Letter from . . . Chicago

Insider medicine

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Last year the physician general collaborated with the collector of rare diseases to send three cases of Wolff-Parkinson-White syndrome to Upper Volta in exchange for five cases of Loa loa, ten cases of white wine, and two machine guns. From Ougadougou the worm victims travelled across the desert in great secrecy. In the back room of a Cairo brokerage house they were exchanged for six cases of classical schistosomiasis. These were diverted to Leningrad and swapped for a handful of giardia infested dissidents, who were traded first for two rare Israeli specimens of periodic Mediterranean fever (with amyloid) and later for two Americans with an unusually favourable third party insurance pattern. The Americans were smuggled back to a United States hospital by the CIA. Here they were exchanged for a 99 year old demented woman who had outstayed the diagnosis related groups (DRGs) and a young man with a gangrenous hernia on whom payment had been denied because the reviewer said that the surgery should have been done as an outpatient. During the ensuing scandal a bedraggled hospital finance officer admitted that he had received insider information that the quota for denials on hernias still needed to be filled, whereas the Wolff-Parkinson-Whites could stay as long as they wanted, provided that the surgeons refrained from cutting up their various and incomprehensible conduction bundles.

A few weeks later a man who had lingered too long near those ten cases of white wine staggered into the emergency room complaining of weakness. A scrupulous physical examination by an intern from Upper Volta showed that he had no worms crawling across the whites of his eyes but instead a large inguinal hernia. He was admitted to the ward of a resident from Egypt who thought that the man was too young to be incommoded by the DRGs and could wait to have his surgery a few days later. The patient seemingly disagreed and went into delirium tremens (DTs), to the great consternation of the Egyptian resident who diagnosed acute Creutzfeldt-Jakob syndrome and was under the impression that DTs was a local brand of snail killer. But the nurses put the patient in restraints, where he aspirated in the middle of the night; became anoxic; was intubated by the recently arrived exchange student from Leningrad; developed pneumonia; was given gentamicin by the resident from Israel; went into renal failure; had a chest tube inserted after the pulmonary fellow tried to tap the postneumonic effusion; and astounded the whole international crowd by recovering. He also survived a stint on the chest ward, where a surgeon from Lower Volta and his intern from Upper Egypt worked hard to find out why so much pus was coming from the chest tube. He went home cured of his DTs, still bothered by his hernia, and anxious to find out what happened to the remaining cases of white wine.

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Hopeless bear market

In the books of the reviewers he clearly figures as a justified admission. If he were old enough to be on Medicare the hospital would be paid for at least 10 of his 120 hospital days. He also falls outside the national average length of stay for 1985 of 7·7 days; and he helps but little the statistics indicating that the rate of hospitalisation in the United States is lower now than ever in the past 15 years, an indication of a hopeless bear market. But neither the insiders nor the outsiders were surprised to hear that in Illinois the current average daily cost of staying in hospital is $665—of which $280 covers bed and board (in surroundings varying all the way from the Salvation Army to the Hilton), while the rest pays for the laboratory, pathology, and pharmacy. The doctor's fee is extra—if he gets paid at all. But then something inspired the Secretary of Health and Human Services to prepare for the president a report described as confidential and therefore published in every newspaper, also on the basis of insider information. The proposal was to provide coverage for catastrophic illnesses, thus running against the president's views of shifting more of the responsibility for health care from the federal government to the states and the private sector. No point then in describing how the employers, the states, the insurance companies, higher premiums, and tax credits would pay for this project because we may never hear about it again, despite the Democrats taking over the Senate. Yet the confidential memo is reported to have concluded that "the threat of catastrophic illness is real" and that the solutions will become harder to find as the population grows older.

One way to prevent trouble with hernias would be to send every patient straight to the subspecialist, bypassing the Sir William Oslers and other complete physicians. Once in New York a patient had paid primary care doctors multiple $80 bills for check ups and tune ups yet continued to have angina on exertion, on accelerating, and on turning to the left, but subsiding on rest or idling. Though barely 10 years old, he was already earmarked for a nursing home in a heartless society that has neither time nor respect for the aged. Then the local paper had an article on how a specialist autodoctor had diagnosed exactly the same symptoms as indicating carburettor trouble. The final outcome was that a carburettor specialist took a carburettogram and fixed the trouble promptly and cheaper than the bumbling generalists.[1]

It follows that our man with the hernia and the DTs might have done better with Dr McHernia.[2] This surgeon, who specialises in one procedure only, repairs 20 hernias a week in a private clinic without ever causing pneumothorax. A graduate in economics, he charges only $1250 a hernia compared with the hospital's $4000, presumably on the same principle that allowed small airlines to compete successfully with the larger carriers. He also believes that in medicine practice makes perfect, his actual motto being "your rupture is our rapture." In this singleminded approach he is joined by other surgeons specialising exclusively in varicose veins, haemorrhoids, or circumcisions. Yet none of these surgeons ever get bored. The varicose vein man explained to the newspaper that he had never seen two veins that looked alike. The other surgeons were not interviewed.

