THE DAILY CLIPS

September 22, 2005

News, commentary, and opinion
compiled by the East Carolina University News Bureau from:

The Greenville Daily Reflector
The Raleigh News & Observer
   The New York Times
   The Wall Street Journal
   USA Today
   The Charlotte Observer
   The Fayetteville Observer
The Greensboro News & Record
   Newsweek
   U.S. News & World Report
   Business Week
   Time

East Carolina University News Bureau
E-mail to durhamj@mail.ecu.edu  Web site at http://www.news.ecu.edu
252-328-6481 FAX: 252-328-6300
Local medical team to staff mobile hospital in Mississippi

Hurricane Katrina struck the Gulf Coast, but the Greenville area is feeling its impact. Katrina Notebook will report how the disaster is changing daily life here. Call 329-9573 to share an anecdote.

By Jennifer White
The Daily Reflector

ECU and Pitt County Memorial Hospital employees are heading to Mississippi on Friday to help staff a mobile hospital in an area devastated by Hurricane Katrina.

The medical team includes 22 local members and five health care workers from other hospitals in the state. They will leave Charlotte in a plane provided by the Hendrix NASCAR racing team.

Dr. John Meredith, director of emergency preparedness at the hospital, will be leading the team. He formerly served as director of emergency services at Eglin Air Force Base in Florida.

“The devastation has been almost unprecedented in United States history, and the health care system that is present there is in severe distress,” said Meredith, also an East Carolina University emergency medicine physician and clinical assistant professor.

“I feel a tremendous responsibility to help.”

Immediately after the hurricane, the National Disaster Medical System requested help from the N.C. Office of Emergency Medical Services. The state department asked University Health Systems and other health systems in the state to provide medical teams for relief efforts.

Teams are stationed at Carolinas Med-1, a mobile field hospital now stationed in Waveland, Miss. The unit was purchased by Carolinas Medical Center in Charlotte with grants from the Homeland Security Office. Med-1 supports two operating rooms, X-ray machines and about 100 beds.

Medical teams from around the state have been staffing Med-1 for one-week stints since Sept. 2.

This is the first time that a team will include ECU and Pitt Memorial staff. They will be joining other teams for a total of about 100 health care workers.

Barbara Dunn, public relations coordinator at the hospital, said that more than 250 staff members volunteered for the team. Team members were chosen based on their skills, personal health, immunization history and whether or not they had disaster relief experience.

“There were people who volunteered who were not in optimal health themselves,” Dunn said. “We don’t want them to become patients.”

Meredith volunteered to lead the team after experiencing firsthand the devastation that Hurricane Floyd caused Pitt County in 1999.

“Hurricane Floyd was a benchmark for eastern North Carolina,” he said. “It taught us a lot of things, and unfortunately, that benchmark wasn’t translated in other areas of the United States. Now we’re seeing the results of it.”

Meredith said that Waveland, a community 2 miles inland, experienced at least a 6-foot tidal surge.

“Practically all the buildings are damaged and uninhabitable, and that’s both homes and businesses,” he said. “What I’m expecting is something very much like a war zone.”

The local team will include nurses, physicians, mental health specialists, pharmacists, respiratory technicians and support personnel.

Earlier teams reported between 200 and 300 patients a day. The local team expects to see patients injured during the cleanup process. They also anticipate treating respiratory problems, since mold in the air can aggravate conditions such as asthma and emphysema.

Nettie Evans, director of University Health System’s health careers program, said physicians normally see a lot of chain saw injuries after rebuilding starts. But teams already working in the area said that has not been the case.

“There is no need to use a chain saw because the trees are all down and the houses are all destroyed,” Evans said. “It’s not like you have to move a tree from a house so somebody can make progress.”

Med-1 is staffed with basic supplies, but the local team will be taking some medications with them. Team members are allowed to take one 40-pound bag of personal belongings.

They will be given matching T-shirts and cargo-type pants when they arrive so they can easily recognize each other. Meals will be provided by churches in Waveland.

FEMA will be reimbursing the hospital and university for the team members’ salaries while they are away.

