practice?—then the public policy question is how to use the instruments of government to get institutions to develop and enforce safe systems.

Like Mr. Levin, I favor more regulation, not less. But I support a different kind of regulation. I would like to see boards, departments of public health, the Health Care Financing Administration, and others set and enforce standards that would ensure patient safety rather than just react to egregious episodes. We know many of the causes of errors and do nothing about them: long hours, excessive workloads, inadequate training, sloppy procedures, poor supervision, and so on. Why aren't boards of medicine and nursing more concerned about these causes of patient injury? Why are residents allowed to work 24 hours a day? Nurses to work double shifts? Why aren't all hospitals required to adopt safe medication practices, such as unit dosing, pharmacy mixture of intravenous medications, and computerized ordering? Why aren't hospitals required to establish standards of professional conduct and competence and enforce them?

It is not just the doctors and hospitals that have failed to take responsibility to protect the public; so have our instruments of public policy. There's enough blame to go around, but the time has come to go beyond blame to change our systems both inside the hospitals and out.

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Hearing Impairment Data

I am writing to comment on the article "Deafness and Mortality: Analyses of Linked Data from the National Health Interview Survey and National Death Index" (Public Health Rep 1999;114:330-6). The national data reported were based in part on the 1990–91 Hearing Supplement to the National Health Interview Survey, which was cosponsored by the National Institute on Deafness and Other Communication Disorders (NIDCD). A previous National Center for Health Statistics (NCHS) report compared the 1990–91 findings to those from two earlier Hearing Supplements conducted in 1971 and 1977.[1] One important result from the 1990–91 Hearing Supplement was that the prevalence of reported hearing impairment for US adults had increased 14% since the first Hearing Supplement in 1971, after allowing for the "aging" of the population. This increasing prevalence of deafness and other hearing trouble in the US underscores our need to better understand the relationships between hearing impairment, other conditions, and activity limitations, health care access, and risk of mortality.

The article by Barnett and Franks contributes important information to this discussion. After adjustment for sociodemographic variables and self-reported health status, they found that subjects with postlingual deafness (per their definition) did not differ in mortality risk from control subjects. The one caveat was that the adjustment for health status included restrictions in daily living, some of which may have been affected by deafness. Because of this and other limitations to the available data, the authors concluded that in future national surveys special consideration should be given to increasing the sample of deaf individuals and improving the description of hearing loss categories, which will permit more informative analysis of the deaf population.

The NIDCD is continuing to work with NCHS in co-sponsoring more detailed studies of hearing impairment in the US population. One result of this interagency collaboration is that the Fourth National Health and Nutrition Examination Survey (NHANES IV), 1999–2004, has begun conducting hearing examinations on a nationally representative sample of the US adult population ages 20 to 69 years. This is the first nationally representative hearing examination survey of US adults since NHANES I, 1971–75. Many other health conditions of participants in NHANES are assessed simultaneously. We expect that these data will provide more detailed information on hearing loss categories and other associated health conditions for the US population. Also, in 1997 the National Health Interview Survey (NHIS) was revised. Each year this survey provides new estimates of the number of hearing impaired in the population. By continuing to strengthen national surveys, we will increase our knowledge of health conditions associated with hearing loss and the implications for improving the years of healthy life for deaf individuals. NIDCD is committed to achieving this goal.

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***PHR* Readers:**
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