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THE AUTHORS REPLY: Dr. Blander is concerned that recent data do not support our statement that the use of oral contraceptives is associated with a small but significant risk of breast cancer. Our conclusion rests on the 1996 meta-analysis of oral-contraceptive use and breast cancer.¹ We agree that results reported by Marchbanks et al., which received a favorable comment from one of us,² did not support this association. However, the conclusion from the study by Marchbanks et al. must be tempered by the subsequent report by Kumle et al.,³ which described a prospective study of more than 100,000 women between the ages of 30 and 49 years at the time of enrollment. It demonstrated that current or recent use of oral contraceptives is associated with an increased

risk of breast cancer. For this reason, we continue to believe that the totality of the evidence suggests a small but real increase in the risk of breast cancer for current users. Of course, this small absolute risk must be considered in the context of the numerous health benefits that oral-contraceptive use affords to so many young women.

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Curing the Nursing Shortage — The Role of Compensation

TO THE EDITOR: Like many others who discuss remedies for the shortage of nurses, Chaguturu and Vallabhaneni (Oct. 27 issue)¹ mention the issue of pay only in passing and emphasize such nebulous measures as the “creation of work environments that are challenging yet rewarding.” Yet unrewarding working conditions cannot be the heart of the problem. Chronic shortages do not arise in other occupations with difficult working conditions, because the pay stays high enough to induce a sufficient supply of workers to endure them. We need to pay more attention to hospital practices that keep nurses' wages from rising enough to prevent the shortage from continuing.

The market for nurses is split into metropolitan areas, each dominated by a relatively small number of large employers, which facilitates anti-competitive behavior. We know that some hospitals have engaged in agreements to refrain from offering higher wages to attract nurses working for other hospitals in their area.² In 1996, the Department of Justice and the Federal Trade Commission, which are aware of this problem, issued

guidelines for hospitals that defined anticompetitive behavior,³ but stronger measures are needed. One measure could be the filing of a rash of antitrust suits by groups of nurses. At this writing, such suits are in preparation in a number of metropolitan areas. Another measure could be a drive for minimum nurse-to-patient ratios nationwide. If such measures increased pay and as a result attracted more new nurses and reduced departures, then working conditions, which are affected by staffing shortages at hospitals, would improve. Nursing schools, which have contracted, would expand. A 10 percent increase in nurses' pay and a 10 percent increase in the number of nurses employed would add about 1 percent to the nation's overall cost of health care.⁴

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DR. CHAGUTURU AND MS. VALLABHANENI REPLY:

Dr. Bergmann correctly notes that low salaries, which have not increased substantially since 1991 (after an adjustment for inflation), probably play a role in the declining supply of domestic nurses.¹ However, increasing wages alone is unlikely to resolve the domestic nursing shortage and will probably exacerbate the global nursing shortage. Inadequate staffing, heavy workloads, a lack of respect and recognition, and a perceived lack of authority are frequently cited as key areas of job dissatisfaction among nurses.

A General Accounting Office report cites several studies that explored this issue.² Of nurses who had considered leaving the patient care field, 18 percent wanted more money, whereas 56 percent were concerned about the stress and physical demands of the job. Another study showed that 39 percent of nurses were dissatisfied with their

compensation, but 48 percent were dissatisfied with the level of recognition they received from their employer. In another survey, 57 percent of nurses were satisfied with their salaries, but only 33 percent felt that their facilities were adequately staffed, and only 29 percent felt that the hospital administration responded to their concerns.³

The approach to addressing the nursing shortage should be multifaceted; increasing wages alone may in fact exacerbate the “pull” factor for nurses from the developing world.

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Postmortem Analysis and Retrieval of Implantable Pacemakers and Defibrillators

TO THE EDITOR: Recent recalls of implantable pacemakers and defibrillators have cast a spotlight on the need for improved product reliability.¹ Although it is estimated that the failure rate of these devices is low, the true rate of device malfunction is not known. The Food and Drug Administration recently stated that it supports a policy requiring that defibrillators be returned to the manufacturer to be studied for possible defects after the death of a patient.² The few published guidelines available for morticians concerning the handling of devices make no mention of routine interrogation or retrieval.^{3,4} Therefore, we surveyed embalmers or directors at 100 funeral homes in the Chicago area to determine their current practices and opinions.

The rate of response to the survey was 71 percent. Each funeral home reported providing services for an annual mean (\pm SD) of 343 \pm 437 deceased persons, and the mean percentage of deceased persons with an implantable device was 11 \pm 9 percent (range, \leq 1 to 33). Only four respondents recalled an interrogation of an implantable device. The mean number of devices removed per year was 7 \pm 10 (range, 1 to 50). Many embalmers mentioned that the most common reason for removal was preparation for cremation, because devices explode in extreme heat. The national cremation rate is 27 percent, and this rate is expected to rise to 36 percent by 2010.⁵ Table 1 summarizes the responses with regard to the disposition of devices. Several respondents re-