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

growing number of uninsured and underinsured individuals, undue emphasis on technical interventions and increasing neglect of the human side of caring, high administrative costs and outrageous profits, care that is too often of poor quality and delivered in inappropriate settings, and financial incentives for doctors that set them at odds with patients. National health insurance offers an affordable option for universal access without punitive restrictions. □

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The Quality of Data Reported on Birth Certificates

The letter by Kirby[1] recommending a moratorium on the publication of statistical analyses based on the check-box items from birth certificates was stimulated by an article by Watkins et al.[2] The check-box format was adopted in the 1989 revision of the US standard certificate of live birth because previous efforts to obtain information via open-ended questions had resulted in inappropriate, inconsistent, and incomplete entries, along with underreporting.[3,4] Data from check-box items have been used to accurately monitor changes in attendant and place of delivery, changes in cesarean delivery and vaginal birth after cesarean delivery, and patterns of tobacco use among pregnant women.[5–7] Despite the new format, Watkins et al. corroborated our own analyses indicating that check boxes have not overcome the problems inherent in detecting and reliably recording congenital anomalies as part of the birth registration process.

Watkins and her colleagues do an excellent job of pointing out the limitations of information about congenital anomalies reported on birth certificates. The key problem is substantial underreporting of birth defects on the birth certificate. Watkins et al. conclude that for even the most obvious anomalies, the birth certificate is not a good source of such information.

Despite its shortcomings, we agree with Watkins et al. that information about congenital anomalies from the birth certificate can be used "as long as one remains cognizant of the limitations," and we also agree that birth certificate data provide "at least low-end estimates of birth defect rates." Moreover, the information reported has been shown to be useful for identifying populations at risk and for suggesting avenues of more in-depth research, although the data are probably not adequate for case–control studies. We therefore continue to recommend that information about congenital anomalies from birth certificates be used with great caution. The severe limitations of the check-box format in terms of congenital anomalies do not apply to other check-box items, and the recommendation of a moratorium is unwarranted.

The vital statistics system operated by the National Center for Health Statistics (NCHS) and its state partners is in transition; electronic birth registration has become common, and the periodic process of revising the US standard certificate of live birth will soon begin. One challenge to the National Vital Statistics System is the fact that hospital stays for delivery have shortened, sharply reducing the time available to collect the information needed to complete the birth certificate. However, meeting these challenges in a way that ensures data quality and completeness is a high priority of NCHS and the states. □

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Ethical and Health Implications of Directive Counseling on Long-Acting Contraception

Moskowitz and Jennings[1] propose to override widely accepted principles of informed consent, according to which clients have the right to make their own decisions about contraception in an unpressured atmosphere.[2] These principles form the basis of the declarations on reproductive health and rights adopted at the international conferences recently held in Cairo and Beijing.[3] Instead, the authors suggest adopting a medical model based on a counselor's judgment that long-acting contraception is in a woman's "best interest." In our opinion, the only people capable of asserting their best interests are clients themselves.

The proposal ignores lessons of history in the international family planning field. As one example, recent work has demonstrated that a "cafeteria approach" with contraceptives is more successful than restricting methods[4] (whether through nonavailability or directive counseling).

To reduce unwanted pregnancy and improve reproductive health, we would, first, strongly advocate risk reduction counseling for men, unconventional but critically important clients in family planning settings. Recent work in both the family planning and acquired immunodeficiency syndrome (AIDS) prevention fields is turning toward the man's role, and communication between partners, to achieve long-term protective behaviors in a couple.[5]

Second, we would support greater education about postconception techniques when prevention fails (emergency contraception and abortion).

Third, we would urge a renewed focus in family planning clinics on preventing disease. The chasm between family planning and human immunodeficiency virus (HIV)/sexually transmitted disease care providers must be bridged in order to give women access to the full gamut of reproductive health services in one visit.[6,7] There are many good reasons why this integration should be located in the family planning clinic.[8]

Moskowitz and Jennings maintain that directive counseling on long-acting contraceptives is designed for women's own protection from risk. They would do well to ask themselves, "Risk of what?" Although they touch briefly on the role of condoms in family planning clinics, they fail to address the concrete scenario of a woman at high risk for both HIV/sexually transmitted dis-