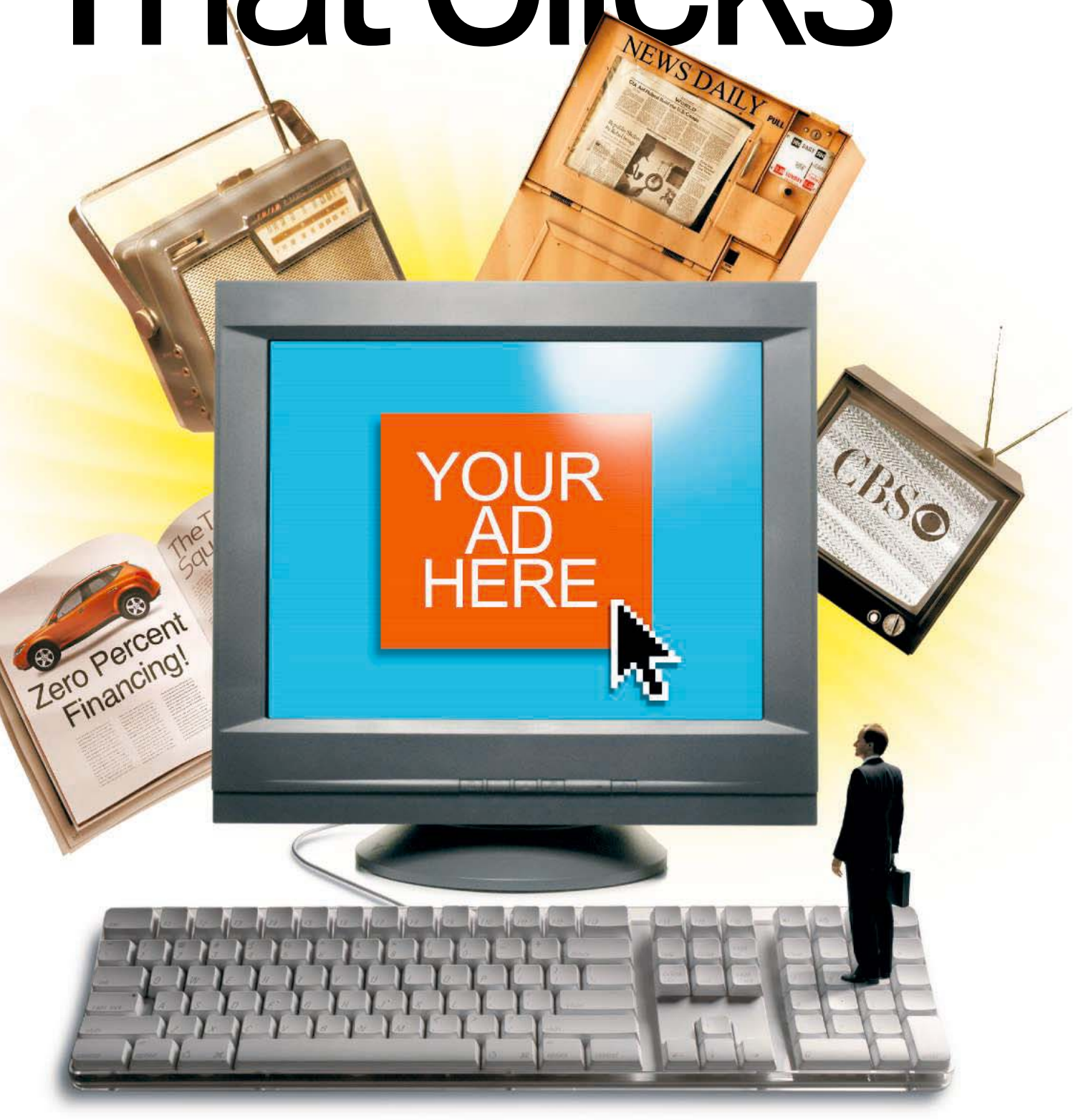
But traditional advertisers are starting to catch up, and Web publishers are scrambling to respond to their requests. Each type of medium is facing a unique set of issues. Newspapers suffer from shrinking circulations and the loss of lucrative real-estate and help-wanted classifieds. Television networks struggle with the rapid adoption of digital video recorders, which let people skip commercials. Free radio is dealing with competition from satellite radio and its more than 6 million paid subscribers.

Each one is turning to the Internet, where their advertisers increasingly want to be—and where they demand an answer to the question "Is the ad working?" says David Hallerman, analyst at eMarketer. That question is difficult to answer from a network television spot, and easier to answer from placing an ad on a page where someone has specifically searched for a product. "Online is absolutely an effective vehicle for us," says Michael Farello, vice president of marketing for the U.S. consumer business of Dell Computers, which spent $119.5 million online in 2004, according to TNS Media. "It's easy for us to measure—we can see where the clicks are coming from."

Relevance. At Dow Jones, which owns the *Wall Street Journal, Barron's,* and other news properties, being able to deliver highly targeted ads has been key to its online operations. It uses tracking technology to deliver relevant ads to readers wherever they are on their sites. If a reader searches for news about a specific type of car, for instance, Dow Jones tags that person as someone interested in buying a car. It will serve up auto ads, even if the reader moves on to read a story about healthcare or economics. Dow Jones acquired finan-cial news site *MarketWatch.com,* in which

ILLUSTRATION BY WILLIAM DUKE FOR *USN&WR*

That Clicks



ONLINE ADVERTISING IS EXPECTED TO TOTAL $12.9 BILLION IN 2005.

CBS had an interest, for $528 million.

Even with such detailed information, says Gordon Crovitz, president of electronic publishing for Dow Jones, educating advertisers about the nascent medium remains a challenge. "I think we have overcome much of the damage done during the dot-com bubble," he says. "The challenge for publishers is to accelerate the process of helping advertisers understand the full value of online advertising."

Some advertisers understand it better than others, and they know what to ask for in their negotiations with media salespeople. Integrated packages are becoming increasingly popular among both publishers and advertisers, enabling companies to take advantage of promotional opportunities across various types of media outlets. During the NCAA basketball tournament in March, Nissan promoted its Frontier truck through ESPN's sports bars, on its website, on the TV network, and in *ESPN* magazine. At the *Sporting News*, advertisers are promoting in print, online, and on the radio. "The more educated our salespeople are across platforms, the better we are at meeting their needs," says Jason Kint, general manager of its online operations. "Our salespeople have to be able to talk in all languages."

At the Weather Channel, advertisers want integrated packages in order to maximize their exposure to weather watchers. *Weather.com*'s Peter Green says the company has learned that people watch the cable channel in the morning and check *weather.com* while at work, which helps it to customize a holistic strategy that works for advertisers.

As broadband connections become more widespread, television networks rely on Web video to deliver news to people where and when they want it. Both CBS and CNN recently expanded their free online offerings to viewers, with video clips accompanied by advertisements that cannot be skipped as they can on TiVo. And *U.S. News* is expanding its own Web offerings, particularly in the areas of education and consumer health.

Even radio is rapidly responding to the changing environment in its own unique way. The growing popularity of portable audio players has created a new market for podcasts, downloadable audio clips, which can come with brief advertisements or sponsorships. "Radio buyers are a lot more savvy than they were three years ago," says Marc Horine, who oversees new media for ABC Radio. "I get questions about podcasts every day now."

Faster Internet connections are allowing more creativity in online ads, which publishers expect will help lure more traditional advertisers online. Those ads that move across your screen and the video clips in the corner may be an annoyance to Web surfers, but they are gold to advertisers. And so far, it seems advertisers and publishers are not concerned about consumer backlash as Web pages become even more crowded and flashy. "Many people say they skim by ads online. On TV, it's time to go make the popcorn," says eMarketer's Hallerman. "It's called ignoring."

While many people ignore the ads, it's the ones who respond to them who matter most to advertisers. And it's not yet known what they are worth to advertisers. Some publishers selling integrated packages want advertisers to pay a flat fee for them, while others insist on charging by the click. Many content providers are still trying to figure out if they should be charging for their material. The *New York Times* will soon start charging for some of its editorial content, but not all. About the only thing that is certain in the economics of Web publishing is that nothing is certain.

Underpricing. At the *Wall Street Journal*, which pioneered the art of charging for editorial content and has 744,000 paying subscribers and among the highest online advertising rates in the industry, executives are still trying to figure out how online ads will change as more blue-chip firms enter the fray. "I think the industry is significantly underpricing online ads," says Crovitz. "The traditional laws of economics have not appeared in the online equation in terms of value delivered and value received."

Publishers are pitching advertisers using the specific demographics of their online audiences, with the hopes that a more targeted delivery of ads will lure a new class of advertisers. "Advertisers are used to thinking in terms of cost per click and cost per acquisition," says Caroline Little, CEO of Washingtonpost.Newsweek Interactive. "We have to really walk them through what it is they want to achieve online and how to do it. You can't just take a 30-second TV spot and slap it on the Web."

For many in the ad business, the memories of the dot-com meltdown loom fresh in their minds. They are leery of paying too much or committing too soon. Publishers, meanwhile, are loath to give up on a business model that has served them well for decades. For now, the two sides are jockeying for position—and power—while trying to grab as many of the dollars being tossed around as possible. ●

OLD MEDIA LEARNS NEW TRICKS

Major media companies have been spending money to beef up their online offerings. A sampling of recent deals:

MEDIA COMPANY	STRATEGIC MOVE
CBS	Launching 24-hour, on-demand broadband network at ***CBSNews.com***
DOWJONES	Acquired online financial site ***Market Watch.com*** for $528 million in January
The New York Times Company	Bought information site ***About.com*** for $410 million in March
News Corporation	Acquired **Intermix Media** last week for $580 million; formed Fox Interactive Media division
The Washington Post	Acquired online magazine ***Slate.com*** for undisclosed amount in December; launched dual home pages

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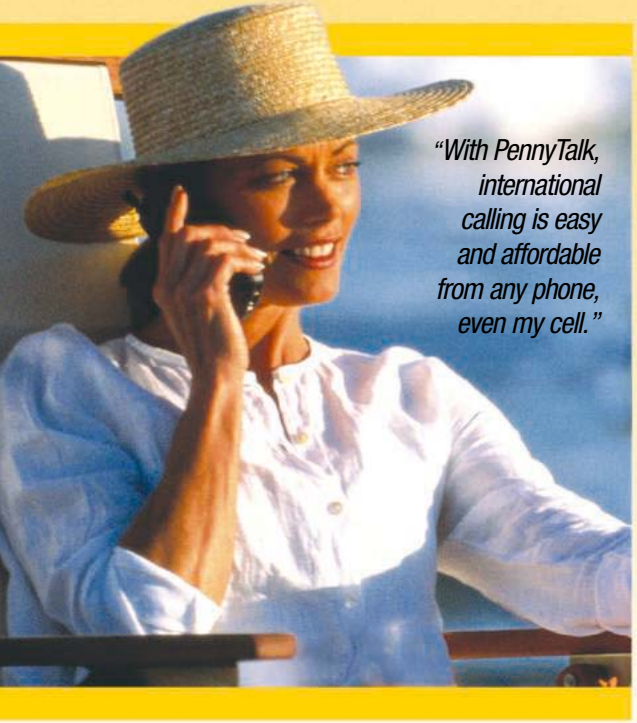

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PORTRAIT: RICHARD SANDOR

Free Market, Cleaner Air

By Marianne Lavelle

The Chicago Climate Exchange may be an experiment, but don't suggest to its creator, economist Richard Sandor, that it is a humble one.

CCX, as it is known, attempts nothing less than using market forces to slow global warming. Sandor bristles at some environmentalists' doubts about the voluntary program, begun in 2003, for polluters to cut emissions of greenhouse gases such as carbon dioxide. "Our goals are not modest," he says, noting that some purportedly stringent Capitol Hill proposals would not force companies into commitments as ambitious as the ones they've already made to join his market-based solution. CCX's legally binding reductions, he says, are "a major environmental achievement."

Sandor, 63, is used to having a big impact—and to facing harsh skepticism. Known now as a leader in the free-market approach to environmental protection, he long ago made his mark as a finance pioneer. As chief economist for the Chicago Board of Trade in the 1970s, he helped develop U.S. Treasury futures—allowing traders to hedge interest-rate risk much as farmers manage exposure to market swings through pork belly futures. Financial futures are now a multitrillion-dollar market, accounting for 82 percent of the Chicago Board of Trade's business, and the financial industry's initial coolness to the concept is scarcely remembered—except by Sandor.

"I have been thrown out of almost every bank in America," he says. "They said that interest rates weren't volatile, and there was no risk in not hedging, and it was a stupid idea and I should go back to Berkeley," where he had been a professor in the 1960s. But he kept championing a financial futures market as a solution to the problem of tight money and soaring interest rates.

The same thinking, he says, underpins his approach to climate change. "Back then, you had to price money, and now you have to price clean air," Sandor says. "These are both scarce commodities."

> **"Back then, you had to price money, and now you have to price clean air."**

Born: Sept. 7, 1941

Family: Wife, Ellen. Children, Julie and Penya. Three grandchildren and another on the way.

Education: B.A., City College of New York, 1962; Ph.D., economics, University of Minnesota, 1967

Academic: Research professor, Kellogg School of Management, Northwestern University

CCX members agree to reduce their overall carbon dioxide emissions by 1 percent per year. Those who can do more sell "credits" to other members who can't cut as much—in effect, the latter pay a price to pollute. The 102 participants include American Electric Power, Ford, IBM, DuPont, the cities of Chicago and Boulder, Colo., and Tufts University.

The so-called cap-and-trade system is modeled on the program initiated in the early 1990s to combat acid rain; nationwide sulfur dioxide emissions have been cut far more rapidly than originally planned at a fraction of the anticipated cost. The program design drew heavily on a position paper by none other than Richard Sandor, then a Drexel Burnham Lambert executive. It was his first foray into environmentalism.

Sandor began writing on emissions trading as an antidote to global warming. He spoke at the 1992 United Nations environmental conference that laid the groundwork for the Kyoto agreement on climate change five years later. "There were literally no ideas on the table" about financing until Sandor came along, says Paula DiPerna, then a vice president of the Cousteau Society. She calls him a "practical visionary." A few years later, as president of the Joyce Foundation, DiPerna got

the nonprofit's board to fund the launch of the Chicago Climate Exchange.

Then, Sandor says, "everything that could have gone wrong went wrong." President Bush withdrew from the Kyoto agreement, meaning U.S. businesses had little incentive to reduce carbon emissions. The dot-com crash, recession, 9/11, and corporate scandals followed. Not the best time to convince companies they should sign a contract to reduce their greenhouse gases. "My knees were bloody from groveling," Sandor says. Start-up of trading was delayed while he kept the project going with "as much money as I could put together from friends and family." (CCX is a private, for-profit company. A spokesman declined to say whether it is profitable, but it stands to make money from transaction fees should trading take off.)