“Some of us will wash dishes, some of us will care for patients,” Evans said. “We’ll do what needs to be done.”

See NOTES, B3
Rotary donation

A former member of the Greenville Evening Rotary club who is now Iraq's ambassador to Australia recently donated $500 for Katrina efforts.

Ghanim Al-Shibli, an Iraqi diplomat who defected to the U.S. during the rule of Saddam Hussein, was employed by Eastern Carolina Vocational Center in Greenville for several years.

After the U.S. invasion of Iraq, he served on the Iraqi Security Council in Baghdad. He was later appointed as the Iraqi ambassador to Australia.

Dan Le Roux, director of ECVC, and Scott Griffin of Practicon, both Rotary members, spoke to Al-Shibli shortly after the hurricane struck. He said he wanted to help in some way, even though he is so far away, Griffin said.

Jim Moyer, president of the Greenville Rotary Club, accepted a contribution from Al-Shibli presented on his behalf by Griffin, club member and an assistant district governor for Rotary District 7720.

Al-Shibli spoke with the club via telephone during the meeting.

He expressed sympathy for all affected by the hurricane and concern about Hurricane Ophelia and its possible effects.

Jennifer White can be reached at 329-9571 and jewhite@coxnc.com.
SAVING MORE LIVES

Area medical centers take steps to cut unexpected patient deaths

BY KATHY WILLIAMS

If all goes well, hospital patients in the Triangle will hear “Rapid Response, Rapid Response,” broadcast over the intercom more frequently than “Code Blue.”

It’s part of a nationwide effort to reduce deaths in the hospital caused by medication problems, surgical mistakes, infections and poor respiratory practices.

A 1999 study by the Institute of Medicine suggested that nationwide 44,000 to 100,000 people die unexpectedly each year in the hospital. Ever since, hospitals and agencies that regulate them have put more focus on bringing those numbers down.

Last winter, the Institute for Healthcare Improvement, a nonprofit group that works for better patient safety, asked hospitals to voluntarily participate. Hospitals in the Triangle quickly signed up and are busy rolling out parts of the campaign, including the innovative Rapid Response Teams.

WakeMed is one of the first hospitals in the Triangle to launch a Rapid Response Team — one of the tactics that will save the most people, area patient safety personnel said. Here’s how it works:

When a patient’s nurse or caregiver suspects a patient’s condition is rapidly deteriorating, the response team may be called. At the Raleigh campus of WakeMed, the team is made up of a critical care nurse, a respiratory therapist and a clinical administrator led by a physician.

Betsy Gaskins-McClain, executive director of the WakeMed heart center, said the team is one of the best ways to immediately improve safety. “We’ve had a code blue in place for years and this team is not a replacement,” Gaskins-McClain said. “The teams are being developed to prevent a code blue from being called. Code blue indicates that a patient’s heart has stopped. We don’t want a patient to reach that level of distress.”

SEE SAFETY, PAGE 3E

Duke Hospital has had an informal response team for years and is working toward a structured system, said Gail Shelby, patient safety coordinator. Shelby, a former intensive care nurse, said the teams have proved to work very well and it is often a nurse who just “has a gut-feeling that something is wrong.” Having a team to call in for a closer look helps slow or stop a deteriorating condition.

A look at local efforts

Using a formula that estimates unexpected patient deaths, the Institute for Healthcare Improvement said 75 lives a year could easily be saved at a moderate-size hospital with 15,000 patient admissions annually. Of course, the results may not be accurate for every hospital; the numbers could be higher or lower. Hospitals are not required to keep public records of the number of deaths inside their walls, and most hospitals choose not to report them publicly. For perspective on hosp-
tal size, Duke has about 37,000 patients a year, UNC has about 31,300, and WakeMed has 29,800.

Each hospital has emphasized a different part of the plan. At Rex Healthcare, one of the initial improvements has been hand-washing efforts to help avoid infections. "From the time you check in at the time clock, you start seeing signs reminding you to wash your hands," said Susan Sherman, patient safety coordinator.

Duke is putting an emphasis on better medication records, attaching an up-to-date record on each patient file. "Patients move from one part of the hospital to another. It's important that they have an updated medication file," Shelby said.

