tine in the shredded tobacco paper of the three types of Eclipse we tested were very similar. Eclipse contains and potentially delivers the same amount of nicotine as conventional cigarettes. The basis for the description of different styles such as "full flavor" and "mild" is not explained by nicotine content or by outward appearance.

The nicotine yields listed on the Eclipse packs invite consumers to conclude that smoking Eclipse exposes them to much less nicotine than smoking conventional cigarettes (Table 1). However, available data indicate that nicotine (and carbon monoxide) intake by people smoking Eclipse is similar to that from smoking conventional cigarettes.[4,5] Thus, as is the case for conventional cigarettes, standardized machine-determined nicotine yields for Eclipse are poor predictors of actual nicotine exposure.[1] Any health risks related to nicotine (and/or carbon monoxide) would be expected to be similar in Eclipse and conventional cigarettes. The potential benefits of lower risks via reduced exposure to other toxins from smoking Eclipse (vs conventional cigarettes) remain to be explored. □

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Emergency Department Costs

I concur with the recent paper titled "US Emergency Department Costs: No Emergency" that it is a misconception that high emergency department use causes high medical costs.[1] As the authors explain, many of the costs of an emergency department are fixed. As a result, the true costs of accommodating nonemergency visits represent only marginal costs. My concern about inappropriate emergency department use is based primarily not on costs but on the type of care rendered.

The actual costs associated with inappropriate emergency department use are, in my opinion, much greater than the simple economic measure. As the authors note, "non-urgent [emergency department] visits symbolize our failure to provide accessible primary care to all." Their data confirmed that groups with reduced access to primary care—the poor, the uninsured, and Black men—are disproportionately dependent on emergency departments. The additional costs associated with treating an infant's ear infection in the emergency department as opposed to a family practice clinic are probably not substantial. But if that child lacks immunizations or is falling off the growth curve, the substituted emergency room visit will represent a missed opportunity for prevention. It is probable that the marginal costs for seeing a 48-year-old Black man with eczema or a 27-year-old woman with bronchitis would not be that much greater in the emergency department than in a primary care physician's office. However, if the patient uses tobacco, has early prostate cancer, or is overdue for a Pap test, it is unlikely that those issues will be addressed in the emergency department. In contrast, primary care physicians are expected to manage the individual's health by providing longitudinal care and continuity of care for both acute and chronic conditions as well as clinical preventive services. If done correctly, this can result in considerable long-term savings and improved outcomes that are not reflected in emergency department marginal cost calculations.[2]

Emergency departments exist to respond to life-threatening emergency and urgent conditions and represent appropriate supplemental sources of care for individuals already being cared for by primary care providers. In large urban centers, such as Los Angeles, low-income, inner-city residents tend to use emergency departments as a substitute for the family doctors they do not have.[3] Since this is their only source of care, their care is fragmented, uncoordinated, incomplete, and inappropriate. Clearly, emergency departments have a most important role in such a system, but they should not be considered substitutes for comprehensive primary care, regardless of their low marginal costs. □

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We agree with Dowling that the emergency department is not an optimal setting for primary care. But we doubt that allowing patients access to an emergency department is an important cause of inadequate primary care. Restricting patients' emergency department access, an increasingly popular measure among health maintenance organizations, neither improves primary care for those without access to other primary care sites nor saves much on patients who use the emergency department as an occasional supplement to their usual caregiver. For the uninsured, and many of the poor, the emergency department is not a substitute for comprehensive primary care but an alternative to no care at all. Even for many with coverage, barriers to emergency department care shut off an important place of refuge and assistance for the frightened or troubled.

It is poor public policy to punish or proscribe emergency department use without ensuring better and more practical alternatives. Our present system is inefficient and inhumane by many measures: a