Letter from . . . Chicago

Competition

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Sleeping on the job has never been acceptable behaviour in our work-ethic dominated society, not even on a hot Chicago summer's day. So that when I found little Willie Mae Smith, our usually jovial waitress, quietly dozing behind the food counter in the hospital cafeteria, I coughed loudly until she began to stir. "I suppose you have had a rough day," I suggested. "No," she replied, "it's the blood pressure pills Doctor Blood has been giving me, and they is making me sleepy."

I said no more, for this was clearly not a case for court-martial. Nor was it any of my business if our sleeping beauty should slumber on for a thousand years from taking too much methyldopa. Yet I almost experienced a primitive territorial reaction, something akin to what Robert Audrey described in the European stickleback, the howling monkey, and the Siamese fighting fish. For, I should explain, Dr Blood is a board-certified surgeon who practises internal medicine.

Unnecessary operations

Like many of his surgical colleagues in community hospitals and even in teaching institutions, Dr Blood spends much of his time in his office treating asthma, hypertension, angina, or rheumatism; and he admits medical cases under his care to the hospital, where he gets along by calling in several subspecialists who are only too happy to consult and de facto manage his patients. Some of Dr Blood's confreres, I might add, have large surgical practices as well as aspiring to be "compleat physicians," thus approaching that state of universal knowledge so valued in the days of Paracelsus or Aristotle. But Dr Blood hardly ever operates; and his particular predicament stems from the cruel law of nature that places a limit on how many organs can be cured by the knife, just as there is a limit on how many weeds can grow in one's yard. Already those given to calumny have suggested that zealous Hippocratic gardeners are cutting down too many lilies and chrysanthemums; and now, unkindest cut of all, the nurses have also broken ranks—for in a recent poll conducted by a nursing journal nearly half of the 12 500 participants said that they thought that 30% of all operations were unnecessary.

So Dr Blood stoically wields the pen rather than the knife, prescribing cortisone instead of removing ovarian cysts, not even blaming the new-fangled second opinion programmes designed to save money and innocent gall bladders—for has he not read somewhere that such programmes actually increase the volume of surgery, especially when a second "confirmatory" opinion helps bring around an initially sceptical potential surgical candidate? Nor does he feel that peer review has cut into the surgeon's business—for, while everybody is busily reviewing everybody else's charts, the present legal arrangements make it easier for a judge to send an innocent man to the gallows than for a medical staff to restrict the operating privileges of one of its members, no matter how incompetent or impaired he may be. Besides, Dr Blood is scrupulously honest and has no quarrel with scientifically minded tissue committees insisting that every indirect inguinal hernia should yield a hernial sac for the pathology laboratory.

Yet, in this imprecise art that leaves so much room for honest scientific disagreement, we find Dr Blood's difficulties compounded by the antihysterectomy lobby, the antitonsilectomy society, and the citizens' coalition for the preservation of lily-white appendices. The Italians now claim that many women treated with a lumpectomy or quadrantectomy have the same survival rate and the same incidence of local and distant recurrences as those treated with a total mastectomy, a piece of news avidly taken up by the daily papers.[1] The radiotherapists are making cruel inroads into territories where once surgeons reigned supreme. And now the therapeutic radiologists are threatening a $1·5 billion-a-year industry by promising to achieve for $1000 by transluminal coronary angioplasty what surgeons can do for $15 000 by opening the chest[2]—just at a time when the internists have come around so nicely that you cannot go to a medical dinner without sitting near some physician who has had his coronaries reamed out for symptoms that once would have merely called for nitroglycerin.

Washoe, the talking monkey

And then there is also the trouble with Washoe, the talking monkey, who once brilliantly called swans "waterbirds" and watermelons "drink fruits" but now stands referred to as a "wild and vicious animal" in a surgeon's $2·7m lawsuit against the ape trainer, the university, and the cage manufacturer. It seems that this confrere of Dr Blood's was visiting the monkey house when Washoe pulled his right arm through the bars of the cage, bit off his middle finger, and severely damaged the nerves, muscles, and tendons of his hand, leaving him "permanently disabled." Yet, why should a learned monkey commit such a heinous act? Could too much knowledge be a dangerous thing? Was the surgeon contemplating a simian coronary bypass, or was he pointing the finger at the monkey just as an aborigine medicine man would point the bone at a disgraced tribesman? Was Washoe objecting to the noise, a factor shown to increase a monkey's blood pressure by 27%—just as blaring transistor radios on the beach may induce attacks of rage and biting in otherwise peace-loving citizens? Or was Washoe merely an internist at heart, objecting like Audrey Dart's howling monkeys to Dr Blood's impinging on his territory, indignant about Willie Mae being first overdosed with methyldopa and then admitted

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for neurological tests, with Dr Blood calling in Dr Brain to scratch the soles of her feet, stick electrodes in her scalp, and work her up for possible narcolepsy.