The effort will not work, however, without patient participation, said Lee Ann Scott who coordinates patient safety at WakeMed.

"Sometimes patients, especially older ones, are intimidated," she said.

Patients should ask questions:
- What is this pill for?
- Why am I having this test?
- Did you wash your hands?

Jackie Williams of Raleigh agrees. She has been a frequent patient at WakeMed and says she always asks lots of questions.
"I like this hospital, but I want to make sure that I'm getting the right meds and why."

Staff writer Kathy Williams

can be reached at 829-4567
or kwililiam@newsobserver.com.
Breast cancer therapy at issue

Few insurers cover new treatment

By Jean P. Fisher
Staff Writer

Three years after the U.S. FDA approved a radiation therapy that allows more women with breast cancer to avoid mastectomy, many insurance companies still refuse to cover it. Just this week, Blue Cross and Blue Shield of North Carolina, the state’s largest health insurer, said it won’t cover the treatment until clinical research can show definitively that it is at least as effective as an older, prevailing type of radiation treatment.

The issue points to a problem in modern medicine: Many patients and their doctors want cutting-edge treatment, but insurers want proof it’s money well spent.

The older treatment, whole-breast radiation therapy, zaps the patient’s entire breast and is usually given five days a week for six weeks. A newer treatment, MammoSite, is partial-breast radiation therapy. It directs a highly concentrated dose of radiation only to the site of the tumor and treatment is done twice a day for just five days.

Radiation is a must for breast cancer patients after surgery, to reduce the risk of recurrence, but some patients, such as those who can’t get time away from work or who live in remote areas, can’t fit six weeks of daily treatment into their lives. Without the quicker option, some women choose not to have radiation at all and instead have one or both breasts removed — a more drastic method of minimizing the risk of recurrence.

“Women in North Carolina are choosing not to get the best care available,” said Dr. Andrew Kennedy, a radiation oncologist with Wake Radiology Oncology Services in Cary, which has offered MammoSite for about two years. For now, the treatment is limited to women with early-stage breast cancer and small tumors.

Numerous studies tracking women treated with partial-breast radiation show that fewer than 5 percent experience recurrences after five years — similar to results achieved with whole-breast radiation therapy.

“I believe the information so far is good enough,” Kennedy said. “I would let my sister, my mother, my wife ... have MammoSite.”

But many health insurers still consider MammoSite and other types of partial-breast radiation experimental. Among the top four private health insurers operating in North Carolina, only Aetna covers it as a first-line treatment.

Blue Cross and other insurers want a large, long-term study comparing different types of partial-breast radiation methods with the older, whole-breast therapy to show that the newer treatment is at least as good at preventing recurrences before they agree to cover it. Insurers and, for that matter, physicians, typically rely on such research to show the way to the most effective treatments.

Dr. Roger F. Anderson Jr., a radiation oncologist with Triangle Radiation Oncology Services in Raleigh, is among those physicians who think more research on partial-breast radiation is needed.

“The assumption you’re making is that this is an equivalent treatment,” said Anderson, who does not give partial-breast radiation as a stand-alone treatment. “Are we exposing a certain number of women to a greater risk of recurrence or maybe even death from breast cancer?”

The good news for breast cancer patients who want partial-breast treatment to be covered is that a major new clinical trial, sponsored by the National Cancer Institute, is being started to produce the data insurers want. If patients receive partial-breast radiation as part of the trial, federal law mandates that their insurance pay for it.

But it will be years before results begin to be published.

Anderson’s practice will participate in the trial. So will Kennedy’s.

In the meantime, Kennedy said he sees no reason to withhold a safe, effective and more-convenient treatment from his patients.

He notes that, when it comes to prostate cancer patients, health in-
surance routinely covers a very similar type of radiation therapy — without the benefit of comparative clinical trial data.

Nancy Bassham, 57, of Manteo, decided on MammoSite after she had surgery this spring to remove a small tumor in her breast. Bassham, who owns a wholesale flower importing business, said she could not have afforded to stop or scale back work to have six weeks of whole-breast radiation. She also liked the idea of treating only the area of her breast that had been affected, the place recurrences are most likely to sprout.