Finally, a vehicle was established on the London Stock Exchange through which institutional investors could plow money into Sandor's venture. CCX raised $18 million a week before it opened for trading. Because Europe signed on to the Kyoto agreement, it has become an important locus of business for CCX. European companies trade carbon credits at a subsidiary, the European Climate Exchange. "We feel we are a good way towards our goal of being the international brand" as an emissions-trading platform, says Sandor.

Of course, while carbon dioxide emissions credits in Europe have surged in value from about $9 to $30 per ton since Kyoto went into effect early this year, in Chicago they have hovered between $1 and $2 since 2003. With no mandate from Uncle Sam, the market hasn't put much premium on reducing carbon emissions here.

Chess match. But last week, the Senate held the first of several planned climate-change hearings, following a bipartisan "sense of the Senate" resolution adopted earlier this summer that mandatory greenhouse gas cutbacks were needed. Lawmakers have moved closer to the idea because businesses, like those involved in CCX, have shown it can be done. Sandor notes that he has been criticized by both left and right, but that as a chess enthusiast (he once beat the legendary Bobby Fischer when both were teenagers in Brooklyn), he knows that the game is controlled from the center.

While the Senate considers climate change, Sandor already is on his next big idea; the Joyce Foundation has given him $440,000 to explore the idea of trading in another scarce commodity: water. "How can you create incentives for conservation without compromising people's right to access?" asks Ellen Alberding, current president of Joyce (DiPerna now is an executive with CCX). "Again, his track record led us to invest another chunk of money."

When he isn't thinking about new markets, Sandor works on his art collection, which covers the 150-year history of photography. He points out that many authorities didn't consider photography an artistic medium when he began his collection three decades ago; as in the finance world, his contrarian instincts proved prescient. "I always try to find the value proposition," he says, "where one isn't being recognized." ●

KEVIN HORAN FOR *USN&WR*

By Paul J. Lim

THE WEEK AHEAD

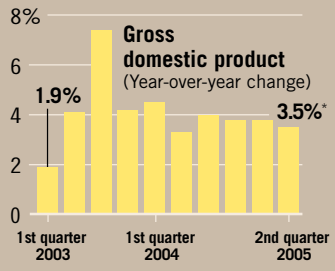
HOMELY PRICES

Bubble or not, the residential real-estate market is playing an ever larger role in the health of the domestic economy. Since 2001, 2 out of every 5 jobs created in the private sector have been tied to the real-estate boom, according to Merrill Lynch economist David Rosenberg. What's more, 70 percent of the rise in household net worth in recent years can be attributed to gains in home values. No wonder economists fret about the health of the housing market. This week, the **National Association of Realtors** and the Commerce Department will release data on June home sales. Though existing home prices have been steadily rising, prices on new homes have quietly started to drop. The median sales price on a new house in May was $217,000, down from $232,000 in April and $237,000 in February. If price tags continue to fall, it could be cause for concern on both Wall Street and Main Street.

PARTY ON, GDP

By some estimates, high oil prices are shaving three quarters of a percentage point off **gross domestic product.** Yet somehow, the economy is finding a way to grow. In fact, economists now think GDP rose a healthy 3.5 percent in the second quarter.

RESILIENT ECONOMY



*Estimate

Sources: Bureau of Economic Analysis, Reuters

China's Currency Move Won't Float All Boats

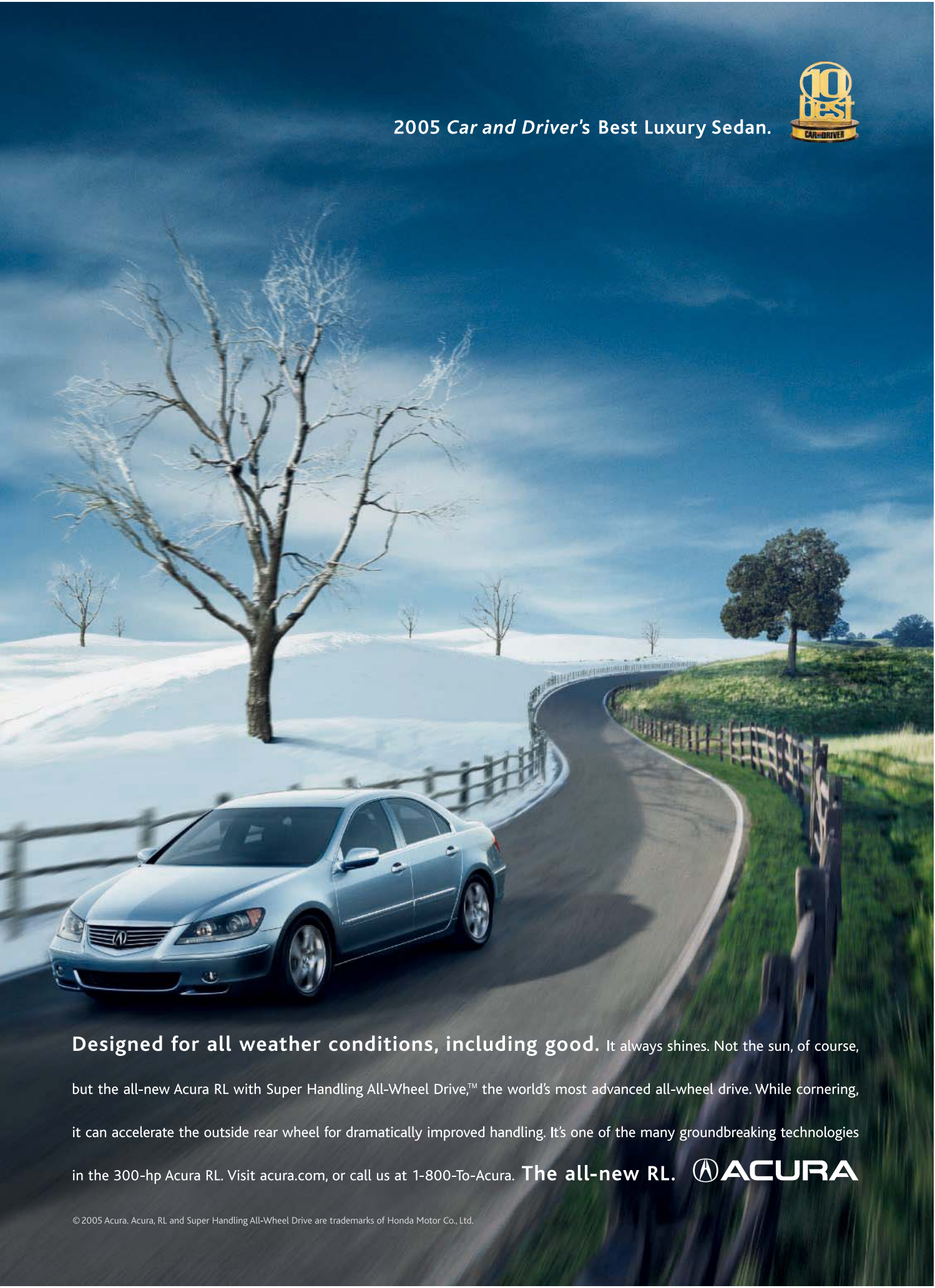
Make no mistake: China didn't do all Americans a favor by agreeing to revalue its currency. For some time, U.S. officials have pleaded with the Chinese to allow the yuan to float more freely rather than pegging it so strictly to the dollar. That's because the weak dollar has made Chinese goods sold abroad that much more attractive, putting a crimp on U.S. exports. Last week, China finally complied, raising the value of the yuan versus the dollar and then agreeing to unhitch it from the greenback, linking it instead to a basket of foreign currencies. "China's full implementation of its new currency regime will be a significant contribution toward global financial stability," said U.S. Treasury Secretary John Snow. But even though U.S. manufacturers may have gotten what they wanted, many segments of the U.S. economy don't necessarily win. For starters, though China revalued earlier than expected, it did not go as far as some had hoped. China allowed the yuan to strengthen by about 2 percent against the dollar. Ashraf Laidi, chief currency analyst with MG Financial Group, was "expecting China to revalue later in the year by as much as 3 to 5 percent." For U.S. consumers, the fact that Chinese goods sold here will now be more expensive means inflation will remain a cause of concern. For U.S. companies that buy parts and services from China (whose red-hot economy grew by 9.5 percent in the second quarter compared with a year earlier), costs could rise and profit margins shrink. This is particularly true of retailers and technology firms, says Sam Stovall, chief investment strategist for Standard & Poor's. For U.S. homeowners, it could mean a temporary end to record-low mortgage interest rates. After all, if the Chinese stop buying as many U.S. dollars to support their currency, they're likely to purchase fewer treasury bonds, which means bond yields should rise. Last week, the yield on the 10-year treasury note jumped from 4.18 percent before the announcement to 4.28 percent. And finally, for U.S. critics of Chinese attempts to purchase American companies, this could be trouble. If the Chinese currency strengthens, so too does the ability of Chinese investors to buy publicly traded U.S. firms, just as China's state-owned oil giant CNOOC is trying to buy California-based Unocal.

You've Got (Totally Unsolicited) Mail

American consumers are doing a better job managing certain aspects of their massive credit card debt. Card delinquencies are down, for instance, and fewer folks are responding to those annoying offers in the mail. So what are card companies doing in response? They're stuffing even more offers into our mailboxes. According to the research firm Synovate, card issuers mailed out a record 1.4 billion offers in the first quarter, putting them on track to send out nearly 6 billion solicitations this year. ●

MORE **MONEY & BUSINESS** NEWS, FEATURES, AND ADVICE ARE AT **WWW.USNEWS.COM/BUZZ**

FROM TOP: DAVID BUTOW—REDUX FOR *USN&WR;* C SQUARED STUDIOS / GETTY IMAGES; CHART BY *USN&WR*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CAN HIGH TECH SAVE YOUR LIFE?

It just might: Computer use in hospitals is now linked to lower death rates

By Josh Fischman

It is just before 1 p.m. on a Friday in late June, and Brenda Coulter is making her rounds. Coulter is an intensive care nurse, and she's checking on a patient coming out of heart-bypass surgery at Aurora St. Luke's Medical Center in Milwaukee. But she's not actually at St. Luke's. She's in a low brick building several miles away, closer to the Milwaukee airport than it is to the hospital. "Hello, how are you? I'm Brenda Coulter, a nurse, just making sure everything's OK," she says into a microphone. On one screen in a bank of five computer monitors in front of her, a man looks up from his bed, his face partly covered by an oxygen mask, and nods his head. "Good," Coulter says. On another screen, the man's heartbeat traces a regular rhythm, up and down, up and down.

This is the Aurora eICU, from which a team of

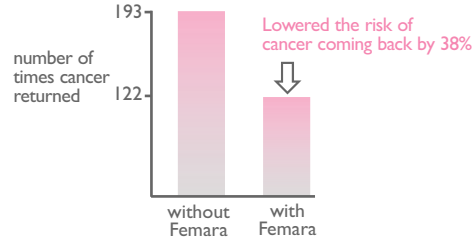
ILLUSTRATION BY SARA HAYWARD FOR *USN&WR*

You had breast cancer.
You had tamoxifen.
Now what?

Introducing Femara. After breast cancer, after tamoxifen, there's something more you can do to increase your chances of staying cancer free.

Clinical trial results from an international study involving over 5,000 postmenopausal women show that Femara greatly increased the chances of staying cancer free (that is, Femara reduced the risk of cancer returning by 38% compared to placebo).

Femara is approved for the extended adjuvant treatment of early breast cancer in postmenopausal women who are within three months of completion of five years of tamoxifen therapy. The benefits of Femara in the clinical trial are based on 24 months of treatment. Further follow-up will be needed to determine long-term results, including side effects.



In addition to increasing the chances of staying cancer free, Femara also significantly lowered the risk of breast cancer returning to another part of the body. For the thousands of women who've recently completed tamoxifen, Femara is more than hope, it's help.

Important Safety Information

You should not take Femara if you are pregnant as it may cause fetal harm. You must be postmenopausal to take Femara.

Commonly reported side effects are generally mild to moderate. Those seen more often with Femara versus placebo were hot flashes (50% vs 43%), joint pain (22% vs 18%) and muscle pain (7% vs 5%). Other side effects, which were comparable to placebo, include fatigue (34% vs 32%), swelling due to fluid retention (18% vs 16%), headache (20% vs 20%), increase in sweating (24% vs 22%) and increase in cholesterol (16% vs 16%).

Longer follow-up is needed to determine the risk of fracture associated with long-term use of Femara. The percentage of patients on Femara versus placebo reporting a fracture was 5.9% vs 5.5%. The percentage of patients reporting osteoporosis was 6.9% vs 5.5%. Bisphosphonates, drugs to increase bone strength, were given to 21.1% of Femara patients and 18.7% of placebo patients.

Femara is a convenient, once-a-day prescription therapy.
Ask your oncologist if Femara can increase your chances of staying cancer free.

For more information, call 1·866·346·1743
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Femara®
(letrozole tablets)

Please see important product information on the next page.

Novartis Pharmaceuticals Corporation C-FEM-1033

Femara®

(letrozole tablets)

2.5 mg Tablets

Rx only

BRIEF SUMMARY: Please see package insert for full prescribing information.

INDICATIONS AND USAGE: Femara® (letrozole tablets) is indicated for the extended adjuvant treatment of early breast cancer in postmenopausal women who have received 5 years of adjuvant tamoxifen therapy *(see Clinical Studies in the full prescribing information).* The effectiveness of Femara in extended adjuvant treatment of early breast cancer is based on an analysis of disease-free survival in patients treated for a median of 24 months *(see CLINICAL PHARMACOLOGY, Clinical Studies in the full prescribing information).* Further data will be required to determine long-term outcome.

Femara is indicated for first-line treatment of postmenopausal women with hormone receptor positive or hormone receptor unknown locally advanced or metastatic breast cancer. Femara is also indicated for the treatment of advanced breast cancer in postmenopausal women with disease progression following antiestrogen therapy.

CONTRAINDICATIONS: Femara® is contraindicated in patients with known hypersensitivity to Femara or any of its excipients.

WARNINGS: Pregnancy: Letrozole may cause fetal harm when administered to pregnant women. Studies in rats at doses equal to or greater than 0.003 mg/kg (about 1/100 the daily maximum recommended human dose on a mg/m^2 basis) administered during the period of organogenesis, have shown that letrozole is embryotoxic and fetotoxic, as indicated by intrauterine mortality, increased resorption, increased postimplantation loss, decreased numbers of live fetuses and fetal anomalies including absence and shortening of renal papilla, dilation of ureter, edema and incomplete ossification of frontal skull and metatarsals. Letrozole was teratogenic in rats. A 0.03 mg/kg dose (about 1/10 the daily maximum recommended human dose on a mg/m^2 basis) caused fetal domed head and cervical/centrum vertebral fusion.

