Letter from . . . Chicago

Auctioning Brenda

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It seemed at first that the professor's decision to sell his intern in an auction merely served to confirm the thesis that conscience is self-eliminating. For, although he remembered that ruin and tragedy are the inevitable outcome when each herdsman goes on increasing the number of his cattle on the common pasture,[1] he had forgotten Professor Hardin's admonition that acts of conscience are ineffective; that if you alone cut down the size of your herd the others "will secretely condemn you for a simpleton who can be shamed aside while the rest of us exploit the commons"; and that nature herself has set up "a selective system that works towards the elimination of conscience from the race."[1] A bad conscience is a kind of illness, said Nietzsche —probably meaning that if you alone turn down your thermostat in the middle of January you alone will catch penumonia, while your less conscience-stricken neighbours carry on as usual in their overheated houses. And if you alone stop your intern from ordering every test under the sun you alone will have no house staff—for your intern will surely apply to work on the more academic endocrinology service, and you will most likely catch double pneumonia, firstly from turning down your thermostat, and secondly from having to go to the hospital on a freezing winter's night to treat single-handedly a patient with diabetic coma, while a team of seven endocrinology interns are valiantly struggling to save an emergency case of fulminating dwarfism.

So mused the professor during his postdiplococcal convalescence. Yet his motives had been honourable; and he remembered listening to that stirring speech on conserving energy, and stepping hard on the accelerator to get home early and quietly experiment with alternative energy producing fluids. A truly creative evening ensued, as purple clouds of Beaujolais rose higher and higher, floating up through the foramen of Bochdalek, whirling past the foramen magnum, and entering that wide expanse where the imagination knows no bounds. And then in the morning, on curing his cephalogastric syndrome by acidifying the humours with salicylates and alkalising them with baking powder, he felt sufficiently restored to spring into action.

Brenda must go

He had already considered both sides of the argument. On one hand was Brenda, a stunning beauty, with flowing blonde hair, an irresistible smile, and an unlimited capacity for work. On the other hand was the incontrovertible evidence that morbidity had risen since the firm had expanded to nine interns, four externs, 12 students, a resident, and two research fellows —allowing for a doctor:patient ratio of 9:1, not counting the junior and senior consultants. So perhaps Brenda was expendable after all; there would be no cutbacks in patient services; nor could the house-staff union object, since with appropriate cross-coverage the night call schedule would still remain at one in 35. The hospital would go on as usual. There would be no need to recall the administrator from Montego Bay for another round of negotiations. Indeed, the proceeds from the sale could be used to relocate him permanently and save more money and trouble.

Then there was also the issue of the total body lymphangiogram, which Brenda thought was part of the routine work-up of every seriously ill patient. There was the 103-year-old lady who inexplicably flipped her T waves and whom Brenda wanted to exercise on a treadmill because in her nine months of vast experience she had seen many similar patients who had responded ever so favourably to aggressive management. There was always some patient who "deserved" at least another week on the cardiac monitor. Then there were Brenda's allies to contend with, her fellow interns on the various biopsy services, who invariably took her side and supported her to the hilt, so to speak. And though Brenda's intentions were pure and her dedication unquestionable, there was trouble after trouble and argument after argument. She ordered a third CAT scan on the epileptic who had once again stopped taking his pills and had been readmitted to hospital for the nineteenth time. She insisted on a cerebral angiogram on the drunk who had not yet woken up after four hours of observation. She declared in no uncertain terms that she alone was in charge of the patients, and that attending physicians were merely to teach, advise, and consult. And the situation came to a head when she attacked supported by two legions of endocrinologists demanding that the fulminating case of dwarfism, who had already spent 100 days in the intensive care unit, "deserved" a further work-up equal in cost to the yearly budget of the Islamic Republic of Mauritania. There was no longer any doubt: Brenda had to go.

Repercussions

But if the decision to auction off Brenda was made with relatively little difficulty, the repercussions were enormous. Three students and two externs resigned, reducing the doctor: patient ratio to a critical 6:1. There were mass meetings and violent demonstrations. The Black Student Caucus issued a statement deploring the return to white slavery. The department of medicine held an all-night emergency meeting to decide whether Brenda would be eligible to take the endocrinology boards. The director of medical education insisted that the entire transaction should be a subject for a series of grand-rounds, with appropriate credits being given for continuing medical education. The public relations lady said she needed time to prepare a special illustrated brochure. The chief of personnel ruled that one could part with the position but not with the body. The director of finance said that the hospital had no mechanism for accepting the money from the sale and suggested setting up a special fund to pay for a hotline to Montego Bay. There was the

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question of Brenda signing an informed consent form before being sold. The union asked about her malpractice insurance and health benefits being continued after her transfer to her new owner. But the chief of endocrinology thought it might be more expedient to retain Brenda and work up the dwarf.

Special hearings were held in the sumptuously renovated industrial relations offices—across the hall from the operating theatre with the leaking roof. The negotiations were protracted, with the delegates of the house staff union repeatedly threatening to walk out. At last an industrial arbitrator was called in to impose a settlement, and a memorandum of understanding was promulgated. In exchange for free meals on Sunday, 24-hour hair dressing services, and an abolition of all forms of night-call, the union agreed to a quiet auction, to be conducted by placing a dignified advertisement in the *New England Journal of Medicine*, soliciting bids in writing. This done, the mailroom was immediately flooded with offers.