Bassham knew her insurer, Blue Cross, would not cover the treatment but she went ahead, prepared to pay out of her own pocket. According to Proxima Therapeutics, which makes the MammoSite device, treatment costs about $15,000. Whole-breast radiation costs $8,000 to $10,000, according to the company.

As expected, Blue Cross denied the claim. Bassham appealed and the company, after reviewing her case, again refused to pay. She appealed a second time and an independent panel of medical and radiation oncologists overruled Blue Cross, citing widespread use of partial-breast radiation and numerous studies that show high rates of success. The insurer has since paid Bassham’s medical bills.

“Tink knew how to work the system,” Bassham said. “How many other women would have to just live with Blue Cross saying no?”

Staff writer Jean P. Fisher can be reached at 829-4753 or jfisher@newobserver.com.
HOW IT WORKS

The MammoSite procedure treats breast cancer with focused radiation. When it is used as primary therapy after surgery, patients are treated twice a day for five days.

Procedure

1. After a tumor is removed, an **uninflated balloon** is placed inside the tumor cavity.

2. The balloon is inflated with saline and a "contrast agent," which helps the doctor see the balloon more clearly.

3. A radioactive source attached to a wire travels through the applicator into the inflated balloon, delivering a precise dose of radiation. The radioactive source does not remain in the patient's body.

4. After a series of radiation treatments, the balloon is deflated and removed.

Source: Proxima Therapeutics

Benefits

- Radiation is delivered from within the cavity, limiting the radiation to healthy tissue.
- The radiation is targeted to the area where cancer is most likely to recur.
Study differs with Duke on fluid

An analysis finds carcinogens in fluid mistakenly used to clean surgical instruments.

BY JIM NESBITT
STAFF WRITER

Heavy metals that can cause cancer and microscopic particles of carbon and machinery metal were found in the hydraulic oil waste mistakenly used to wash surgical instruments at two Duke University Health System hospitals in Raleigh and Durham last year, lawyers said Wednesday.

Results from an independent laboratory analysis ordered by the lawyers differ sharply from an earlier study Duke commissioned. Lawyers David Henson of Raleigh and David Weinstein of Tampa said their study found 22 contaminants in a sample of the fluid. The broad chemical mix includes arsenic, lead, cadmium, chromium, zinc and nickel, and indicates a higher health risk to the approximately 3,800 patients who were exposed to the contaminated surgical wash.

For example, arsenic has been associated with bladder, skin and lung cancer, said Annette B. Santamaria, a Houston environmental health consultant working for the lawyers, who have been contacted by numerous patients.

Cadmium and nickel have been associated with lung cancer, and lead has been linked to neurological disorders, said Santamaria, a toxicology and public health expert.

Exposure to these and other toxins found in the hydraulic oil waste can also cause other health problems, such as fatigue, pneumonia-like illnesses, repeated infections and autoimmune disorders, she said. There are also gastrointestinal disorders linked to the mineral oil that makes up the bulk of the hydraulic fluid.

The hydraulic fluid foul-up occurred when elevator repair workers drained used liquid into empty detergent drums that were later distributed to the two hospitals, Durham Regional and Duke Health Raleigh, as cleaners.

Duke health officials stood by the results of a study conducted by RTI International at Research Triangle Park and released in late June. That study tested the hydraulic fluid waste for levels of 11 heavy metals that can cause health problems with high exposure, including aluminum, chromium, manganese, lead and zinc. Only zinc showed up in higher levels than trace amounts, the study showed.

"Based on these findings, Duke maintains this low exposure was not harmful to patients," Jeffrey L. Molter, a Duke University Health System spokesman, said in a written statement.

Another independent lab study commissioned by Duke showed that the sterilization systems at the two hospitals worked and were able to kill bacteria, viruses and fungi on surgical instruments.

"It is very important to remember that patients were only exposed to the instruments after the instruments underwent the sterilization and cleaning process; patients were not exposed to the bulk fluid," Molter said in the statement.

But Weinstein said the RTI study wasn't as finely calibrated as the lawyers' lab test.