Letrozole is embryotoxic at doses equal to or greater than 0.002 mg/kg and fetotoxic when administered to rabbits at 0.02 mg/kg (about 1/100,000 and 1/10,000 the daily maximum recommended human dose on a mg/m^2 basis, respectively). Fetal anomalies included incomplete ossification of the skull, sternebrae, and fore- and hindlegs.

There are no studies in pregnant women. Femara® is indicated for postmenopausal women. If there is exposure to letrozole during pregnancy, the patient should be apprised of the potential hazard to the fetus and potential risk for loss of the pregnancy.

PRECAUTIONS: Since fatigue and dizziness have been observed with the use of Femara® and somnolence was uncommonly reported, caution is advised when driving or using machinery.

Laboratory Tests: No dose-related effect of Femara on any hematologic or clinical chemistry parameter was evident. Moderate decreases in lymphocyte counts, of uncertain clinical significance, were observed in some patients receiving Femara 2.5 mg. This depression was transient in about half of those affected. Two patients on Femara developed thrombocytopenia; relationship to the study drug was unclear. Patient withdrawal due to laboratory abnormalities, whether related to study treatment or not, was infrequent.

Increases in SGOT, SGPT, and gamma GT ≥5 times the upper limit of normal (ULN) and of bilirubin ≥1.5 times the ULN were most often associated with metastatic disease in the liver. About 3% of study participants receiving Femara had abnormalities in liver chemistries not associated with documented metastases; these abnormalities may have been related to study drug therapy. In the megestrol acetate comparative study about 8% of patients treated with megestrol acetate had abnormalities in liver chemistries that were not associated with documented liver metastases; in the aminoglutethimide study about 10% of aminoglutethimide-treated patients had abnormalities in liver chemistries not associated with hepatic metastases.

Bone Effects: Preliminary results (median duration of follow-up was 20 months) from the bone sub-study (Calcium 500 mg and Vitamin D 400 IU per day mandatory; bisphosphonates not allowed) demonstrated that at 2 years the mean decrease compared to baseline in hip BMD in Femara patients was 3% vs. 0.4% for placebo (P=0.048). The mean decrease from baseline BMD results for the lumbar spine at 2 years was Femara 4.6% decrease and placebo 2.2% (P=0.069). Consideration should be given to monitoring BMD.

Drug Interactions: Clinical interaction studies with cimetidine and warfarin indicated that the coadministration of Femara with these drugs does not result in clinically-significant drug interactions. *(See CLINICAL PHARMACOLOGY in the full prescribing information.)* Coadministration of Femara and tamoxifen 20 mg daily resulted in a reduction of letrozole plasma levels by 38% on average. There is no clinical experience to date on the use of Femara in combination with other anticancer agents.

Hepatic Insufficiency: Subjects with cirrhosis and severe hepatic dysfunction who were dosed with 2.5 mg of Femara experienced approximately twice the exposure to letrozole as healthy volunteers with normal liver function. *(See DOSAGE AND ADMINISTRATION.)*

Drug/Laboratory Test-Interactions: None observed.

Carcinogenesis, Mutagenesis, Impairment of Fertility: A conventional carcinogenesis study in mice at doses of 0.6 to 60 mg/kg/day (about 1 to 100 times the daily maximum recommended human dose on a mg/m^2 basis) administered by oral gavage for up to 2 years revealed a dose-related increase in the incidence of benign ovarian stromal tumors. The incidence of combined hepatocellular adenoma and carcinoma showed a significant trend in females when the high dose group was excluded due to low survival. In a separate study, plasma $AUC_{0\text{-}12hr}$ levels in mice at 60 mg/kg/day were 55 times higher than the $AUC_{0\text{-}24hr}$ level in breast cancer patients at the recommended dose. The carcinogenicity study in rats at oral doses of 0.1 to 10 mg/kg/day (about 0.4 to 40 times the daily maximum recommended human dose on a mg/m^2 basis) for up to 2 years also produced an increase in the incidence of benign ovarian stromal tumors at 10 mg/kg/day. Ovarian hyperplasia was observed in females at doses equal to or greater than 0.1 mg/kg/day. At 10 mg/kg/day, plasma $AUC_{0\text{-}24hr}$ levels in rats were 80 times higher than the level in breast cancer patients at the recommended dose.

Letrozole was not mutagenic in *in vitro* tests (Ames and *E. coli* bacterial tests) but was observed to be a potential clastogen in *in vitro* assays (CHO K1 and CCL 61 Chinese hamster ovary cells). Letrozole was not clastogenic *in vivo* (micronucleus test in rats).

Studies to investigate the effect of letrozole on fertility have not been conducted; however, repeated dosing caused sexual inactivity in females and atrophy of the reproductive tract in males and females at doses of 0.6, 0.1 and 0.03 mg/kg in mice, rats and dogs, respectively (about one, 0.4 and 0.4 the daily maximum recommended human dose on a mg/m^2 basis, respectively).

Pregnancy: ***Pregnancy Category D*** *(See WARNINGS.)*

Nursing Mothers: It is not known if letrozole is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when letrozole is administered to a nursing woman *(see WARNINGS and PRECAUTIONS).*

Pediatric Use: The safety and effectiveness in pediatric patients have not been established.

Geriatric Use: The median age of patients in all studies of first-line and second-line treatment of metastatic breast cancer was 64-65 years. About 1/3 of the patients were ≥70 years old. In the first-line study, patients ≥70 years of age experienced longer time to tumor progression and higher response rates than patients <70. For the extended adjuvant setting, more than 5100 postmenopausal women were enrolled in the clinical study. In total, 41% of patients were aged 65 years or older at enrollment, while 12% were 75 or older. No overall differences in safety or efficacy were observed between these older patients and younger patients, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out.

ADVERSE REACTIONS: Femara® was generally well tolerated across all studies in first-line and second-line metastatic breast cancer as well as extended adjuvant treatment in women who have received prior standard adjuvant tamoxifen treatment. Generally, the observed adverse reactions are mild or moderate in nature.

Extended Adjuvant Treatment of Early Breast Cancer in Postmenopausal Women Who Have Received 5 Years of Adjuvant Tamoxifen Therapy: The median duration of extended adjuvant treatment was 24 months and the median duration of follow-up for safety was 28 months for patients receiving letrozole and placebo.

Table 1 describes the adverse events occurring at a frequency of at least 5% in any treatment group during treatment. Most adverse events reported were Grade 1 and Grade 2 based on the Common Toxicity Criteria Version 2.0. In the extended adjuvant setting, the reported drug-related adverse events that were significantly different from placebo were hot flashes, arthralgia/arthritis, and myalgia.

Table 1: Percentage of Patients with Adverse Events

	Number (%) of Patients with Grade 1-4 Adverse Event		Number (%) of Patients with Grade 3-4 Adverse Event	
	Letrozole N=2563	Placebo N=2573	Letrozole N=2563	Placebo N=2573
Any Adverse Event	2232 (87.1)	2174 (84.5)	419 (16.3)	389 (15.1)
Vascular Disorders	1375 (53.6)	1230 (47.8)	59 (2.3)	74 (2.9)
Flushing	1273 (49.7)	1114 (43.3)	3 (0.1)	0 (0)
General Disorders	1154 (45.0)	1090 (42.4)	30 (1.2)	28 (1.1)
Asthenia	862 (33.6)	826 (32.1)	16 (0.6)	7 (0.3)
Edema NOS	471 (18.4)	416 (16.2)	4 (0.2)	3 (0.1)
Musculoskeletal Disorders	978 (38.2)	836 (32.5)	71 (2.8)	50 (1.9)
Arthralgia	565 (22.0)	465 (18.1)	25 (1.0)	20 (0.8)
Arthritis NOS	173 (6.7)	124 (4.8)	10 (0.4)	5 (0.2)
Myalgia	171 (6.7)	122 (4.7)	8 (0.3)	6 (0.2)
Back Pain	129 (5.0)	112 (4.4)	8 (0.3)	7 (0.3)
Nervous System Disorders	863 (33.7)	819 (31.8)	65 (2.5)	58 (2.3)
Headache	516 (20.1)	508 (19.7)	18 (0.7)	17 (0.7)
Dizziness	363 (14.2)	342 (13.3)	9 (0.4)	6 (0.2)
Skin Disorders	830 (32.4)	787 (30.6)	17 (0.7)	16 (0.6)
Sweating Increased	619 (24.2)	577 (22.4)	1 (<0.1)	0 (0)
Gastrointestinal Disorders	725 (28.3)	731 (28.4)	43 (1.7)	42 (1.6)
Constipation	290 (11.3)	304 (11.8)	6 (0.2)	2 (<0.1)
Nausea	221 (8.6)	212 (8.2)	3 (0.1)	10 (0.4)
Diarrhea NOS	128 (5.0)	143 (5.6)	12 (0.5)	8 (0.3)
Metabolic Disorders	551 (21.5)	537 (20.9)	24 (0.9)	32 (1.2)
Hypercholesterolemia	401 (15.6)	398 (15.5)	2 (<0.1)	5 (0.2)
Reproductive Disorders	303 (11.8)	357 (13.9)	9 (0.4)	8 (0.3)
Vaginal Hemorrhage	123 (4.8)	171 (6.6)	2 (<0.1)	5 (0.2)
Vulvovaginal Dryness	137 (5.3)	127 (4.9)	0 (0)	0 (0)
Psychiatric Disorders	320 (12.5)	276 (10.7)	21 (0.8)	16 (0.6)
Insomnia	149 (5.8)	120 (4.7)	2 (<0.1)	2 (<0.1)
Respiratory Disorders	279 (10.9)	260 (10.1)	30 (1.2)	28 (1.1)
Dyspnea	140 (5.5)	137 (5.3)	21 (0.8)	18 (0.7)
Investigations	184 (7.2)	147 (5.7)	13 (0.5)	13 (0.5)
Infections and Infestations	166 (6.5)	163 (6.3)	40 (1.6)	33 (1.3)
Renal Disorders	130 (5.1)	100 (3.9)	12 (0.5)	6 (0.2)

The duration of follow-up for both the main clinical study and the bone study were insufficient to assess fracture risk associated with long-term use of letrozole. Based on a median follow-up of patients for 28 months, the incidence of clinical fractures from the core randomized study in patients who received Femara was 5.9% (152) and placebo was 5.5% (142). The incidence of self-reported osteoporosis was higher in patients who received Femara 6.9% (176) than in patients who received placebo 5.5% (141). Bisphosphonates were administered to 21.1% of the patients who received Femara and 18.7% of the patients who received placebo.

Preliminary results (median duration of follow-up was 20 months) from the bone sub-study (Calcium 500 mg and Vitamin D 400 IU per day mandatory; bisphosphonates not allowed) demonstrated that at 2 years the mean decrease compared to baseline in hip BMD in Femara patients was 3% vs. 0.4% for placebo. The mean decrease from baseline BMD results for the lumbar spine at 2 years were Femara 4.6% decrease and placebo 2.2%.

The incidence of cardiovascular ischemic events from the core randomized study was comparable between patients who received Femara 6.8% (175) and placebo 6.5% (167).

Preliminary results (median duration of follow-up was 30 months) from the lipid sub-study did not show significant differences between the Femara and placebo groups. The HDL:LDL ratio decreased after the first 6 months of therapy but the decrease was similar in both groups and no statistically significant differences were detected.

A patient-reported measure that captures treatment impact on important symptoms associated with estrogen deficiency demonstrated a difference in favor of placebo for vasomotor and sexual symptom domains.

First-Line Breast Cancer: A total of 455 patients was treated for a median time of exposure of 11 months. The incidence of adverse experiences was similar for Femara and tamoxifen. The most frequently reported adverse experiences were bone pain, hot flushes, back pain, nausea, arthralgia and dyspnea. Discontinuations for adverse experiences other than progression of tumor occurred in 10/455 (2%) of patients on Femara and in 15/455 (3%) of patients on tamoxifen.

Adverse events, regardless of relationship to study drug, that were reported in at least 5% of the patients treated with Femara 2.5 mg or tamoxifen 20 mg in the first-line treatment study are shown in Table 2.

Table 2: Percentage (%) of Patients with Adverse Events

Adverse Experience	Femara® 2.5 mg (N=455) %	tamoxifen 20 mg (N=455) %	Adverse Experience	Femara® 2.5 mg (N=455) %	tamoxifen 20 mg (N=455) %
General Disorders			**Injury, Poisoning and Procedural Complications**		
Fatigue	13	13	Post-Mastectomy Lymphedema	7	7
Chest Pain	8	9	**Metabolism and Nutrition Disorders**		
Edema Peripheral	5	6	Anorexia	4	6
Pain NOS	5	7	**Musculoskeletal and Connective Tissue Disorders**		
Weakness	6	4	Bone Pain	22	21
Investigations			Back Pain	18	19
Weight Decreased	7	5	Arthralgia	16	15
Vascular Disorders			Pain in Limb	10	8
Hot Flushes	19	16	**Nervous System Disorders**		
Hypertension	8	4	Headache NOS	8	7
Gastrointestinal Disorders			**Psychiatric Disorders**		
Nausea	17	17	Insomnia	7	4
Constipation	10	11	**Reproductive System and Breast Disorders**		
Diarrhea	8	4	Breast Pain	7	7
Vomiting	7	8	**Respiratory, Thoracic and Mediastinal Disorders**		
Infections/Infestations			Dyspnea	18	17
Influenza	6	4	Cough	13	13
Urinary Tract Infection NOS	6	3	Chest Wall Pain	6	6

Other less frequent (≤2%) adverse experiences considered consequential for both treatment groups, included peripheral thromboembolic events, cardiovascular events, and cerebrovascular events. Peripheral thromboembolic events included venous thrombosis, thrombophlebitis, portal vein thrombosis and pulmonary embolism. Cardiovascular events included angina, myocardial infarction, myocardial ischemia, and coronary heart disease. Cerebrovascular events included transient ischemic attacks, thrombotic or hemorrhagic strokes and development of hemiparesis.

Second-Line Breast Cancer: Femara was generally well tolerated in two controlled clinical trials.