But on the medical side specialisation can also be exciting in these days of overseas travel. Hence the specialty of emporiatics—derived from the Greek emporium, to travel—and said to be found in the dictionary, though not in mine. Imagine the excitement of working with a patient returning from a trip to Upper Volta, Egypt, Leningrad, Jerusalem, and the CIA. Some universities have even set up travel clinics that can tell malaria from flu, hookworm from abdominal migraine, and Hantaan river disease from Lassa fever. Not only do they offer advice on immunisation, boiling water, and where to exchange dollars, but also on jet lag, altitude sickness, moving one's legs to prevent venous thrombosis, avoiding raw fish to escape tapeworm infestations, or not going to Leningrad at all.[3] Yet all this could bring emporiatics into competition with the 850 members of the Wilderness Medical Society, who take care of adventurous "basically healthy, happy people" who get into trouble scaling heights, climbing mountains, scuba diving, hiking or skiing, getting lost in deserts or canyons, developing hypo- or hyperthermia, or bumping into sharks, sea urchins, poisonous snakes, vibrios, or toxic plants.[4] Better then to stay at home and become doctor to the Chicago Bears, a quicker way to fame than writing 100 papers on giardiasis, though not since the terrible defeat by the Redskins. More élitist in some ways is arts medicine, which may require helping artists with the acquired immune deficiency syndrome (AIDS), rape, or skin disorders; or focusing on clarinet players' thumbs, lutists' wrists, or violinists' backs and chins. Special skills are needed to handle correctly musicians' "overuse syndrome—an unfair reward for zeal and application."[5]

Dangers of wind instruments

It may likewise require an odontologist to counsel wind instrumentalists on the effects of prolonged intraoral pressure, to advise in selecting a wind instrument, and to carry out periodic check ups. The odontologist may have to match the type of dental occlusion —neutroclusion, distoclusion (the Bugs Bunny appearance), or mesoclusion (the bulldog faces)—with the instrument to be used. Wind instruments, incidentally, were classified as early as 1939 according to their mouthpiece into cup shaped (trumpet, horn, trombone, and tuba), single reed (clarinet, saxophone), double reed (oboe, bassoon), and aperture (flute, piccolo). Wind instrument players also run the risk of developing subcutaneous emphysema, palatal paralysis, or patulous eustachian tubes. The otolaryngologist may have to deal with pharyngoceles and laryngoceles; the pulmonary physician with asthma, bronchitis, or problems with breath control; and the insider physician with smuggling trumpets and flutes in exchange for hookahs and hubble-bubbles.

The physician caring for singers may need to advise about stagefright and whether to take propranolol; also about using other drugs or having surgical procedures that could adversely affect the voice. He needs to warn against excessive fatigue and mental strain; and should advise the singer to select roles that are within a comfortable vocal range and will not damage the voice. But the arts physician inclined towards emergency care may prefer to limit himself to providing first aid at the opera. He may then find himself quietly carrying out cardiopulmonary resuscitation during the soldiers' chorus of *Il Trovatore*, or taking care of young people fainting in the standing room only area. He may need to treat the sprained ankles of high heeled socialites rushing to take their seats before curtain, or dress the wounds of spectators coming to blows over the merits of their favourite tenor or the demerits of talking, humming, or eating popcorn during the performance. But the more contemplative natures may prefer to indulge in armchair speculations about the skills and qualifications of Doctors Malatesta, Spinelloccio, Caius, Dulcamara, and Miracle, of the practitioners from *La Traviata*, *Il Forza del Destino*, and *Wozzek*, of barber surgeon Figaro, or the phony Mesmerian impersonator Despina.[6] All of which and much more is discussed in last spring's issue of the *Cleveland Clinic Quarterly*.[7]

Darker side to specialisation

Yet there is a darker side to this specialisation. Listen to the complaint of a generalist who finds that each specialist acts as a member of an insider group bent on blowing out of proportion the importance of his particular discipline.[8] He thus believes that "our teachers have let us down" because they have swamped him with so many instructions on what to do that he has ended up confused and dissatisfied. Already he spends 45 minutes on a routine history and physical and writes at least one page of notes, which to him seems reasonable and to most general practitioners around the world probably excessive. But now he is upset because he has read an article by a geneticist who lists half a page of questions to be asked and provides a blank family tree to be filled in with dots and squares. He frets because he was told that every patient needs a complete neurologic examination, when he has long ago given up scratching and pinching people who have no symptoms referrable to the nervous system. He does not even make them grimace or wiggle their toes, nor (oh blasphemy) does he routinely carry out the ancient ritual of striking their knees with a hammer ("by the way, does anyone know what that's supposed to reveal anyway?" he asks irreverently). But the pretty young dietitian thinks that she should spend more time taking a nutritional history; the psychiatrist insists that a complete mental evaluation should be routine; the eye doctor claims that everybody needs visual fields and colour vision testing; the cardiologist insists on a routine examination of the heart in three positions; and the nose doctor is the real pits. Not only does he think that everybody should have his turbinates checked but he is pretty arrogant about it. "But," asks the generalist, "what should I do as a routine, in about two minutes?" "You can't do anything in two minutes," comes the stern reply, "the only reasonable exam is a thorough one, and you would not feel comfortable missing . . .?"—and here comes a long list of all the diseases of the nose.[8] All of which leaves the generalist frustrated and eventually ready to participate in one last grand scheme: to exchange four nose specialists, three cardiologists, two dietitians, and one geneticist for a partridge in a pear tree.

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