"Duke didn't use a very strong magnifying glass and didn't find the metals we found," said Weinstein, an experienced litigator who specializes in environmental and business law.

Carol Svec, who had surgery on a torn rotator cuff at Duke Health Raleigh in November and has yet to regain full range of motion in her left shoulder, was dismayed by the latest lab results.

Before the latest study, patients exposed to the contaminated surgical instruments worried most about autoimmune disorders, persistent inflammation and infection, and gastrointestinal ailments, Svec said.

"Now we get to add cancer to the list," she said. "It's another thing to worry about, another stress, another thing to keep us awake at night."

Henson said his firm has been contacted by 500 of the patients who had surgery with the contaminated instruments but has yet to file suit. Weinstein said the latest study was the first step in treating patients exposed to the contaminated instruments who have complained of a wide range of health problems that have plagued them after their surgeries.

"These people deserve answers, and those answers can only be provided through a careful, case-by-case analysis," he said.

News researcher Denise Jones contributed to this report.
Rural areas train own teachers

BY MARTI MAGUIRE
STAFF WRITER

CLAYTON — It would be tough to call what brought Al Batten to North Johnston High School 35 years ago a recruiting effort.

He had just returned to Johnston County from N.C. State University, where he studied agriculture. The principal asked Batten whether he would like to teach students about farming, and he said yes.

"It was a wonderful job in a wonderful place," said Batten, 57, who retired this year from the rural high school in northeastern Johnston County, where he once was a student.

These days, recruiting teachers is a more cosmopolitan affair, with representatives of Johnston schools jetting off to states such as Indiana and New York to find teachers. But unlike Batten, many of the recruits don't stick around. Fourteen percent of Johnston teachers left the district this year, costing the system more than $1 million a year to recruit and train their replacements.

Some go to neighboring Wake County, where pay is higher. Others move to bigger cities or return to their hometowns after a few years in Johnston.

The problem has experts making efforts to produce more teachers with local ties. East Carolina University has sought to fill that niche for Johnston and other rural counties with a program that brings teacher education courses to community colleges.

Close to home

Most teachers will work within 50 miles of where they go to college, said Mike McLaughlin, who headed a 2004 study on teacher shortages for the N.C. Center for Public Policy Research. So programs that train teachers who already live near the schools that need them offer the best long-term solution to teacher shortages in rural counties, he said.

"Those teachers will stay longer because they're already in and aware of that community," McLaughlin said.

Now in its second full year, a program called Wachovia Partnership East offers four-year teaching degrees in elementary education and special education from ECU at Wayne, Craven and Edgecombe community colleges, in Eastern North Carolina.

The program will expand in May to offer classes for students who want to teach at middle schools.

"The rationale is to grow our own teachers," said Debbie Grady, who oversees the program at Wayne Community College in Goldsboro.

Students from six surrounding counties, including Johnston, travel to Goldsboro for evening classes once a week or less and do the rest of their work online. Similar programs offer classes to students in other eastern counties.

About 80 students are enrolled in the Wayne program, mostly from Johnston and Wayne counties. The first group will graduate in 2007.

Others are finishing their first two years of classes at their local community colleges and plan to transfer to Wayne Community College.

Many of them work as teacher's assistants, school secretaries or cafeteria workers. Most have to work during the day and would not have traveled to Raleigh or Greenville to get a four-year degree, Grady said.

Fulfilling a dream

Roxanne Wells makes the 20-minute trip from her home in Johnston County near the Wayne County line about once a month for her classes. She said she hopes to find a job teaching special-needs children at Johnston schools, a specialty in which the shortage of teachers is most dire.

A graduate of North Johnston High, she works as a teacher's assistant at Micro-Pine Level Elementary, where her son goes to school.

"I'm fulfilling a dream I've had for 20 years," she said of working toward her degree. "I can't wait to get in the classroom."

Local school officials are looking forward to a new crop of teachers like Wells.

School officials in Johnston County figure the teachers they recruit from out of state likely won't stick around for more than five years, said Robin Little, director of human relations for the district.

"If they stay here two years, three years, five years, then go home, we say 'Thank you very much,'" Little said. "That's five years those students had an excellent teacher."