Study discontinuations in the megestrol acetate comparison study for adverse events other than progression of tumor occurred in 5/188 (2.7%) of patients on Femara 0.5 mg, in 4/174 (2.3%) of the patients on Femara 2.5 mg, and in 15/190 (7.9%) of patients on megestrol acetate. There were fewer thromboembolic events at both Femara doses than on the megestrol acetate arm (2 of 362 patients or 0.6% vs. 9 of 190 patients or 4.7%). There was also less vaginal bleeding (1 of 362 patients or 0.3% vs. 6 of 190 patients or 3.2%) on letrozole than on megestrol acetate. In the aminoglutethimide comparison study, discontinuations for reasons other than progression occurred in 6/193 (3.1%) of patients on 0.5 mg Femara, 7/185 (3.8%) of patients on 2.5 mg Femara, and 7/178 (3.9%) of patients on aminoglutethimide.

Comparisons of the incidence of adverse events revealed no significant differences between the high and low dose Femara groups in either study. Most of the adverse events observed in all treatment groups were mild to moderate in severity and it was generally not possible to distinguish adverse reactions due to treatment from the consequences of the patient's metastatic breast cancer, the effects of estrogen deprivation, or intercurrent illness.

Adverse events, regardless of relationship to study drug, that were reported in at least 5% of the patients treated with Femara 0.5 mg, Femara 2.5 mg, megestrol acetate, or aminoglutethimide in the two controlled trials are shown in Table 3.

Table 3: Percentage (%) of Patients with Adverse Events

Adverse Experience	Pooled Femara® 2.5 mg (N=359) %	Pooled Femara® 0.5 mg (N=380) %	megestrol acetate 160 mg (N=189) %	aminoglutethimide 500 mg (N=178) %
Body as a Whole				
Fatigue	8	6	11	3
Chest Pain	6	3	7	3
Peripheral Edema[1]	5	5	8	3
Asthenia	4	5	4	5
Weight Increase	2	2	9	3
Cardiovascular				
Hypertension	5	7	5	6
Digestive System				
Nausea	13	15	9	14
Vomiting	7	7	5	9
Constipation	6	7	9	7
Diarrhea	6	5	3	4
Pain-Abdominal	6	5	9	8
Anorexia	5	3	5	5
Dyspepsia	3	4	6	5
Infections/Infestations				
Viral Infection	6	5	6	3
Lab Abnormality				
Hypercholesterolemia	3	3	0	6
Musculoskeletal System				
Musculoskeletal[2]	21	22	30	14
Arthralgia	8	8	8	3
Nervous System				
Headache	9	12	9	7
Somnolence	3	2	2	9
Dizziness	3	5	7	3
Respiratory System				
Dyspnea	7	9	16	5
Coughing	6	5	7	5
Skin and Appendages				
Hot Flushes	6	5	4	3
Rash[3]	5	4	3	12
Pruritus	1	2	5	3

[1]Includes peripheral edema, leg edema, dependent edema, edema
[2]Includes musculoskeletal pain, skeletal pain, back pain, arm pain, leg pain
[3]Includes rash, erythematous rash, maculopapular rash, psoriasiform rash, vesicular rash

Other less frequent (<5%) adverse experiences considered consequential and reported in at least 3 patients treated with Femara, included hypercalcemia, fracture, depression, anxiety, pleural effusion, alopecia, increased sweating and vertigo.

OVERDOSAGE: Isolated cases of Femara® overdose have been reported. In these instances, the highest single dose ingested was 62.5 mg or 25 tablets. While no serious adverse events were reported in these cases, because of the limited data available, no firm recommendations for treatment can be made. In general, supportive care and frequent monitoring of vital signs are also appropriate. In single dose studies the highest dose used was 30 mg, which was well tolerated; in multiple dose trials, the largest dose of 10 mg was well tolerated.

DOSAGE AND ADMINISTRATION: Adult and Elderly Patients: The recommended dose of Femara® is one 2.5 mg tablet administered once a day, without regard to meals.

No dose adjustment is required for elderly patients.

Renal Impairment: No dosage adjustment is required for patients with renal impairment if creatinine clearance is ≥10 mL/min.

Hepatic Impairment: The dose of letrozole in patients with cirrhosis and severe hepatic dysfunction should be reduced by 50%. The recommended dose of Femara® for such patients is 2.5 mg administered every other day.

Store at 25°C (77°F); excursions permitted to 15-30°C (59-86°F) [see USP Controlled Room Temperature].

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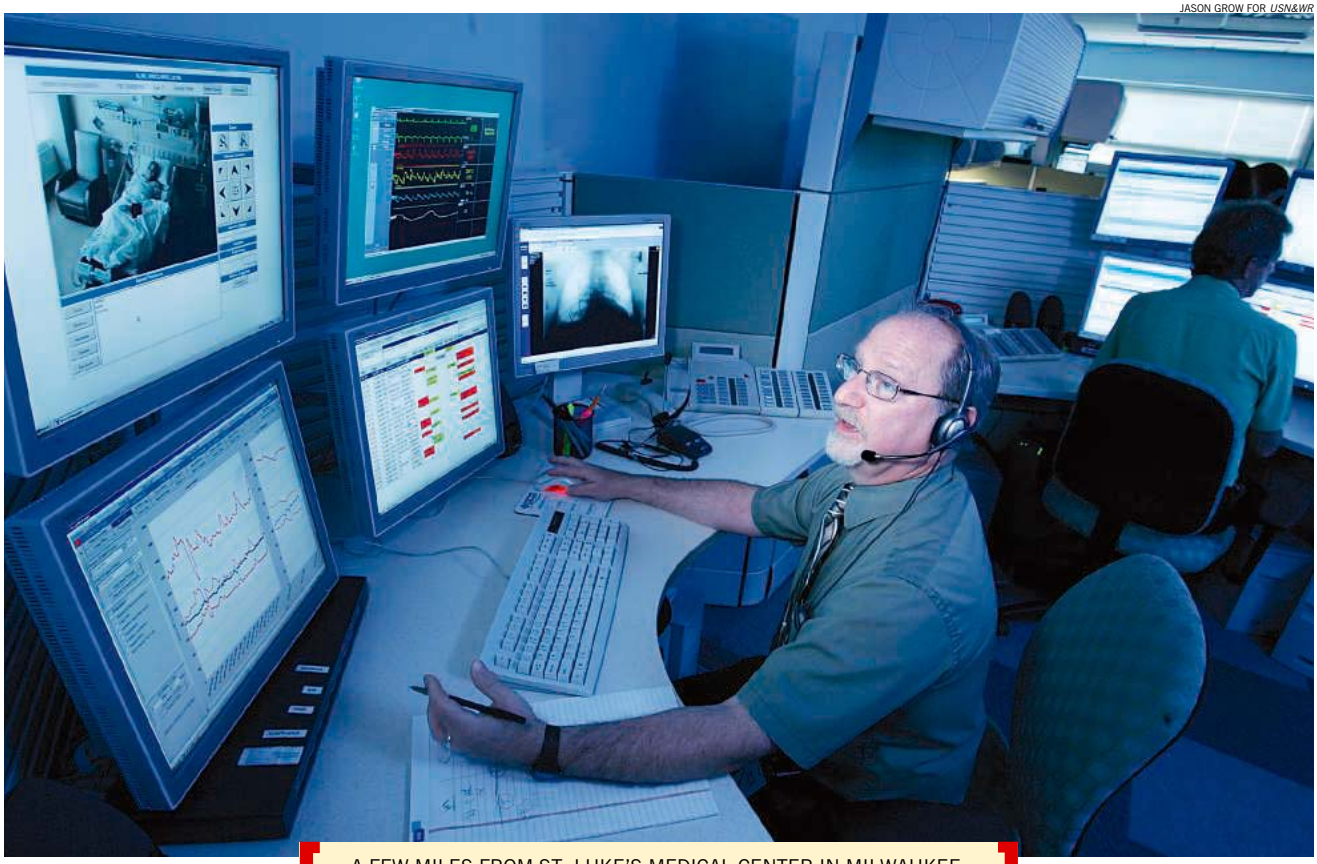

A FEW MILES FROM ST. LUKE'S MEDICAL CENTER IN MILWAUKEE, IN THE HOSPITAL'S REMOTE EICU, CRITICAL CARE DOCTOR ROBERT GOLDMANN KEEPS A CLOSE EYE ON AN INTENSIVE CARE PATIENT.

doctors and nurses keeps constant watch on more than 10 intensive care units in four different hospitals spread across eastern Wisconsin. The idea is not to make care more remote. "Actually, the goal is to bring expertise to a patient's bedside faster than we ever could before," says David Rein, the unit's medical director.

Rein is a critical care doctor. Most hospitals have them, as well as nurse specialists like Coulter, and most also have trouble getting them to look at all patients in all ICUs on all different floors. The clinicians aren't sloths. They simply can't be in two—or 10—places at once. That is, unless they're in the eICU. From their workstations, Rein, Coulter, and three other nurses control cameras that can zoom in so tightly they can see capillaries in a patient's eyes. Monitors display vital signs and a patient's electronic chart, which records medications and the time given, notes on their condition, lab test results, and X-rays. Not only can Rein and Coulter spot trouble early; they also can coach nonspecialists in the patient's room about what to do to fix it.

This is one of the more dramatic ex-

HIGH-TECH SERVICES

The 2005 Most Wired Hospitals survey revealed several differences between those institutions and the typical U.S. hospital. First, wired hospitals tended to put more technology in the hands of patients, allowing them to find out more about their health. Second, wired hospitals made sure their technology was widely used by physicians. And third, they kept tabs on more patients using electronic alerts, tied into patients' records.

PATIENT SERVICES AVAILABLE ONLINE

	TYPICAL HOSPITALS	WIRED HOSPITALS
Review test results	7%	30%
Prescription renewal	12%	32%
Appointment scheduling	15%	42%
Request doctor's advice	17%	44%

FREQUENT USE OF WIRED TOOLS BY DOCTORS

	TYPICAL* HOSPITALS	WIRED* HOSPITALS
Clinical guidelines	38%	59%
Order entry–lab	34%	52%
Order entry–radiology	32%	48%
Order entry–pharmacy	27%	41%

ALERT SYSTEM USING ELECTRONIC SURVEILLANCE

	TYPICAL HOSPITALS	WIRED HOSPITALS
For critical care units	52%	77%
For step-down units	33%	56%
For surgery/general med.	24%	34%
No surveillance system	45%	21%

*At least 61% of doctors in these hospitals used such tools.

THE GOOD AND THE WIRED

The 47 hospitals below just garnered double distinctions. First, they were listed among America's Best Hospitals, *U.S. News & World Report's* ranking of hospitals based on their expertise, their ability to save lives, their reputation among specialists, their commitment to nursing excellence, and several other factors. They also made the "100 Most Wired," a list of hospitals and health systems with the most complete information technology compiled by *Hospitals & Health Networks*, a publication of the American Hospital Association.

What does it mean to be most wired? About 1,200 hospitals were surveyed, and the 100 finalists made the most use of IT in five different areas:

SAFETY AND QUALITY. Reducing errors in prescribing medications, providing clinicians with patients' electronic health records, monitoring changes in patients' conditions and sending real-time alerts to staff, and more.
CUSTOMER SERVICE. This involves duties such as preregistering patients and helping them research health problems.
BUSINESS. Buying supplies and conducting financial transactions with insurance companies are part of this area.
WORKFORCE. Training physicians and other clinicians, and measuring staff performance, among other things.
PUBLIC HEALTH. Participating in health cooperatives, using security measures to safeguard patient confidentiality, and monitoring and improving specific clinical practices.

Advocate Lutheran General Hospital, Park Ridge, Ill.*
Aurora Sinai Medical Center, Milwaukee*
Aurora St. Luke's Medical Center, Milwaukee*
Baylor Institute for Rehabilitation, Dallas*
Baylor University Medical Center, Dallas*
Beth Israel Deaconess Medical Center, Boston*
Brigham and Women's Hospital, Boston*
Cedars-Sinai Medical Center, Los Angeles
Children's Hospital Boston
Children's Hospital of Pittsburgh*
Christ Hospital and Medical Center, Oak Lawn, Ill.*
Comm. Health Partners Regional Health System, Lorain, Ohio*
Dartmouth-Hitchcock Medical Center, Lebanon, N.H.
Duke University Medical Center, Durham, N.C.*
F. G. McGaw Hospital at Loyola University, Maywood, Ill.
Georgetown University Hospital, Washington, D.C.*
Good Samaritan Hospital, Cincinnati*
Hackensack University Medical Center, N.J.
Hospital of the University of Pennsylvania, Philadelphia*
Inova Fairfax Hospital, Falls Church, Va.*
Jewish Hospital, Louisville, Ky.
LDS Hospital, Salt Lake City*
Lehigh Valley Hospital, Allentown, Pa.*
Magee-Womens Hospital of UPMC, Pittsburgh*
Massachusetts General Hospital, Boston*
McLean Hospital, Belmont, Mass.*
Memorial Hermann Hospital, Houston*
Memorial Sloan-Kettering Cancer Center, New York
Methodist Hospital, Houston*
New England Baptist Hospital, Boston*
Northwestern Memorial Hospital, Chicago
Ohio State University Hospital, Columbus*
Ohio State University James Cancer Hospital, Columbus*
Poudre Valley Hospital, Fort Collins, Colo.*
Rush-Copley Medical Center, Aurora, Ill.
Rush University Medical Center, Chicago
Sentara Norfolk General Hospital, Norfolk, Va.*
Spaulding Rehabilitation Hospital, Boston*
St. Elizabeth Hospital Medical Center, Youngstown, Ohio*
Texas Heart Inst. at St. Luke's Episcopal Hospital, Houston*
University Hospital, Albuquerque, N.M.*
University of Alabama Hospital at Birmingham*
University of Pittsburgh Medical Center*
University of Wisconsin Hospital and Clinics, Madison*
Vanderbilt University Medical Center, Nashville*
Washington Hospital Center, Washington, D.C.*
Yale-New Haven Hospital, New Haven, Conn.*

*In a healthcare system named on the "100 Most Wired" list

amples of the "wiring" of America's hospitals, as health systems try to harness information technology to improve the quality and safety of care. A few weeks ago came the first strong evidence that all this gee-whiz high tech can make a difference. A large survey of hospitals identified the "100 Most Wired," and, when compared with other institutions, their patient mortality rate was 7.2 percent lower, on average. That held true no matter the hospital size or whether it was an academic medical center.

That has a lot of healthcare researchers excited. While the survey—conducted by *Hospitals & Health Networks*, a publication of the American Hospital Association—doesn't prove that technology actually *causes* better patient outcomes, it does show there is a strong connection, says Carolyn Clancy, director of the federal Agency for Healthcare Research and Quality. "Many hospitals are struggling with technology right now, and this survey offers a beacon of hope."

