Letter from . . . Chicago

Matters of turf

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The prevailing economic doctrine of the day holds that the public always stands to gain from increased competition in the market place. Under this doctrine, enthusiastically embraced by the Federal Trade Commission, sick "consumers" will get well quicker, cheaper, and more conveniently if all kinds of people are allowed to set up shop and start playing doctor.[1] As a result optometrists compete with ophthalmologists, exercise physiologists substitute for cardiologists, respiratory physiologists offer to treat emphysema, and colonic irrigators obviate the need for gastroenterologists. Nutritionists are setting up independent cholesterol lowering practices; nurse practitioners see patients on their own, charging $25 for a house call; and dental hygienists are happy to be rid of the dentist as they polish their clients' teeth for that wonderful bright smile. Psychologists set up fashionable Jungian or Freudian consulting practices in affluent neighbourhoods without bothering about psychiatrists; chiropodists reach towards the knee or even above, though facing competition from the podiatrists; and even "our long term allies the pharmacists" are clamouring for a piece of the action.[1]

Another group, the chiropractors, though never in danger of being our allies, are also benefiting from competition economics. They have indeed come a long way in the 100 years since their visionary founder renounced mesmerism and phrenology in order to massage and manipulate backs.[2] Yet they had repeatedly been denounced as ineffective, dangerous, and unscientific by their more advanced "allopathic" brethren who had long ago discovered leeching, cupping venesection, and later moved on to colectomy for focal sepsis, gastric freezing for ulcers, and hyperalimentation for everything else. Ethics were invoked, under which a doctor could no more associate with a chiropractor than a high caste shastri with an untouchable. Yet over the years chiropractic steadily gained ground, abetted by a lobby of grateful patients and some excellent lawyers. In 1979, under an agreement reached with the American Medical Association, the chiropractors moved up a notch, so that physicians could now associate with them without risking contamination.[2] But even this was not enough for an upward moving caste. For almost a decade legal skirmishes continued; and again the 30 000 strong chiropractic profession won out over their powerful rivals. In September a federal judge ruled that the American Medical Association had indeed violated antitrust laws and caused an "unreasonable restraint of trade" by "orchestrating a campaign to eliminate the chiropractic profession" through boycotts, denials of reimbursement or hospital privileges, and rules forbidding doctors to refer patients to chiropractors or work with them. The judge then ordered the American Medical Association to inform its members within 30 days, as well as publishing in its journal, that doctors were free to associate with chiropractors if this seemed to be in the best interests of the patient. While the lawyers for the chiropractors hailed all this as a major breakthrough the American Medical Association announced that it would appeal against the decision.

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Pharmacists entering doctors' territory

Another group of professionals, or what are nowadays so charmingly described as "health care providers" or "vendors," are the pharmacists. Being human as well as professional these vendors are not above also wishing to expand their turf. Hence the kindly, white coated chemist has never hesitated to suggest a remedy for a cold, a cough, a pain, or a bout of indigestion. In recent years, moreover, his armamentarium has been considerably increased by certain remedies such as antihistamines, minor tranquillisers, or diet pills being available for sale without prescription. From here it was only one more step for pharmacists to be allowed to prescribe, a right achieved in certain states, notably Florida, and greeted by consumer advocates as yet another important gain for the public. In teaching hospitals, meanwhile, graduates from pharmacy schools have increasingly been assigned to intensive care or surgical units, acting as consultants on drug interactions or on determining the proper dose of drugs in altered metabolic states such as uraemia or liver failure. Again, it was only one further step for some of them to start functioning as de facto doctors. This would happen especially on surgical wards, often in neurosurgery or transplant units, where the surgeons would be operating all day, leaving the more mundane aspects of care to nurses, medical students, the occasional intern who could be spared from the other end of the retractors, and, increasingly, the pharmacists. Dressed in white and addressed as doctors, these doctors of pharmacy at the hospital thus joined their colleagues from the chemist shop in making increasingly deep forays into doctor territory.

Recently, however, the pharmacists may have been getting back some of their own medicine. Since time immemorial medical doctors have transgressed over the thin line separating the professions by selling and dispensing drugs from their offices. This popular means of supplementing the often meagre income derived from cognitive activities has become even more important in these days of falling revenues. It has grown considerably in recent years with the advent of so called repackaging firms that buy drugs wholesale and package them in small containers that may be easily dispensed from the doctor's office. So far about 5% of practitioners are believed to be dispensing drugs but the practice is growing, and it could add as much as $20 000 to the yearly income from a busy practice. By 1995 nationwide sales have been predicted to rise from the current $500 000 to $1 billion a year.

Not surprisingly prescribing by physicians has become the focus of controversy. Despite the apparent satisfaction of a consumer oriented public that places a high premium on one stop shopping, opponents of this practice worry about the conflict of interest of doctors prescribing medications on which they make a profit. They could overprescribe, overcharge, prescribe unnecessarily, or favour

the drug that they are trying to move off their shelves and in the process degrade a distinguished profession to the level of a trade. It has been argued that doctors are advisers, not vendors—despite the notices from government agencies. Selling medicine could be viewed as being no different from the church selling indulgences. Nor is the potential conflict of interest resolved by the American Medical Association's new ethical guidelines, which support the doctor's right to dispense drugs provided that it is done in the patient's best interests. In addition, dispensing doctors must face the inconvenience of keeping records and maintaining inventories, the risk of losing money on outdated drugs that cannot be sold, and the restriction of having limited prescribing options.