Batten saw a parade of teachers march through in his last few years at North Johnston High, which pulls students from some of Johnston County's smallest towns and rural areas.

For the first 20 years, he said, he worked with a steady group of North Johnston alumni. But as they retired, their replacements didn't stay as long.

Batten timed his retirement so that another North Johnston alumnus could take over his job. "Unless I'm badly fooled," he said, "he'll stay."
Residents grapple with UNC-CH plans

Clash feared of community values

BY MATT DEES
STAFF WRITER

CHAPEL HILL — As Nancy Salmon sees it, plans for 140 housing units near Bolin Creek in Carrboro pit two community values against one another.

On one hand, the units to be slated for lower-income UNC-Chapel Hill faculty and staff members will provide much-needed affordable housing.

On the other, Salmon said, the development, which earned tentative approval Wednesday from the UNC-CH Board of Trustees, could threaten the-sensitive creek's ecosystem.

Salmon, who lives near the creek and has advocated for its preservation, would prefer the 63-acre site be left alone.

The housing is part of the university's slowly emerging plans for Carolina North, a satellite research campus that has many residents and town leaders concerned about its impact.

Many, like Salmon, are starting to see the project as a mixed bag.

It will mean more affordable housing, but fewer trees; economic growth generated by new jobs, new research and new companies, but also growing traffic problems generated by same.

At the very least, Salmon said, "I would like to see them leave a wide corridor around the creek."

UNC-CH officials said Wednesday they intend to do that, though they haven't begun detailed planning for the site west of Chapel Hill High School.

The trustees approved designating the site for the affordable units but will have to sign off on a site plan later. Then it will go to Carrboro leaders for approval.

Dwayne Pinkney, a UNC-CH assistant vice chancellor, said the project likely could be built under existing zoning laws, though that isn't definite.

The trustees also approved Wednesday plans for an 80,000-square-foot "incubator" building south of Estes Drive.

UNC-CH would lease space in the building to "nascent" biotechnology companies that in some way are started by research being conducted by the university, said Tony Waldrop, vice chancellor for research and economic development. Plans for that project also were vague, but Waldrop called it critical.

"We're one of a very small number of large, public research universities that do not have this capacity," he told the trustees.

But this project, like the affordable housing proposal that already sparked debate at a recent Carrboro public hearing, is sure to be controversial.

Staff writer Matt Dees can be reached at 932-8760 or mdees@newsobserver.com.
Body fat may stiffen teens' blood vessels

THE ASSOCIATED PRESS

DALLAS — Excess body fat in teens, even those who are not overweight, seems to be linked to less elastic blood vessels, a condition that can mean future cardiovascular disease, researchers say in a new study.

The findings underscore the dangers of the obesity epidemic, even in youngsters. An estimated 30 percent of schoolchildren are thought to be overweight.

"The message about this is that it's yet another reason to be concerned about the rise in overweight and obesity among young people," said Peter Whincup, lead author of the study and professor of cardiovascular epidemiology at St. George's Hospital Medical School in London. "One does need to avoid becoming overweight."

The relationship of fat to blood vessel elasticity is continuous, "so a few pounds will make a difference," Whincup said.

"It is surprising that in early adolescence there is already evidence of this change," said Dr. JoAnn Manson, chief of preventive medicine at Harvard's Brigham and Women's Hospital. "The fact that that is apparent even in young adolescents is of great concern."

If one's blood vessels are elastic, it is easier for them to pump more blood. The heart has to work harder to pump blood through stiff blood vessels, leaving a person more likely to develop high blood pressure.

"What you want is a very pliable blood vessel that has a lot of give and take," said Dr. Sarah Blumenschein, director of preventive cardiology at Children's Medical Center-University of Texas Southwestern. "Obesity itself appears to be an independent factor for decreased flexibility."

For the study published this week in the American Heart Association journal Circulation, researchers used ultrasound to measure the elasticity of blood vessels in 471 children ages 13 to 15. There were 152 children in the study who had undergone similar evaluations when they were 9 to 11.