That struggle was highlighted a few months ago in a *Journal of the American Medical Association* study of "computerized physician order entry." Computer systems had been widely hailed as the big fix for medication-ordering errors (sloppy physician handwriting, obscure abbreviations, etc.) that can kill patients. But the study showed that such systems could actually introduce new errors, such as double dosing, that can be just as bad. "If a system's screens are badly designed, if they don't ensure clear communication between nurses and doctors and pharmacists, they are going to create mistakes," says physician Graham Hughes, vice president for product strat-

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Software building the future of healthcare >>

MISYS

egy at IDX, a developer of computer systems for healthcare.

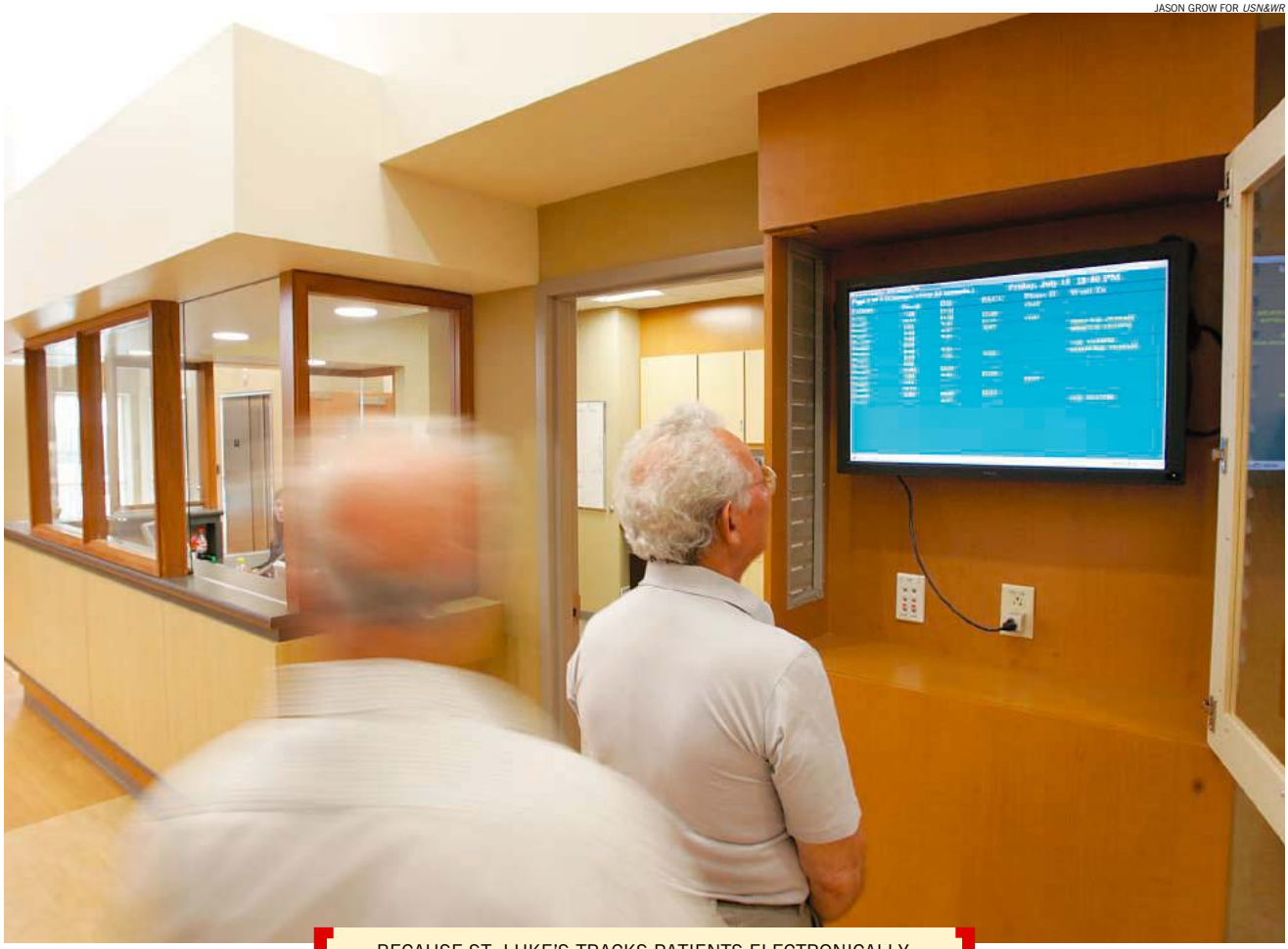
Poudre Valley Hospital in Fort Collins, Colo., one of the 100 Most Wired, learned this firsthand when it introduced electronic patient records into its emergency department. "The screens didn't fit how the doctors and nurses worked. They wanted to note vital signs about a trauma patient's condition, but the first screens were asking about next of kin and insurance information," says Craig Luzinski, the chief nursing officer. "There's a standard protocol for stabilizing a patient: Check the airway, then breathing, then circulation. But the circulation screen popped up first. So people just didn't use the system." That's not good if the goal is to input treatment info that will follow the patient through the hospital so other caregivers can use it to make better decisions later on. "It took us a few days to get it to the point where the docs were happy. And now they all use it."

Use of electronic health records by most staff, in most situations, is one factor that distinguishes the 100 Most Wired and may play into better outcomes. "It's not the technology but the culture of using it and getting everyone to buy into that," says physician Scott Thompson, vice president for medical operations at Aurora St. Luke's, another hospital on the Wired list. If a nurse administers an antibiotic, the timing has to be noted in the computer so Rein, over in the eICU, can call up the chart and see whether the patient's heart rate has changed because the patient is still fighting an infection and the drug isn't helping. So the St. Luke's system prompts staff to enter the time a drug was given, and places computers so staff have easy access.

Poudre Valley made sure nurses and doctors are part of the technology committee, so they can quickly spot and fix glitches like the ones that cropped up in the emergency department. And Luzinski's hallways are lined with wireless COWs, or computers-on-wheels, so staff can update records while tending to a patient, as well as get reminders of "best practices" for treatment.

A hospital does not have to be wired to make this effort, of course. Metropolitan Hospital in Grand Rapids, Mich., is not on the list of 100, yet it is one of the nation's leaders in medication safety. "We've done a lot of things with staff education," says Pete Haverkamp, the director of pharmacy services. "But we also cut out distractions for pharmacists. We put colored tape on the floor around the area where they check orders. It signals everyone else to leave them alone." The percentage of patients with problems due to improper narcotic or sedative orders dropped, within a year, to zero. And the place is so unwired that the tape wasn't even electrical. ●

JASON GROW FOR *USN&WR*

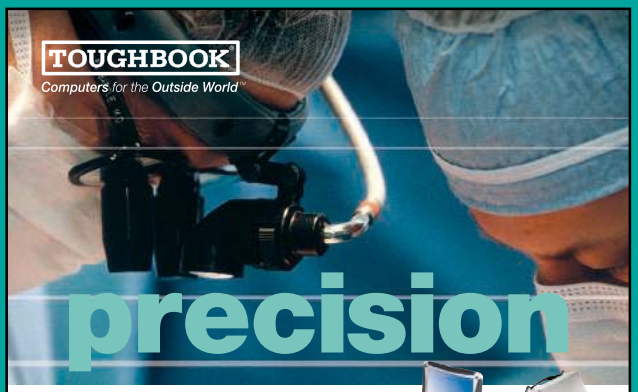


BECAUSE ST. LUKE'S TRACKS PATIENTS ELECTRONICALLY, CHARLES GIORDANO (CENTER) CAN FOLLOW HIS BROTHER'S PROGRESS FROM SURGERY TO RECOVERY ON A WALL MONITOR.

More information on the Most Wired Hospitals appears at usnews.com/wired.

Tele-Health Resources

More and more innovations and new developments are changing the face of medicine in America. Many of them are taking place outside the hospital. At clinics, HMOs, walk-in centers and even right at home, we are learning how to access and take advantage of these new technologies. Some of them are showcased on this page.



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HOUSE CALLS

Remote monitors can be lifesavers for chronic disease patients

LINDA AND GEORGE GRANDE HAVE SENT VITAL SIGNS TO NURSES WITH A CELLPHONE AND A MONITOR LINKED TO A SCALE AND A BLOOD PRESSURE CUFF.

JASON GROW FOR *USN&WR*

By Josh Fischman

An extra pound doesn't seem like much. But for George Grande, that little quiver on the bathroom scale could signal that his heart is drowning. Grande, 82, has heart failure, and what used to be a strong, muscular pump now lets blood and fluid pool in his lungs, adding an extra pound or two. More fluid and he'll end up unable to breathe, fighting for his life.

That's the last thing he wants. "I've been to the hospital so many times," says Grande, who lives in the small town of Boxford, Mass., about 20 miles from Boston. His voice sounds tired as he recites the litany: "Three open-heart surgeries, an aorta problem, a leaky heart valve." To keep him safe at home, any weight change needs to be spotted quickly.

It is. About three months ago, Grande's nurse gave him a little device called a monitoring station, which let him input his vital signs. "Every morning it reminds me to check myself," says Grande. "I plug in a blood pressure cuff and a scale, and it sends that stuff over the phone, right to my nurse. A few weeks ago, it picked up a weight gain, and they called me right away and told me to adjust the dose of my medication. That's very reassuring, to know someone is always watching out for me."

Daily care. More healthcare professionals are watching out for patients with chronic conditions like Grande using this kind of remote monitoring. Heathcare agencies spent about $55 million in 2003 on telehealth and expect to spend $260 million in 2010. The key is the daily check of vital signs, a drill that can catch problems much faster than a monthly clinic visit. The technology is easy to use for senior citizens and for kids and adaptable to a wide range of illnesses. Study after study has shown that it helps keep people healthy and out of the hospital and allows scarce medical resources to be stretched over a wider

area for a longer period. "It's been great for our patients and great for our agency," says Rhonda Chetney, director of clinical operations for Sentara Home Care Services in Chesapeake, Va. "These are very brittle patients who go in and out of the hospital a lot. With these units in the home, that stops."

Partners HealthCare, Grande's health plan, has placed American TeleCare Monitoring Stations in hundreds of homes and cut hospital readmissions for its heart failure patients by 33 percent. In Brooklyn, N.Y., Coney Island Hospital gave similar devices to 69 asthmatic kids who had been hospitalized at least once a month during the previous winter, and during the next winter all but one avoided the hospital completely. Across the country, the Department of Veterans Affairs has been testing these appliances in the homes of patients with diabetes and lung diseases as well as heart failure; it has found a 35 percent reduction in readmissions and a 60 percent drop in emergency visits. "Plus we get 90 percent patient satisfaction ratings," says physician Adam Darkins, the VA's chief consultant for care coordination. "That's why we'll have these devices in 12,500 homes by the end of this year."

The monitors are hooked up to patients' telephone lines. Using buttons or a touch-screen, the devices engage people in a dialogue about their condition by asking how they feel and if they took their medications. "It will ask a question like 'Are you short of breath?' " says Lisa Canterbury, a nurse and director of a branch of Deaconess Home Care in the small town of Magee, Miss. Her agency uses a four-button device called a Health Buddy. "Then it will follow up with 'Is this *unusual* shortness of breath?' because a lot of our patients are short of breath anyway."

Better behavior. Some of the monitors also have plug-in gizmos that measure pulse, blood pressure, and weight automatically. The patients' answers and the medical data are zapped to the home care agency, where clinicians can immediately review them. Anything that seems out of whack triggers an alert and a phone call. "It keeps me on my toes," says Charles Thomas, 82, a pulmonary disease patient in Downingtown, Pa. "The other day I missed a question, and my nurse was on the phone, asking why."

The daily back-and-forth helps change patient behavior, and that is crucial. Nothing is as effective as a motivated patient. A nurse or doctor can remind a patient to do something during a weekly or monthly visit, but patients often forget the advice in a few days. "Once you put these units in the home, patients actually start taking better care of themselves," says Chetney. "They get on a scale and see 2 extra pounds and can relate that to yesterday's hot dogs at the Fourth of July picnic and go, 'Whoa!' "

Chetney, whose service uses a touch-screen device called the Vitel Net's Turtle, likes the ability to customize the virtual chat. If she has a question she wants to ask a specific person—say, whether the patient's spouse is around or away—she can easily do that herself.

On the clinical side, telehealth lets agencies spread expertise further than ever before. At Partners, for instance, the agency has several patients with open wounds, from operations or recurring diabetic ulcers. But the agency has only four wound-care nurse specialists. It could take several weeks for the four nurses to visit all the patients, during which time the wound could get infected. Yet a staff nurse can get there in a few days, take photos of the wound with a digital camera, and send them to a wound specialist, who can provide specific instructions on care. "A telehealth visit costs me one third of what it costs to send a nurse out," says Chetney. "When insurance, like Medicare, only gives you a lump sum for home care, you can rip through that really fast with daily visits." Deaconess, in Mississippi, charges patients $9 per day for telehealth monitoring, while a nurse visit costs at least $100 per day.

The VA's Darkins cautions that the technology, though alluring, is not appropriate for every illness. Alzheimer's patients, for instance, may not have the cognitive ability to use the monitors. Yet for people with mild cognitive impairment or stroke, the devices might work quite well, reminding them to take their medications.

Another concern is that the monitors won't be effective without trained nurses and doctors behind them. Agencies can't simply buy the technology and expect miracles, Darkins says. Telehealth works because it provides continuous care, and if the staff doesn't know how to use the machines correctly, there will be gaps in care. But when the monitors are employed with training and commitment, that is exactly what telehealth will prevent: having patients fall through the gaps. ●

EACH DAY, NURSES AT NEIGHBORHOOD HEALTH AGENCIES IN WEST CHESTER, PA., CAN VIEW MEDICAL DATA SENT IN BY PATIENTS FROM HOMES MANY MILES AWAY, SPOTTING TROUBLE BEFORE IT GETS BAD ENOUGH TO SEND PEOPLE TO THE HOSPITAL.

DAVID GRAHAM FOR *USN&WR*

SAFETY NET

Creating a national patient record system is a daunting but worthy goal

By Christopher J. Gearon

Jason Schaffer is an emergency room doctor in Indianapolis. That alone makes him better equipped to do his job than many of his colleagues nationwide. Thanks to an online registry containing the healthcare records of 1.5 million central Indiana patients, Schaffer can instantaneously review a patient's medical background. When an individual is brought to Clarian Methodist Hospital's emergency room, Schaffer can learn all about his patient's recent hospitalizations and ER visits, medications, allergies, recent lab results, and previous diagnoses. All of it is instantly culled from a Google-type search of a patient's medical records from 21 area hospitals, 800 local doctors, and area pharmacies, imaging centers, laboratories, and public-health departments.