Attempts to restrict prescribing by doctors

Yet the main opposition to dispensing by doctors predictably comes from the pharmacists. This has resulted in a coalition of pharmacy and retail store organisations persuading a congressman to propose a bill prohibiting doctors from dispensing drugs for profit. The bill, which emerged successfully from a congressional subcommittee, limits dispensing by doctors to emergencies and some rural areas. It seeks to protect the public from a perceived conflict of interest and to preserve the present system of checks and balances by maintaining the separation between the medical and pharmacy professions. Opposing the bill were the American Medical Association, the drug repackaging firms, and the Federal Trade Commission, which viewed the legislation as anticompetitive, restrictive of trade, and harmful to the consumer. The commission pointed out that dispensing by physicians enjoyed a long tradition, and that until some 30 years ago "the family physician who made house calls and dispensed medication was a familiar figure," whereas nowadays the patient received a prescription and needed to make a special trip to the pharmacy. Prescribing by physicians would increase competition and benefit the consumer, thought the Federal Trade Commission, whereas legislation to the contrary could lead to federal antitrust charges.

Some economists, too, think that the public benefits from having the various services integrated under one roof, and that in fact the doctors' prices are often lower than those in the drug stores. True, the doctor could overcharge, but in today's educated consumer world he would soon be found out and lose both his patient and his reputation. The overcharging argument also loses much of its force when you consider the enormous mark up in pharmacies on certain widely used drugs such as antihistamines. But be that as it may, the antidispensing bill was sent to another committee for evaluation of possible antitrust violations. It may well die there because it lacks public interest and support.

Another problem, that of rising drug prices, recently also led to a congressional hearing. It was suggested at the time that the drug companies were taking advantage of the people who needed their products, that prices charged for new drugs were excessive, that the price of old drugs was rising by almost 10% a year—three times the rate of inflation—and that drug companies were charging what the market would bear. The drug companies countered by pointing to the high cost of research and development, the need to obtain approval to market new drugs, the growing competition from generic manufacturers, the inherent uncertainties of marketing a new product, and the risk that its commercial life would be cut short by an unforeseen adverse reaction or by the introduction of a similar but better drug. They also suggested that compared with the overall cost of living, the price of drugs was by no means excessive.

Another point of view, moreover, is to think of the drug firms as competing with the hospitals for a relatively fixed health budget and to interpret the present boom enjoyed by the pharmaceutical industry as the outcome of several decades of innovation and discovery. During this time new antibiotics, antihypertensives, and antacids—to name just a few—have transformed radically the way that medicine is practised; and it is not without reason that the profits of drug companies are soaring while those of hospital corporations have declined and hospitals throughout the nation are closing. This revolution, which began at the end of the second world war, has gathered such momentum within the past few years that fewer patients need the services of the hospital than ever before. Thus, we no longer admit patients to control their blood pressure; patients with heart failure nowadays rarely linger in hospital but undergo outpatient diuresis and "afterload reduction"; and an entire hospital industry of treating peptic ulcers by bed rest or surgery has been wiped out as people stay at home taking ranitidine or famotidine. A patient with chronic renal failure may now be dialysed through a subclavian catheter inserted as an outpatient without ever setting foot in a hospital whereas a decade ago he might well have occupied a hospital bed for an aggregate period of six months. All this progress has been achieved with new drugs and new devices, causing enormous translocations and changes in the way that the money is spent and medicine is practised as the new ways develop and the old ones vanish.

References

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ANY QUESTIONS

What are olfactory hallucinations, and do they tend to occur at any time of the day?

Olfactory hallucinations are subjective olfactory images that arise without the aid of external stimuli and are most often seen as a manifestation of epilepsy. In modern terminology they occur in patients with partial seizures that originate from medial temporal lobe structures, particularly the uncinate region; this used to be called temporal lobe epilepsy. The olfactory hallucination may occur alone, in conjunction with an alteration of consciousness composed of depersonalisation or a dream like reminiscence, or as an aura to a full blown major convulsion. Typically the hallucination is accompanied by a characteristic smacking or pursing of the lips or chewing, tasting, or swallowing movements. The hallucination is almost always of the same odour in any one particular patient, though the patient often finds it impossible to give a precise description of it. Olfactory hallucinations are rarely pleasurable and are often described as unpleasant; a smell of burning, of a freshly opened grave, and of rotting flesh are some of the descriptions used. Olfactory hallucinations are commoner in those patients whose epilepsy is caused by tumours rather than by atrophic lesions.

Patients experiencing olfactory hallucinations as a manifestation of migraine have been described.[1 2] In such cases the olfactory hallucination often persists for many hours, which clearly differentiates it from an epileptic phenomenon. The pathogenesis of olfactory hallucination in migraine is thought to be medial temporal lobe ischaemia. Olfactory hallucinations are rarely seen in toxic confusional states such as delirium tremens, in which visual hallucinations are more common. To the best of my knowledge none of the different types of olfactory hallucinations occur at any particular time of day. Olfactory illusions are false interpretations of olfactory stimuli and are seen in patients who have suffered damage to the olfactory nerves usually as a result of head injury. In such instances the patients have some impairment of smell but they also describe many odours as smelling different and being unpleasant. Occasionally patients are deluded to the extent that they complain of a distortion of their own body odour, which they think is a continuous and powerful unpleasant smell. Such patients do not usually pose diagnostic difficulties in differentiating their condition from olfactory hallucinations.—N E F CARTLIDGE, consultant neurologist, Newcastle upon Tyne.

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