The study found that excess fat was even more strongly linked to stiffer blood vessels than cholesterol levels.
Plan Will Pay 90% of Costs For Students Hit by Storm

By MICHAEL JANOFSKY

WASHINGTON, Sept. 16 — The Department of Education announced a plan on Friday to pay 90 percent of the educational costs of students and schools affected by Hurricane Katrina for one year.

But the plan, which seeks $2.6 billion in new hurricane relief spending, came under attack from Democrats and officials of the nation’s two largest teachers’ unions, who asserted that a major component — payments to families with children in private schools — amounted to a national voucher program.

The department proposed that the bulk of the spending, $1.9 billion, be used to pay states and school districts for absorbing children from the affected areas into their public schools. An additional $227 million would be dedicated to displaced adults with outstanding student loans and to universities that have taken in students from the storm areas.

“TThe federal government is doing something it has never done before,” Education Secretary Margaret Spellings said, referring to a 10-fold increase in federal per-student spending. “Our 9 percent investment is going to 90 percent.”

The budget request also includes $488 million to compensate families with children in private schools, which critics said represented an effort by the Bush administration to initiate a favorite approach to school choice, the use of vouchers.

More than 372,000 schoolchildren were displaced and are now enrolled in schools as far from the Gulf Coast as California and New England. The total includes about 61,000 who attended private schools in Louisiana, 50,000 in Roman Catholic schools.

Under the plan, children in public and private schools would be regarded equally for aid purposes, with a spending cap of $7,500 per student.

Senator Edward M. Kennedy, Democrat of Massachusetts and the ranking member of the Senate education committee, said in a statement that he applauded President Bush’s efforts to serve the educational needs of displaced children.

“But I am extremely disappointed that he has proposed providing this relief using such a politically charged approach,” Mr. Kennedy added. “This is not the time for a partisan debate on vouchers.”

Craig Orfield, a spokesman for the committee chairman, Senator Michael B. Enzi, Republican of Wyoming, said Mr. Enzi had not yet reviewed the department’s request. He also said Mr. Enzi “generally does not favor vouchers.”

Reg Weaver, president of the National Education Association, which represents 2.7 million public school teachers and has opposed voucher programs, said, “Vouchers are a flawed and divisive approach that undermines public education.”

Mr. Weaver’s counterpart at the American Federation of Teachers, Edward J. McElroy, said, “We do not believe that the voucher plan in the Department of Education’s proposal is the right way to provide that assistance.”
Going to the Hospital? Don’t Forget to Pack a Nurse

A FEW years ago, a friend having major surgery was advised to hire a private nurse to be at her bedside in the hospital.

When I heard this, I mentally rolled my eyes. Was this one more example of baby boomer excess — the regular nurses aren’t good enough that we need someone at our beck and call 24 hours a day?

But then, a few weeks ago, my sister-in-law in California was hospitalized with double pneumonia. For a few days, her condition worsened. She was not attached to monitors, and at one point, she seemed to go into respiratory failure. Had her sister not been by her side to alert the nurses, she might have died.

When I began checking around, I heard similar tales. Suddenly round-the-clock attendance by a relative, hired nurse or companion seemed not so outrageous.

“When my sister-in-law went in the hospital for an operation a few years ago, I hired a private-duty nurse,” said Diane Mason, editor in chief of The American Journal of Nursing. The hospital was “one of St. Louis’s finest, but I knew there were some staffing stresses, and I wanted someone to tend to her in the first 24 hours.”

Ms. Mason is not alone. Interestingly enough, almost every medical authority I spoke to noted that when a relative was hospitalized, they made sure someone — either a paid professional or a friend with nursing experience — was at the bedside.

But that doesn’t mean hiring a nurse is a must. The professionals also say it depends on the nature of the illness, the hospital and its nurse-to-patient ratio.

Although it is hard to find statistics on trends, there is no doubt that people’s concerns about nursing shortages over the last decade have prompted more affluent patients to think about hiring their own.

The situation seems to be in flux. The shortage of nurses has deepened every year since 2009, according to the American Nurses Association. But at the same time, over the last few years, studies have demonstrated how dangerous it is to load too many patients onto one nurse.