ER doctors typically don't know much about their patients. But the background Schaffer has at his fingertips may stop him from prescribing medicine that can harm or kill patients in certain situations, such as antibiotics infused into an unconscious patient on a blood thinner that would cause the anticoagulant to "get out of control," notes Schaffer, or nitroglycerin given to a man suffering chest pain who fails to mention he takes Viagra. Such a combination could cause severe or life-threatening low blood pressure. "Having that bit of information saves time, saves money, and potentially saves life," says Schaffer.

People can retrieve cash from an ATM anywhere in the world or find information on just about any topic online. But only a relatively few doctors and hospitals in the nation have electronic access to patient records. Schaffer and some 22,000 doctors, nurses, and healthcare providers using the Indiana Health Information Exchange are at the forefront of an effort to streamline the nation's chaotic healthcare delivery system. Electronically connecting the system, experts say, makes patient care safer, better, and cheaper.

Medical Internet. Today's fragmented system is rooted in paper and pen, with patient information exchanged by phone, fax, mail, and courier—or not at all. It's a big reason why tests and procedures are repeated or done unnecessarily, why patients get the right treatment for their condition only about half

ILLUSTRATIONS BY SARA HAYWARD FOR *USN&WR*

High-Tech Healthcare: How will it affect consumers?

A Roundtable Discussion

Hosted by **U.S.News & World Report**

Sponsored by **Siemens Medical Solutions**

U.S. News executive editor Brian Kelly moderated the panel.

Participants were:

Gary Brazel, MD, CMO, St. John's Health System

Reid Coleman, MD, CMIO, Lifespan

Glenn Crotty, MD, COO, by phone, Charleston Area Medical Center

Phyllis Grant, RN, Baptist Health System

Dave Pecoraro, CIO, Jewish Hospital Healthcare Services

Vincent Pryor, CFO, Ingalls Health System

Linda Reino, CIO, Universal Health Services

Mike Sauk, CIO, City of Hope National Medical Center

Marie Segars, RN, MSN, McLeod Regional Medical Center

John Wiest, CFO, Lee Memorial Health System

On May 4, 2005, *U.S. News* and Siemens convened a panel of health center administrators to take a look at medical technology and discuss its impact on the delivery of medicine – and especially its impact on consumers. Will an emphasis on technology distance doctors from patient care? Will tech in medicine further widen the healthcare gap between rich and poor patients? Or will it level the playing field? Can the healthcare system afford the costs of tech upgrades? Can we afford not to implement them?

Brian Kelly led off the discussion by noting that professionals and consumers alike are often overwhelmed by change in the healthcare field or by processes and devices that don't seem to work the way they expect.

Brian Kelly: *What does the future in your business look like to a patient five years from now?*

Linda Reino: In five to ten years the patient will have more electronic exchanges prior to coming in. The patient will do pre-registration and communicate some clinical demographics. I think that the patient will use the Internet. We'll have more and more of the record online. But I still think they'll be carrying around a paper record. Their experiences may be confusing because they will vary based upon the practitioner: there will be some who will use their PDA and access the wireless Internet on their laptops, and then there will be somebody who comes in with a regular patient chart.

BK: *Reid, do you agree with Linda's assessment?*

Reid Coleman: I think it's very realistic. If I can back up one second, what our patients will experience five to ten years from now will not be driven by technology. The future of medicine is chronic disease. Right now 50 percent of American health dollars are spent on chronic disease; five to ten years from now that will be creeping towards 70 percent. And that shift will mean that we'll have more of an understanding of A) what people are prone to and B) that managing chronic disease is what we need to be doing. As that happens, we'll realize that healthcare is not given in episodes, but across the continuum. That's where we need the tools of IT.

BK: *But an important issue that has to be raised is in the cost. Is it a tradeoff? Does*

> "Today medicine is consumer driven. Customers are defining how they want their healthcare and those customers are our patients." – *Dave Pecoraro*

moving more into the purer technology field like CAT-Scans and PET Scans, mean moving money away from IT?

John Wiest: There's a finite pot of money that is going to be available for capital expenses. So we have to focus on items that have a return on investment (ROI). However the total pot has to generate positive returns overall so you have to mix and match based on that each year. And it's tough.

BK: *When you talk about ROI, one of the issues that's raised in IT today is errors. There may not be a dollars and cents return, but really there is a safety question.*

Marie Segars: If you're not "for safety" then you're not able to deliver quality. If we're going to be efficient then we have to be safe, if we're going to be effective we have to be safe. But organizations like *U.S. News* are educating the consumer to be much more sophisticated in their selections of organizations and I think we'll see a weeding out of the weaker hospitals and healthcare organizations over the next five to ten years.

BK: *Do you think that the technologically superior hospitals will force out the ones that don't make the investment?*

M. Segars: I think patients will select hospitals knowing what their strengths and weaknesses are and they will select hospitals based on the outcome of patient care.

Left: *U.S. News* executive editor Brian Kelly leads the discussion
Below: Mike Sauk and Vince Pryor

> "I think the use of technology by those who care for patients without a doubt makes the environment safer."
>
> – *Marie Segars*

Gary Brazel: Back to the question of assessing the dollar value of errors. It takes a leap of faith to deal with some of these "intangible" dollars. They're there but they're awfully hard to quantify. It's pretty easy to quantify an investment in imaging; it's much more difficult to determine, after you make an IT investment, how much you saved by avoiding errors.

BK: *A couple of years ago (former HHS secretary) Tommy Thompson said that our grocery stores are more technologically advanced than our hospitals. Is that still true?*

Dave Pecoraro: I don't think it's about extremely frustrating for the patient because we look so inept.

M. Segars: We're inept because we're not IT people. We're patient care people and our focus is on the patient. So technology from our IT department overwhelms the physicians and nurses who are trying to take care of patients faster than they were trying to take care of them before. Plus, we're caring for more patients than ever before with more external regulations than anybody can follow.

BK: *That brings us to the question of patient information: are you trying to collect patient data into some type of centralized database? What has been your experience with that?*

GB: I think there is public concern about how easily accessible their online information will be.

LR: I agree with that, but that's not stopping us.

GB: We have a five-year patient repository of patient information and reports.

M. Segars: That's what we have done. We've identified things that we think will be significant over time and we're building a lifetime clinical record. We've been doing that now about three-and-a-half to four years.

GB: We're all moving towards our own repository. I think the privacy issue might start rearing its head when we look at a national repository.

DP: There is a tradeoff between "I want my doctor to be able to see my information" vs. "will some hacker be able to get in and access my information?"

M. Sauk: When I'm healthy, I don't want it out there, but when I'm sick I want it available.

LR: So we're not only supposed to handle the technology so much. Today medicine is consumer driven. This is a big culture shift for us. Customers are defining how they want their healthcare and those customers are our patients. We're going to see consumers saying, "This is how I want to be cared for." It's obvious you can bring new technology into old steps and bad processes. I think we need to reinvent ourselves.

BK: *So there aren't limitations on the technology itself. The state of the art technology allowing you to do what you need to do is available. It's using it in a different way.*

LR: I don't think it's available at the level of accuracy that we need.

BK: *What are some of the things you want? What can the techno-wizards create that would make your jobs better?*

Phyllis Grant: From a clinician's perspective, it's so hard to get a complete picture of information on the person who's in your hospital or office because these systems don't talk to each other. And it's frustrating for the clinicians, but it's

security for the information but we have to manage it for the situation.

M. Sauk: We have information-rich credit card companies that can't protect our information, what makes us think our healthcare organization can?

BK: *So where would patients want it to reside?*

GB: Maybe if there's just a basic card where you have the things you need for the physician to take care of you for the next 24 to 48 hours.

RC: I'd love to have that card, but instead of having the information on it, it would be the key to the repository.

DP: I'm planning on creating a card for my 35 locations and having it be a key. And I'm going to give you a loyalty card that says your information is on this card, and if you go to any one of my facilities they can pop the card in and get information from you right then and there.

M. Sauk: But what about other facilities?

DP: Well, I'm taking care of my facilities right now because there is no national repository. Someone's got to start it.

BK: *What if you had $10 million or $20 million for improving medical information technology – what would you do with it?*

RC: I wouldn't buy another program, but I would flesh out my analytical department, get those people out to patient care areas, figure out the work flow of everyone who touches a patient and then figure out how to get a great new system to use for patient care.

> "I'd put information collection machines in people's homes. I guess you'd call that 'Telemedicine.'" – *Phyllis Grant*

DP: Right now, Siemens is the only company that has workflow embedded within its environment. Most other companies are delivering software that does the same old thing – no updates or changes.

GB: If we could develop something that was tied into our community so that all of our medical staff members who have access to the hospitals were able to capture that information and then share it, that would be a wonderful place to start and would affect 90-95 percent of patient care. Integrating our physician network is where I would want to start.

PG: I'd put information collecting devices out in patient homes, where I can monitor and collect patient information while patients are home and I'm in my office. I guess you'd call that "Telemedicine."

Top (l-r): Marie Segars, John Wiest, Phyllis Grant; Center: Gary Brazel, Linda Reino; Bottom: Reid Coleman, Dave Pecoraro

> "Technology can help replicate repetitive tasks and give caretakers more time at the bedside." – *John Wiest*

LR: I would stay the course. I would continue the road we're going down now – identifying workflow and I would continue to do it bit-by-bit. There is not a holistic solution.

PG: Physician order entry is very important and even as imperfect as it is, it still has demonstrated some benefits, particularly in medical error reduction. Because it takes away having to interpret what the physician wrote. That has been a huge benefit.

M. Sauk: I think the last thing people do is pick a hospital based on the state of its IT systems. First of all, if the IT is good, the patient wouldn't even know about it.

DP: We're installing an electronic IC. During the day, attendants are all over the place and then from 6p.m. to 6a.m. doc-

tors aren't there. And what a clever idea – to have a doctor available and attending whenever a patient crashes. I'm hoping our reputation will be sanctioned by the fact that a patient who needs assistance at 11p.m. has a doctor or nurse attending to them electronically and can save their life.

BK: *How would that work?*

DP: Doctors would sit in a war room and there's a wall with computer monitors with all the medical data on the terminal in front of you. You can see if a patient's bio is changing. Or a nurse can contact the doctor and he can see all the data on a video. And the doctor can issue an order directly to the nurse. And by having the doctor more readily available to you it may cut your stay from seven days to four days, and will increase quality of care.

BK: *It's things like that that consumers think of when they think of the next generation of hospital IT. Is that the direction it's going?*

VP: I've talked to a number of physicians about it and they're not comfortable with hands-off medicine. Their question is, will the patient feel that that's less care rather than more care, will they feel that everything's remote now and there's less interaction?

M. Sauk: It's probably better for the family of the patient, knowing that there's someone there monitoring.

DP: I'll tell you who would be comfortable with it, the nurse on the scene who can turn to another nurse or physician and say, "help."

BK: *Is the government a help or a hindrance?*

PG: It depends on which government agency is making the drive.

M. Sauk: Well, regarding government involvement, one thing I find interesting, now that we're 25 years in (from the creation of JCAHO*) is the focus on patient safety. Everyone was concerned about patient safety and talked about it. But until there were reviews and regulations related to that, you just didn't hear the words as often as you do today. It took a self-imposed regulatory agency to create focus on patient safety.

BK: *What's the cost of actually doing that? Individually, for each hospital?*

RC: I don't think anyone knows.

BK: *Why don't you think you know?*

M. Segars: It's hard to know how much it's going to cost because we haven't seen it yet. We're all working on some parts and we're putting some data in but we haven't seen this thing yet to cost it out.

BK: *Is the average consumer uncomfortable with their medical information residing somewhere other than in their doctor's office?*

DP: I'm very passionate about this particular problem, because if I were a patient, and showed up at a particular emergency room and they didn't know anything about me, I would love to whip out my wallet and pull out a card that had my immunizations, my medical procedures, and my medications and hand it to the doctor and say, "here." And I would say that if the American public can carry a credit card, they can carry their medical information on a medical card that has something like a 4GB chip with the information.

> "The goal is to have technology help doctors so that they have more time to shake a hand, or to inquire about a child's health."
>
> –Linda Reino

M. Segars: Evidence-based medicine is going to be what the consumer expects of us. If somebody comes into the hospital with a heart attack, they're going to expect to survive. They expect not to return in 30 days with complications. They expect not to be in the hospital for any length of time. They should be able to get the best medication available for their condition and get it in the timeframe they need.

M.Sauk: I just wonder how different this discussion would be if everyone sitting around this table had a terminal disease and were asked if we should cut back on the cost of technology. If it were your life at stake, then money would be no object. That's what consumers feel when they're faced with those kinds of situations. But the bottom line is that even if you have good technology, if the patient or family walks away with a bad human experience, it doesn't matter what the outcome was. If you go into any cancer facility and have a dialogue with the patient or family, the first thing out of their mouth isn't the great technology; it's the human care they received from the nurses and the doctors. People want the technology but they also want the human care.

BK: *But what's the tradeoff? The point of a lot of this technology is to make doctors more productive, and more productive usually means less time doing this specific task.*

LR: There is no tradeoff. The goal is to have technology help them streamline their work, not put technology between them and the patient. It's having the technology assist them so that they have more time to shake a hand, have more time to inquire about a child's health.

DP: Technology is an enabling tool, like carrying a cell phone or a pen. A lot of people want to go buy computer systems to fix all of these problems. But there are no significant computer systems that can solve everything.

BK: *Has technology made for better doctors?*

JW: It's given physicians remote access to information on a patient, which is very beneficial for continuity of care. And it can help replicate repetitive tasks and give caregivers more time at the bedside. And it does enhance the experience for the patient as well.

PG: But there's nothing that supplants the clinical judgment by the physician and that gives the final decision about how to treat the patient.

M. Segars: I think the use of technology by those who care for patients without a doubt makes the environment safer. We're humans, we have lapses in memory, we make mistakes, we're not up-to-date on the latest things, we forget things. A hospital that uses technology is safer than a hospital that doesn't.

BK: *As we've learned today, this is a very complex and a very important topic. Fortunately, as we've also learned, very capable people are working on the answers. Thank you to our panelists for taking the time to share their insights and helping us move the process forward.*

***Joint Commission on Accreditation of Healthcare Organizations, est.1975**

the time, and why nearly 100,000 U.S. hospital patients die by mistake every year. "Information technology seems to be the most promising solution," says J. Marc Overhage, a physician and CEO of the exchange.

The federal government wants what's happening in Indiana to be the rule rather than the exception. Last year, President Bush called on the healthcare industry to create a national electronic patient health record system by 2014, a sort of medical Internet that would ultimately allow a doctor in Cody, Wyo., for example, to pull a patient's record instantly from a hospital in Miami.