There were letters from Shiraz, Riyadh, Tripoli, and Patagonia; from a mining company in Zambia; from several Navajo reservations; from the Endocrine Society; and from a county the size of Greenland with no doctor to support the activities of the local hospital. There was an unacceptable offer from a community hospital stipulating that Brenda had to take call one night in three and was not to order total body lymphangiograms without the private doctor's permission. There was another hospital requiring Brenda to order a minimum of 50 radiographs a week; and there was a welfare doctor insisting she had to see 110 patients a day. There were letters from manufacturers of biopsy needles, CAT scanners, and cardiac monitors, who had heard of Brenda's talents, and there was a company that had developed a special geriatric bicycle to exercise 103-year-old angina suspects. A mission in Kansas needed help with an outbreak of aggressive dwarfism. A dean-in-charge-of-programme-evaluation needed a new programme to evaluate. She could take care of 15 000 schizophrenics at the State hospital; cover single-handedly two jails and a penitentiary full of dangerous criminals; moonlight in the emergency room of the hospital that had abolished night-call for its house staff; write articles for the local medical society explaining the perils of socialised medicine; or study law and specialise in malpractice. There were many other written offers. But one bidder broke the rules and applied in person. He was accepted; and hints of conflict of interest were dismissed with a shrug.

The wedding took place near Montego Bay. The former hospital administrator, now chief health planner for the north-western part of the beach (including the dressing shed) acted as best man. The house staff union sent its felicitations. The chief of endocrinology sent a vial of romance releasing hormone (RRH). The dwarf sent his photograph; and the 103-year-old angina suspect donated her bicycle.

The couple, it is reported, are blissfully happy. The professor has developed an interest in acute dwarfism. Brenda is studying the world's energy problems. She has experimented with alternative energy producing fluids and has experienced the ascent of the purple clouds through the foramen magnum. She runs the house on a strict budget, shops for bargains at discount stores, and turns down the lights at night and the thermostat in winter. She often complains about profligate doctors who order too many laboratory tests. Next year she may go into the auditing and peer review business. But she worries about Brenda Minor, her daughter, who almost fell off the 103-year-old lady's bicycle, who hopes her daddy will buy her a seat in medical school, and who threatens to become an endocrinologist. Ever since reading *Alice in Wonderland* Brenda Minor has wondered why people suddenly become so very small. She dreams about becoming chief investigator in the dwarfism section of the National Institutes of Health. She thinks America should give more money to Mauritania. She will probably be put up for auction to the highest bidder in 1998. Meanwhile she has read *Romance on Campus*, by the author of *The Tragedy of the Commons*,[1] which explains that individual conscience, far from being self-eliminating, has its own rewards, that saving on laboratory tests may have far-reaching beneficial effects, and that reducing one's herd by one cow can lead to marrying one's intern.

Reference

[1] Hardin, G, *Science*, 1968, **162**, 1244.

A woman patient was very ill with a typical shingles rash along the distribution of one sciatic nerve, a chickenpox-like rash on her chest, and symptoms of severe encephalitis. She started to improve about 24 hours after the administration of amantadine hydrochloride and her recovery was dramatic. Was this a coincidence?

Amantadine hydrochloride (Symmetrel) is a known mild antiviral agent, so theoretically it might possibly have had a beneficial effect in this patient. Herpes zoster encephalitis is nothing like as sinister as herpes simplex encephalitis, however, and I have seen at least two patients improve dramatically after the initial severe part of the illness. I had one patient with zoster encephalitis who developed severe papilloedema and became unconscious, but after a big dose of cortisone he recovered consciousness within two hours. We did not continue the cortisone at that time so over the next 24 hours he lapsed into coma again and once more a big dose of cortisone was given and again he became perfectly conscious. He then made an excellent recovery without any complications. I therefore think that the response in this case was almost certainly coincidental.

What is the diagnostic and prognostic significance of "extrasystoles" in an apparently healthy middle-aged man?

The answer is unequivocally none. In my view these have been given far too much attention and treatment. They are common in normal people, and the patient needs only explanation and reassurance. Use of potent drugs is usually unjustified; it often fails, and this only increases the patient's concern. Benign extrasystoles usually diminish with the tachycardia of mild exercise, and this can be used therapeutically when symptoms are particularly troublesome.

Is there any danger in administering injections from ampoules that contain glass fragments from the broken neck?

Nurses are instructed to discard ampoules if broken glass enters the liquid. I have not heard of any accidents to patients, and doubt if particles that are invisible to the eye would do much harm if injected. The usual victims are nurses and doctors who cut themselves because they fail to cover the neck of the ampoule with gauze when opening it.

I am told that in Germany "diabetic wines," containing 4 g sugar per litre (or less) are available. Apparently an Auslese wine would have some 6 g per litre. Is this a realistic way of appraising suitability of wines for the diabetic? Is the degree of sweetness to the palate any guide? What other carbohydrates might there be in wines? Is a list of these factors published?

Most wines contain so little sugar that they are quite suitable for diabetics, provided of course that they are drunk in moderation. Malins writes: "One may commend the use of claret, burgundy, and the cheaper but honest wines of Spain, Portugal, Italy, Yugoslavia, and Chile" and gives the following quantities of carbohydrate per bottle: hock less than 1 g, claret and burgundy 1-2 g, sweet sauterne and dry champagne 10-15 g.[1] Obviously these are insignificant amounts in the total dietary carbohydrate intake of the diabetic. The sweeter the wine the more sugar, and while this is mainly fructose there are no doubt others. I don't know of any list, but the British Diabetic Association publishes a useful pamphlet[2] about alcohol and will always provide further information.

[1] Malins, J, *Clinical Diabetes Mellitus*. London, Eyre & Spottiswoode, 1968.
[2] British Diabetic Association pamphlet DH 122. BDA, 3-6 Alfred Place, London WC1E 7EE.