In 1999, California became the first state to pass a law requiring minimum staffing ratios for hospital nurses. The ratio now is five patients for each nurse, except in critical care units. Eighteen states are considering similar legislation.

“When there’s a lot of pressure to improve staffing,” Ms. Mason said, “nonetheless, private-duty nursing is alive and well.”

When Paula Zingarelli of Boston went into Massachusetts General Hospital three years ago for a gastric bypass operation, she said, “I knew nursing ratios were really bad.”

Ms. Zingarelli, 50, had some medical background, having worked as a surgical assistant for a plastic surgeon for many years. She hired a private-duty nurse, which ended up costing her $3,000, to help out and to make sure she got her pain medication on time.

She returned to Mass General for surgery this year to repair complications from the previous operation. This time she decided to wait before hiring a nurse because her sister could help.

“The nurses were extremely attentive,” Ms. Zingarelli said. “My meds were given on time. In fact, I wrote a letter commending them.”

How can some of those who are not familiar with the medical world know if we need to bring our own? After all, it’s not a cheap option, and it’s not covered by insurance. A companion who is not medically trained costs about $15 to $22 an hour; a private-duty nurse $35 to $75 an hour.

If you’re going in for a planned procedure, rather than an emergency, it’s a good idea to ask your doctor’s opinion of the hospital’s staffing and whether you should consider hiring someone privately. Since most physicians have privileges at more than one hospital, you may have a choice.

All the medical authorities suggested checking whether a hospital is a magnet facility. Magnet status is like a seal of approval, developed by the American Nurses Association to encourage hospitals to develop and maintain good practices, both in patient care and in collecting, maintaining and evaluating data.

To find a magnet hospital in your area, go to ana.org/annc. Most hospitals have websites; sometimes they list nurse-to-patient ratios and other information.

“If not, call a hospital and ask,” said Barbara Blakeney, president of the American Nurses Association. “If they are unwilling to divulge that information, then find another hospital.”

It’s hard to pin down a “good ratio,” as it depends on how ill the various patients are on a given floor, as well as how experienced the nurses are. But there should not be more than six or seven patients to one nurse on a floor for those recovering from surgery, Ms. Mason says, and no more than two patients per nurse in an intensive care unit.

It seemed a bit unlikely to me that I would get any satisfactory answers by just calling a hospital out of the blue. So I decided to try it at the hospital where my sister-in-law was treated.

Not identifying myself as a reporter, I simply said I wanted to know about nurse-to-patient ratios on a floor for those recovering from major surgery, and whether they could help me find a private-duty nurse if I decided I needed one.

First the operator transferred me to a voice-mail box. I left a message, but didn’t receive a call back.

I tried again later in the day. I was transferred to someone who was very nice, but put me on hold for about 10 minutes; I was then disconnected.

I called back. This time I was transferred to a floor nurse who told me they’d be glad to supply a list of agencies who offered private nurses or companions once I checked in. She also told me that the nurse-to-patient ratio on her floor was one nurse to about every five patients.

A recommendation directly from the hospital is useful, not only because it gives you some idea of where to go, but because it also means the agency will provide nurses who are familiar with the hospital.

And if you’re going into a specialty unit, like oncology or cardiology, “make sure they are certified,” Ms. Blakeney warned. “Find out what the training and education is in those areas, and whether they have recent experience.”

Not everyone wants or requires a highly trained person at their bedside; often the need, especially at night, is simply for what is called a sitter or companion. That person can offer water, help to the bathroom or simple reassurance.

“Let’s say, God forbid, Mom slips and cracks her hip,” says Louise Weadock, a registered nurse and owner of Access Nursing Services, which provides private-duty nurses and companions to many New York hospitals. “You don’t want her to be alone all night long, yet you have kids or a career. For your own peace of mind, you might hire someone.”

Not all hospitals welcome outsiders coming onto their floors; it depends on the culture.

“When I did nursing, there was certain resentment,” said Jean Whelan, an adjunct professor of nursing at the University of Pennsylvania, who was a practicing nurse for 35 years. “But I loved it at night — it was one less patient to worry about.”