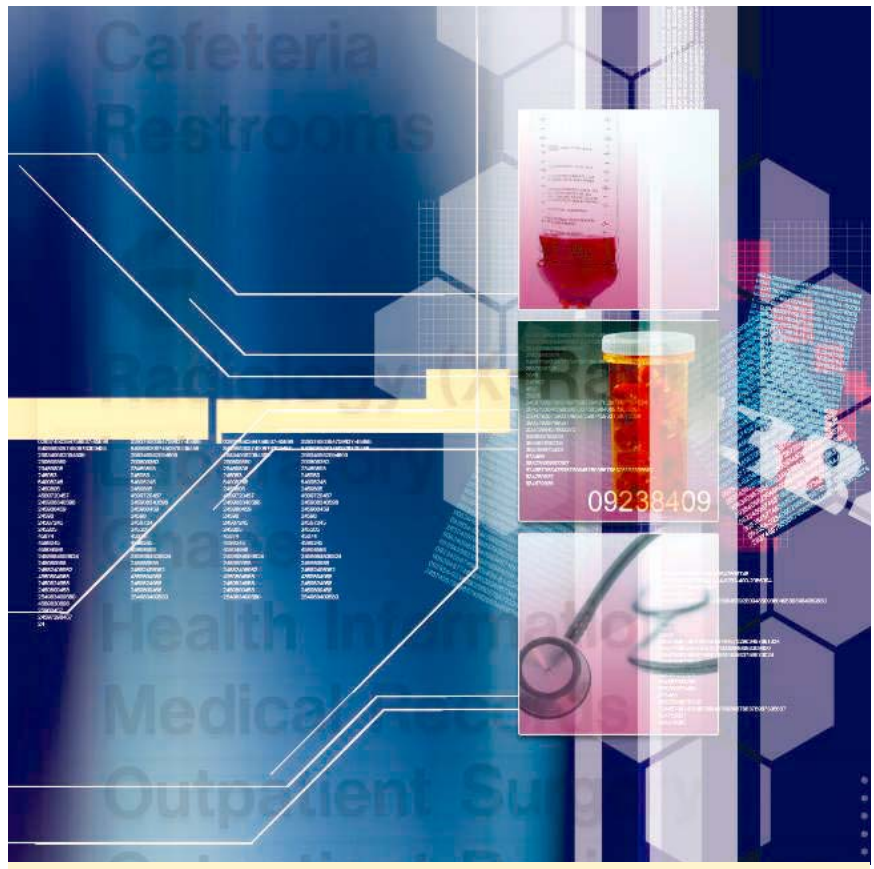
A medical Internet could also supply clinicians with treatment guidelines for cancer, asthma, and scads of other conditions. Such a tool also would help public-health officials detect disease outbreaks sooner rather than later. Moreover, says David Brailer, Bush's national coordinator for health information technology, "we're getting to the world of personalized healthcare." For several years, Anne Perlman of Menlo Park, Calif., has been scheduling doctor visits and viewing test results online through the Palo Alto Medical Foundation. "Looking at my record before I go to the annual physical helps me remember what I want to talk over with the doctor and lets me spend the time in the visit much more productively," says Perlman.

Industry initiatives. Converting the current system to one in which patient data flow securely and seamlessly on demand is a "daunting task," says Micky Tripathi, CEO of the nonprofit Massachusetts eHealth Collaborative (and a founder of the Indiana exchange). While the feds are pushing hard on this goal, it largely falls to industry to make it happen. Janet Marchibroda, CEO of the eHealth Initiative, a nonprofit group bent on improving healthcare quality through technology, says more than 100 local, regional, and statewide initiatives are underway, triple the number of a year ago. Nascent efforts include plans to tie the computers of some 600 physicians' offices in Massachusetts to computers of local hospitals, nursing homes, home health agencies, and other providers in the commonwealth, as well as a test to link a handful of California emergency rooms. Tennessee has a similar initiative. Meanwhile, IBM plans to electronically string test sites in California, Minnesota, and Israel to iron out kinks in delivering patient data over long distances.

But there's one big sticking point: how to connect the resulting patchwork of records into a national database. It's not uncommon for one hospital to have different computer systems that can't communicate. But "the technological issue pales in comparison to the cultural issues," says Rick Wade, a spokesperson for the American Hospital Association. Healthcare organizations are highly competitive. "Every player is essentially an adversary in the market," says Tripathi. And the payment system rewards providers for testing and treating sick people, not for keeping people well. Providers have been slow to develop such costly information technology solutions. "Money is always an underlying issue," Wade notes of the cost to wire hospitals, which typically operate on very thin margins.

The Bush administration is working with industry to figure out ways to connect the potpourri of mini-networks, such as funding promising projects and helping set industry standards. Last week, the feds told doctors it would give them free software to computerize their medical practices to prompt physician involvement.

Back in Indiana, Overhage is beefing up the repository. "Completeness is something people would love to see," he says. It's targeting smaller players like local pharmacies and tailoring the data. A surgeon and a pediatrician, for example, would zero in on different aspects of patient records. Thanks in part to a $5 million federal grant, more of Indiana is plugging in and the exchange is supplying best practices and treatment information. Up next is a statewide public-health surveillance network; hospitals would share emergency department records. "The data is in these little islands or archipelagoes, and each one is different and distinct," says Overhage. Little by little, Indiana is wiring the state. The question remains whether the feat can be pulled off nationwide. ●



RELATIVELY FEW DOCTORS AND HOSPITALS IN THE NATION HAVE ELECTRONIC ACCESS TO PATIENT RECORDS.

By John Leo

Fun With Numbers

ISN'T IT AWFUL, A FRIEND SAID AT DINNER the other night, that 100,000 Iraqi civilians have died since the U.S. invasion? When I asked where the statistic came from, he said maybe it was 8,000, but definitely somewhere between 8,000 and 100,000. That's a pretty broad spread, so I decided to do some checking. The 100,000 estimate is from a survey of Iraqi households conducted last year by a team of scholars from Johns Hopkins University and published in a British medical journal, the *Lancet*. As luck would have it, the team was antiwar, and the study was released just before the presidential election. The study's coauthor called the 100,000 figure "a conservative estimate," the customary phrase attached to politically useful wild guesses. The study said, "We estimate there were 98,000 extra deaths (95% CI 8,000–194,000) during the postwar period." Writing on *Slate,* Fred Kaplan translated that little technical phrase between the parentheses: It means that the authors are 95 percent certain that war-caused deaths totaled somewhere between 8,000 and 194,000. Kaplan's conclusions: "The math is too vague to be useful."

Iraq Body Count and the Oxford Research Group, Britain-based antiwar organizations, released an analysis of Iraqi civilian fatalities last week, based on their collection of media reports *(www.iraqbodycount.org)*. It said 24,865 civilians had died in the first two years after the invasion, with U.S.-led forces accounting for 37 percent of the total, criminal violence 36 percent, and "antioccupation forces/insurgents" 9 percent. The *Times* of London dismissed the study as "an entirely arbitrary figure published by political agitators." But Michael O'Hanlon, who tracks statistics on Iraq at the Brookings Institution, says the study "is probably not far off, and it's certainly a more serious work than the *Lancet* report."

The modern numbers game of war dead began with the Gulf War. Greenpeace said 15,000 Iraqi civilians died. The American Friends Service Committee/Red Crescent claimed that 300,000 civilians died. Various media assessments hovered around 1,200. Later, *Foreign Policy* magazine put the civilian dead at 1,000. Unsurprisingly, the high estimates come from antiwar groups, often described in the media as neutral and nonpartisan. A *New York Times* article during the Afghan war ("Flaws in U.S. Air War Left Hundred of Civilians Dead") relied heavily on Global Exchange, a hard-left, pro-Fidel Castro group blandly identified by the *Times* as "an American organization that has sent survey teams into Afghan villages."

Doing the math. Today, yet another round of inflated estimates is breaking out, this one on the number of homeless veterans. A United Press International story a few months back reported that nearly 300,000 veterans are homeless on any given night. If so, as blogger Megan McArdle pointed out a few weeks ago on *Asymmetrical Information,* that would mean that every single homeless person in America must have served in the armed forces, since 300,000 is about the total number of the homeless. The 2000 census, covering people living in shelters but not those living on the street, counted only 170,706 homeless people. The Department of Housing and Urban Development asked cities and counties getting federal aid for the homeless to provide statistically valid counts. New York City reported 40,000 homeless, Los Angeles County 90,000,and Chicago 9,600.

The problem here is a familiar one. "Advocates for the homeless," as they are called in the usual press catchphrase, cannot resist passing on wildly inflated numbers. The pioneer here was the late Mitch Snyder, a prominent advocate, who admitted making up the "fact" that there were 3 million homeless people in America to give the cause more leverage. The media accepted that estimate for years, though it was surely far higher than the actual number. Now the numbers foisted on the media have soared again. The Department of Veterans Affairs says that some 250,000 vets are living on the street on any given night. Since the department says that number accounts for something like a third of all homeless, this means they are working with a total estimate of more than 750,000 homeless. This makes the department a piker compared with the Urban Institute and the National Survey of Homeless Assistance Providers, which say, in a joint study, that between 2.3 million and 3.5 million people (and 529,000 to 840,000 veterans) are homeless at some time during the year. The lesson? Don't trust advocacy numbers. ●

Why you just can't trust the "statistics" proffered by advocacy groups

JOHANNES KROEMER—PHOTONICA / GETTY IMAGES

The Spin on Ballroom

LISETTE LE BON—SUPERSTOCK

It takes hard work to make dancing look this pretty.

By Michelle Andrews

Since June, Kim Rinderknecht and Justin Plessel have been counting out beats and box-stepping their way around the dance floor of a small ballroom studio in Minneapolis, trying to get a leg up on their upcoming wedding reception duties. One night they happened to catch a fox trot performed on *Dancing With the Stars,* the ABC battle-of-the-ballroom hit that paired sort-of celebrities with professional dancers in a six-week dance-off. "Watching them I just thought, 'Wow, that's not the fox trot *we* learned,' " says Rinderknecht.

Stars and Fox's new reality show, *So You Think You Can Dance,* are inspiring plenty of would-be hoofers. In the first six months of 2005, business at the 150 U.S.-based Arthur Murray dance studios has grown nearly 30 percent compared with the same period last year, says Executive Vice President John Kimmins. But in six weeks or even six months, can a rhythmically challenged Fred Flintstone really turn into an elegant Fred Astaire? Real-world students and instructors say getting that glamour isn't always as easy as 1-2-3.

The "stars" were training one-on-one with professional partners for 35 hours a week or more. "We were busting our butts, really cramming, and sweating like pigs to make it happen," says U.S. Open Dance champion Charlotte Jorgensen, who was partnered with runner-up John O'Hurley of *Seinfeld.* Most ball-

TIPS TO DIP TO

For pockets: Many studios offer a free introductory lesson to beginners.

For pants: Ballroom can be harder for men, who have to learn to lead. The waltz and fox trot are good for starters.

For paunch: Dancing the quickstep for 1½ minutes uses the same amount of energy as an 800-meter race.

room dance students don't have the time or money for that kind of commitment (group lessons typically cost about $10 an hour per person, private lessons significantly more than that). But in six weeks of twice-weekly lessons, students can learn a lot, says Kimmins. "They'll be able to dance comfortably in a club and in most any social situation," he says.

Step by step. The key is to find a class that teaches you solid basic skills. Gravity-defying lifts and dizzying spins aren't that hard to master, say instructors. Dancing together closely without stepping on each other's toes is tougher. "Just learning to walk together is the hard part," says Paul Pellicoro, owner of the Manhattan ballroom studio DanceSport.

Another ballroom dance myth is that it's a great way for couples to spend time together. Sixty-five percent of the students at Arthur Murray studios are couples, but that doesn't mean they're all having fun. Kate VanAlstine, an instructor at the Dancers Studio in St. Paul, Minn.,

SAMANTHA REINDERS FOR *USN&WR*

Dance students in a class in Alexandria, Va.

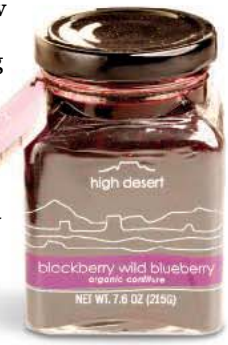
says clashes between couples are common. During group lessons, students change partners every few minutes, which inevitably leads to unflattering comparisons. "The guy will say to his wife, 'You don't dance like she does,' " says VanAlstine, a comment about as winning on the dance floor as it is in other settings.

And don't expect experience in other styles of dance to make it easier to learn ballroom. The 50 hopefuls who are on *So You Think You Can Dance* are mostly trained or self-taught in jazz, hip-hop, or break dancing, says Mary Murphy, owner of the Champion Ballroom Academy in San Diego, who's working with them. "The hip-hop kids, break-dance kids, they've got nothing I can use," she says. But everyone has to start somewhere. "Most people haven't been trained at all when they come into a ballroom dance program, and they're very nervous," says Murphy. "But once they get the hang of it, especially the men, they have the best time." ●

SMART CHART

'One Sauce Fits All' Is the New Flavor

Is it a marinade? A dip? Preserves? Or all of the above? At the Fancy Food Show in New York this summer, new high-end condiments were being touted as multipurpose food solutions for busy cooks. Here's the skinny on these sauces:



THE COMPANY	IN THE STORES	IN THE MOUTH
Private Harvest *(private harvest.com)*, $8.50 per 9-oz. bottle	Four types of marinade, including Mango Chile and Chipotle Raspberry	Mango Chile balances sweetness with a hot kick and pairs well with fish.
Beyond Classics *(beyond classics.net)*, $6 per 12-oz. bottle	Five varieties of dressings, including Garlicky Sesame Ginger	Roasted Shallot Merlot delivers a yummy punch; excellent with mushrooms.
Rising Sun Farms (800-888-0795), $6 per 8-oz. bottle	Six flavored balsamic vinegars, including fig and pomegranate	Tasted bright and fresh as a finishing touch to cheese and a fruit plate.
High Desert *(high desertfoods.com)*, $8.50 per 7.6-oz. jar	Nine kinds of organic fruit preserve, including blackberry and wild blueberry	The preserve perked up pancakes and vanilla ice cream. *–Diane Cole*

ASK US

Q My parents say I spend too much time smoking at the hookah bar since I came home for the summer. But aren't hookah pipes safer than cigarettes?

A It turns out people who use a water pipe to smoke *do* spend more time smoking, 30 minutes to an hour instead of the 10 minutes it takes to smoke a cigarette, according to hookah expert Thomas Eissenberg, an associate professor at Virginia Commonwealth University. But the water doesn't filter out much of the carcinogens or nicotine. In fact, because the moist tobacco used in hookahs is often lit with charcoal, people might expose their lungs to higher amounts of heavy metals including arsenic, chromium, and lead, says Eissenberg. So your parents might be right for a change. *–Cory Hatch*

Some young adults at a hookah bar in D.C.

