Support for hospital-based HIV testing and counseling: a national survey of hospital marketing executives	467
Determinants of breast cancer screening among inner-city Hispanic women in comparison with other inner-city women John P. Fulton, William Rakowski, and Anne C. Jones	476
HealthScope: a model for a low cost health education program using commercial television Kathryn L. Braun and Christopher R. Conybeare	483
Review and needs assessment of materials designed to prevent tobacco use Elaine Bratic Arkin, Joseph G. Gitchell, and John M. Pinney	492

INFORMATION TECHNOLOGY

NCHS under full sail on the information	highway
Sandra S. Smith	

PHS CHRONICLES

The first edition of 'The Ship's Medicine	Chest'	(1881)	504
John Parascandola			

NATIONAL CENTER FOR HEALTH STATISTICS DATA LINE

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Study of nuns turns up clues to brain aging and Alzheimer's disease, Bernardine A. Moore — Largest global study on cocaine use undertaken by WHO, UN — WHO announces 1995-96 influenza vaccine formula - World Health Organization's World Health Report 1995 leading selected causes of mortality, morbidity, and disability — Supreme Court ruling provides needed criterion for vaccine injury claims - Occupational Health and Safety Institute scheduled for Minneapolis - CDC clearinghouse offers new HIV-AIDS treatment information service — New journals on injury prevention, public health management appear - Johnson program seeks community health leaders - Oral health data base fact sheet and thesaurus available from NOHIC - PHS slates conference on women's health in medical education.

EDITORIAL	
A new Public Health Reports	. 512
Subscription Information	382
Information for Contributors	466
Important Notice	Cover 3

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506

508

the previously noted period took disciplinary actions against about 8,000 physicians while hospitals reported about 3,100 practitioners to the Data Bank.

There are a number of possible explanations for the minimal levels of hospital reporting. One is that some hospitals may be circumventing the Data Bank reporting requirements by deliberately taking adverse actions that fall below the reporting threshold. Another is that hospitals, in accord with the continuous quality improvement principles, may be deemphasizing or even avoiding entirely adverse actions against poorly performing practitioners. Still another is that some reportable actions may not in fact be reported to the Data Bank. Given the little that is known about what happens inside the "black box" of hospital quality assurance programs, it is extremely difficult to assess the significance of any of these possible explanations. But each warrants investigation.

One conclusion about which there can be little doubt is that the very existence of the Data bank will continue to be controversial. Even if tensions concerning usefulness, impact, accuracy, timeliness, and the like are defused, pressures to open up access to the Data Bank will almost certainly keep the Data Bank in the spotlight as a "hot-button" issue. And as advances in information and medical technology move us toward what The Economist concludes will soon become a patient-driven health care system (6), these pressures to open up the Data Bank are unlikely to abate.

In this environment, it is vital that considerations of the Data Bank be grounded in objective realities on how it is functioning. Identifying those realities will not necessarily settle differences in perspectives and expectations of the Data Bank, but it could contribute to more intelligent decision making and public policy concerning it. Oshel, Croft, and Rodak make a useful contribution toward that end.

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