Surfeit of neurologists

Yet Dr Brain also has his share of trouble. Once upon a time, especially in British countries, he belonged to a consultant elite whose preoccupations transcended headaches and strokes, soaring to such lofty regions as understanding the nature of speech and thought or finding the lesion in a right-handed man who cannot draw a bicycle with his left hand—and yet all this time remaining firmly ensconced in the fold of internal medicine. But in America neurologists have traditionally made common cause with the psychiatrists, staying apart from general medicine and having separate residency training programmes and boards. Some years ago the people in charge of these arrangements decided that there was going to be a shortage of neurologists and accordingly went about increasing the number and size of their residency programmes. As a result the number of neurologists has now grown from 2000 to 6000 and may be 9000 by 1990.[3]

Yet this impending surfeit of neurologists constitutes a potential problem for Dr Brain, because the modern internist is just as well trained to treat headaches and strokes, has learnt how to order CT scans and can sometimes even read them, and also knows to call for a neurosurgeon if the patient should have something that can actually be cured. So Dr Brain may find himself short of consultations and also short of bread. He may come to rue the day when the leaders of his specialty decided to keep neurology out of internal medicine. He may indeed be willing to learn, and then compete with Dr Blood for the other members of Willie Mae's hypertensive family. Except that, since the ratio of specialists to generalists in internal medicine has become 1 to 1, he must also compete with specialised colleagues running out of endoscopies, cardiac catheterisations, or examinations of bone marrow. Then there are also the family practitioners and the primary care physicians and the new "specialists" in emergency medicine, all trying to find a place in the sun. Yet already the statistics indicate that most visits to casualty departments are unnecessary. Within two years the average number of visits to doctors' offices has declined from 130 to 112 a week; and even oncologists are delivering primary care, especially in those overdoctored sunny areas where they cannot even immunosuppress the common cold.

Reaganomics

So competition stands high in the order of priorities in these days of Reaganomics, as government regulations and national health schemes have become dirty words, and at least five legislators have introduced pro-competition Bills in Congress.[4 5] The details vary, but they all envisage people shopping around for the most attractive health plan offered by competing corporations. There would be incentives in the form of favourable tax treatment for employers, who would be allowed to deduct the premiums from their gross income, provided such premiums did not exceed a certain amount—while employees would receive a given allowance and be permitted to keep the difference if they chose an inexpensive plan. There are differences between the various Bills, but none would please the opponents of commercialism, who see an inherent conflict of interest in such arrangements and who already deplore the inroads of corporate medicine and of the medical-industrial complex[6] into the healing arts. Nor are the traditional supporters of free enterprise pleased with the administration's preoccupation with competition, viewing as they do the proposals as socialised medicine, providing a low quality of impersonal care, abolishing the free choice of doctor and hospital, leading to waiting lines at the office and hospital, and with fees set by an even more coercive bureaucracy. "There's more damned competition in medicine than in anything I know," said recently Dr James Sammons, AMA's executive vice-president—and at its recent meeting the AMA house of delegates opposed such Bills, saying that they would increase government regulations without lowering costs or improving care. And there were also fears that such restructuring of health care would sound the death knell of the individual private practitioner, with doctors ending up as employees of large corporations.

We are left then with the prospect of an uncertain decade for the profession, with many more doctors competing for what may well be a shrinking pie in what society is willing to spend on health. Throughout the current dialogue on future options we are often reminded that competition is the name of the game in the States and that it should be encouraged. We are also told that competition is not alien to the medical profession and that indeed doctors compete at all levels—in medical school, in hospitals, in academia, in office practice. Yet at the same time observers of human behaviour have long deplored the "dog-eat-dog" attitude in this society. "We know that competition turns plenty of guys real mean nasty," once wrote a sporting editor setting out to prove that sailing, hiking, and skating were preferable to competitive ball games. It has been suggested that the present administration does indeed favour a survival of the fittest approach. But it remains to be seen whether a profession already in need of more humanism needs to cultivate the hard-sell, aggressive, competitive approach in the name of cost containment, and whether the patient will benefit from the entry, or should we say the descent, of medicine into the corporate market place.

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My practice is on the South Coast and I have noticed that patients moving here from other parts of the country often develop signs and symptoms of nasal allergy and complain of lethargy. These symptoms usually improve dramatically when they are away from this area. Is there any explanation for this?

It is difficult to explain this observation without knowing more about those patients who develop the signs and symptoms of nasal allergy and about the area to which they have moved. This area may contain plants or grasses whose pollen produces nasal symptoms and which do not exist in the area from which the patients have come. These pollens might not affect local residents, who would have developed immunity over the years. Alternatively, the patients may have moved from areas with a low pollen count to an area with a high pollen count. The question does not state if this observation relates to seasons or not. Has the observation resulted from a sudden rush of consultations at a time when the pollen count is high or is this something which the questioner has observed over a period of years? If so what proportion of the immigrant population are so affected? As to the symptom of lethargy, there are several possible explanations for this. Congestion of the mucous membranes alone is a cause. Moreover, congestion and discomfort arising from this may interfere with sleep, thereby causing tiredness and lethargy. Finally, lethargy may result from self-medication with "hay fever" remedies, which may contain antihistamines.—M R P HALL, professor of geriatric medicine, Southampton.