FROM TOP: JEFFREY MACMILLAN FOR *USN&WR* (4); JESSICA TEFFT

You deserve a factual look at . . . 93

Peace in the Holy Land

Does Israel's "intransigence" stand in its way?

Many hope and believe that at long last peace in the Holy Land may be at hand. And that if it were not for Israel's intransigence, for its unwillingness to make "concessions," peace could have been attained long ago.

What are the facts?

Endlessly repeated myths. The myth that Israel's "occupation of Arab lands" is the root cause of the conflict is just that – a myth! Arabs have been slaughtering Jews long before the "occupation," long before the creation of the State of Israel in 1948. In 1929, for instance, Arabs killed 133 Jews and wounded 399 in Hebron. Those who were not killed fled, making the city, where Jews had lived for centuries, *judenrein*. The Mufti of Jerusalem met in 1941 with Adolf Hitler and declared his kinship with Nazi Germany because "we have the same enemy as Germany, namely the Jews."

Palestine, which incorporated what is now the Kingdom of Jordan, had been part of the Ottoman (Turkish) Empire for centuries. After World War I, Britain was given the Mandate over Palestine, which, in accordance with the Balfour Declaration, was to be the homeland for the Jewish people. This was formalized by the League of Nations and by the 52 nations that comprised it. In 1922, in violation of its Mandate, the British severed all the lands east of the Jordan River – 80 per cent of the Mandate – and gave it to the Arabs who, under the Hashemite rulers, created the Kingdom of Jordan. The Jews acquiesced to this betrayal. Britain finally relinquished its Mandate in 1947 and turned its responsibility over to the United Nations. They came up with a partition plan, by which the Arab sector was to be a contiguous land mass and the Jewish sector three discontiguous pieces. Jerusalem, located in the very center of the Arab sector, was to be "internationalized." Most of the Jewish sector was the desolate Negev desert. The Jews accepted this plan. But the Arabs rejected it out of hand and invaded the nascent Jewish state with the armies of six nations. It cost thousands of lives and caused over 650,000 Arabs to flee. Had the Arabs compromised, they would now have had their state since 1948.

Unending Arab aggression. In the Six-Day War of 1967, Israel again defeated the combined Arab might and remained in possession and administration of the Golan Heights, of Gaza, of Judea/Samaria (the "West Bank"), of the Gaza Strip and of the entire city of Jerusalem. Israel had no intention of staying in possession of these territories. It waited for the Arabs to make proposals for peace, but that was not forthcoming. On the contrary, the Arab League met at Khartoum and promulgated their "three no's": no peace with Israel, no negotiation with Israel, and no recognition of Israel.

On Yom Kippur of 1971, Egypt and Syria once again attacked Israel. And again, the heroic people of Israel defeated the combined Arab armies and drove across the Suez Canal and to within miles of Cairo. In the aftermath of that war, Egypt's president Anwar Sadat came to Jerusalem and spoke to the Knesset, Israel's parliament. He offered a peace treaty, but imposed very tough conditions, among others, the return of the entire Sinai, with the cities that Israel had built; the return of the oil fields that Israel had developed (and which would have made it energy-independent for the foreseeable future); and relinquishing the strategic mountain passes and early warning systems that protected Israel against any future attack. It was the first time in recorded history that the vanquished imposed conditions on the victor. In what was obviously a major act of folly, and once again in its incessant quest for peace, Israel agreed to recognize the murderous PLO, invited it back into Palestine from its exile in Tunis and signed the Oslo Accord, by which governmental authority was to be bestowed on the Palestinians. But instead of accepting the outstretched hand of peace, the Palestinians launched their "intifadas," which have cost thousands of lives and which have left the Palestinians impoverished and with their economy in shambles.

> "Arabs…are the cause for this unending war. Unless and until that mindset changes, things will not improve."

The above is a mere outline of the "peace process." In 2000, under the stewardship of President Clinton, Israeli Prime Minister Ehud Barak made unprecedented concessions for the sake of peace: 98 per cent of the land that the Palestinians requested, control over most areas of eastern Jerusalem, and authority over the Temple Mount. To the dismay of Clinton, Arafat curtly rejected this dramatic offer, under the pretext that Israel would not accept the "return of the refugees." That would have spelled the end of Israel as a Jewish state.

Israel's "intransigence?" No way! At every turn in this almost 100-year strife, Israel has offered compromises and concessions. The current folly, withdrawing from Gaza, is the latest example of that. Arabs, whose almost exclusive concern is the destruction of Israel, are the cause for this ongoing bloodletting and this unending war. Unless and until that mindset changes, things will not improve. But such a change of mindset does not appear on the horizon.

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Putting A Lock On CDs

New antipiracy software affects listening options

By John R. Quain

HARRY CAMPBELL FOR *USN&WR*

What could be easier? Pop a CD into any player and out pours the music. But those carefree days may be coming to an end—especially if you're accustomed to making digital copies of those disks for friends and family.

Record companies, frantic about piracy and the sharing of music via the Internet, have been testing ways to prevent tunes from being copied limitlessly by adding protective software to a handful of releases. The reviews have been mixed. Some consumers have complained that copy-protected disks don't play properly; others have carped when they discovered they couldn't make duplicates of the CDs they bought.

The major record labels, including Sony BMG and EMI, are nevertheless starting to use these tactics on a more widespread basis. Among the new copy-protected disks are *In Your Honor* from the Foo Fighters and *Young, Fly & Flashy Vol. 1* from Jermaine Dupri. I tried out half a dozen new releases to see how the new technology would affect their playability.

Complicated copying. The Foo Fighters disk bears a label warning buyers it's "protected against unauthorized duplication." The disk played without incident in six different CD and DVD players. However, when I inserted it into a PC, I had to install software and accept a licensing agreement only a lawyer could understand before I could even play it. Then things got complicated.

The protection software allowed me to copy songs onto my Windows XP computer and then copy those files to a portable music player that reads Windows Media files. But it wouldn't let me make copies at the best quality setting nor copies in the popular MP3 format, which has no copy restrictions. Most disappointing of all: I could not put song files on an Apple iPod. The CD's software also didn't warn that if I tried to use another program to record the tunes to a blank CD, the music probably wouldn't play properly. This oversight caused me to waste some blank CDs.

Jermaine Dupri's new disk presented a different array of restrictions. The label indicates that songs can be copied to a Windows PC, then transferred to a portable player that uses protected Windows Media files or copied to a CD up to three times. Unfortunately, I discovered that the Dupri disk would not play on one of my CD players. On a PC, the CD's piracy protection worked in much the same fashion as the Foo Fighters': The only way to make a CD copy of *Young, Fly & Flashy* is to use the software that comes on the disk, and even these legitimate copies would not play in some devices.

Such irritations drove me to seek a solution, and within minutes I completely defeated the defenses on both disks just by changing a single computer security setting. Record company executives admit that the idea is not to absolutely stop all copying—an impossible goal—but to create a "speed bump" that discourages people from making copies for their 100 closest friends.

These speed bumps may prove to be a stop sign for one important group: the owners of more than 20 million iPods, which are incompatible with the antipiracy software. Already in love with just buying single songs at iTunes, they'll have one more reason to tune out CDs. ●

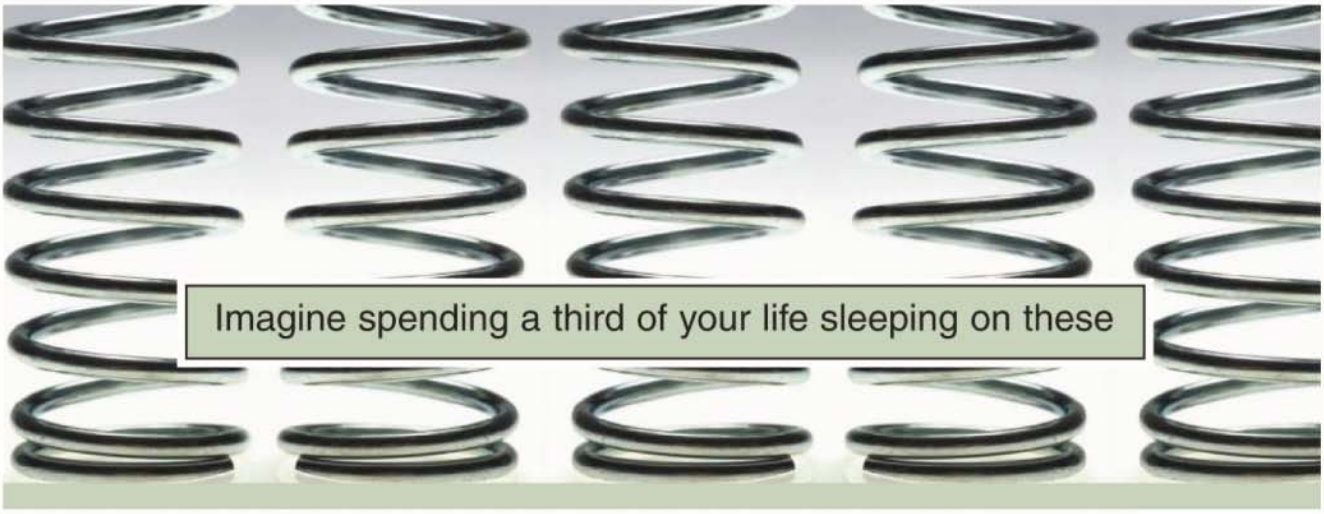
TRY IT OUT

No Point in Peeking at This Keyboard

Take away a kid's training wheels, and he'll learn to ride his bike. But can the same tough-love approach work with learning to type on a keyboard correctly? The all-black **Das Keyboard** ($80 at *www.Daskeyboard.com*) has no markings on any key, a design that forces users to focus on the screen to improve efficiency. And its sinister-chic look beats that drab-beige keyboard sitting on your desk, too.

The Das can be a helpful learning tool or an exercise in frustration. I kept my old keyboard on the floor as a cheat sheet for the first few hours, but eventually I learned to keep my eyes on the screen. Think of it this way: Mastering the Das is as cool as riding a bike with no hands. *–Joshua Davidovich*

JIM LO SCALZO FOR *USN&WR*



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Editorial

By Mortimer B. Zuckerman • Editor-in-Chief

Confronting the Threat

SHEHZAD TANWEER WAS THE BRIGHT, Muslim son of a first-generation Pakistani immigrant into Britain. His father owned a fish-and-chips shop, and Shehzad, at 22, was a university student headed for a profession—the kind of story of immigrant assimilation that is so familiar in America. Instead, Tanweer became a murderer, killing himself and other fellow travelers in the morning rush hour on London's Underground.

Muhammad Bouyeri, born in the Netherlands, shot Theo Van Gogh, a Dutch filmmaker and a descendant of the painter, six times while Van Gogh was bicycling in Amsterdam. Then he cut Van Gogh's throat and, with his knife, carved an Islamic manifesto on his victim's chest. Van Gogh's offense? He made a film about the oppression of Muslim women. In his trial, Bouyeri turned to Van Gogh's grieving mother to say, "I don't feel your pain. I have to admit that I don't feel sympathy for you. I can't feel for you because you're a nonbeliever." (The London bombers and the 9/11 hijackers weren't quite so fastidious: Anybody's blood was good enough to feed their depraved narcissism.)

Lost souls. The outrages committed in the name of Islam are doubly painful in Britain and the Netherlands because, besides the grief and suffering these young Muslim men have caused, there is the viciousness of their betrayal of trust in these notably—perhaps one should say excessively—tolerant European countries. These are the same nations that gave many Muslim immigrants a new start, nurtured their children as Britons and Netherlanders, and listened courteously to the venom of militant Muslim leaders who, like Tanweer and Bouyeri, had assumed the mantle of citizenship. Now, the British, the Dutch, and other European countries must confront the reality of homegrown terrorists in their midst—a more daunting challenge than dealing with infiltrators from abroad.

Economic deprivation does not explain this phenomenon. These killers are relatively well off, educated people, not the indigent and the uneducated. Europe has given sanctuary to second- and third-generation Muslim immigrants who may be even more radicalized than the first, a lost generation vulnerable to anyone who offers them an identity within the wholly imaginary community of their own Islamifascist creeds. This malignancy predates Iraq, Afghanistan, 9/11, and the Bush administration. Militant British Muslims have blamed everything and everybody except themselves, conveniently overlooking the obscenity that it is fanatical Muslims inspired by them who are doing the killing.

In Britain today, there is broad public support for a crackdown. Such a move is more than justified. Britain has provided asylum to so many extremist Muslims that London has become the headquarters of Islamifascism in Europe. London's police chief estimates that there are hundreds of al Qaeda-trained terrorists in Britain. The list of terrorists coming out of London is quite extensive, including Richard Reid, the convicted shoe bomber, Ahmed Omar Saeed Sheikh, who orchestrated the 2002 beheading of *Wall Street Journal* reporter Daniel Pearl, and the British bomber who walked into a popular Tel Aviv pub and killed three and wounded 60. After the London bombings, Islamic websites exhorted: "Rejoice, Islamic nation! Rejoice, Arab world!"

The aspiration of these radical Muslims is to make Islam the world's dominant religion. This kind of messianism and totalitarianism is almost incomprehensible in the West, with its long tradition of cherishing the life and liberty of every man, woman, and child. With 20 million Muslims in Europe, a population likely to double over the next 20 years, national borders are no defense against the insidious ideology of radical Islam.

> We must learn from the Islamifascism now contaminating Europe and take the steps necessary to prevent it from spreading to America.

What should America do?

First, we must tighten our scrutiny of people coming here. Most second-generation European Muslims are citizens of the European Union and, as such, eligible for U.S. visa waivers, which permit them to pass through U.S. immigration checkpoints easily. Greater scrutiny of such visitors is needed immediately. Two, we must harden our determination not to compromise with Muslim terrorism or explain it away by any mealy-mouthed "understanding" of it. "Explanations" of terrorism are unforgivable. It isn't war; it's murder. Terrorists aren't soldiers; they're criminals. Third, we must increase security funding for public transport by land, rail, and buses, where 16 times as many people travel every day as they do in airplanes. This must be done on a risk-based formula, as supported by the 9/11 commission—not as another pork-barrel program for greedy congressmen.

Fourth, we must invest more in intelligence and revise overly restrictive rules on its dissemination and use.

Today, we face a threat to the most fundamental values of our free and democratic way of life. In this modern version of the Thirty Years' War, there is only one objective: We must prevent the 21st century from becoming the century of terrorism. ●

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