Letter from . . . Chicago

The locker room and the doctors' lounge

GEORGE DUNEA

Locker room language at the gym is forceful, vulgar, and realistic. Its vocabulary abounds with expletives, its philosophy is to the point: "I made out good with that broad last night," says young Joey. "The old lady is on a rampage again," says an older Joey. "It's a bitch getting old," says an even more ancient Joey, puffing and sweating after a game of handball, his outlook quite different from the more sedentary but "eloquent historian of nature who fixes our moral happiness to the mature season in which our passions are supposed to be calmed, our duties fulfilled, our ambition satisfied, our fame and fortune established on a solid basis."

"What is the difference between a condominium and gonorrhoea?" asks a real estate man just back from California. The answer, a reflection on the depressed housing market, is that one *can* get rid of gonorrhoea. And the difference between love and herpes, we are told, is that herpes is for ever.

The conversation in the doctors' lounge at the community hospital takes place on a seemingly higher plane: the hospital is one third empty; the government has stopped paying; the insurance companies are cutting ber efits; the schools are turning out too many doctors; there are still too many foreign doctors being let in; five hospitals in the city are up for sale; the times are changing; it's a new ball game; people will have to be satisfied with less; society will have to lower its expectations; social security is going broke; the days of cheap energy are gone; the country is going bankrupt supporting all those old people sitting in the sun and playing volley ball in Florida and Arizona; why on earth are we keeping alive that wasted 80 year old man with three cancers and terminal cor pulmonale; and why are we spending $40 000 a year guarding and supporting a mass murderer in comfortable surroundings so that he can write his memoirs while at the school nearby the children have no books and will graduate barely able to read or write a sentence in English? And what are we to do about the old lady who has been sitting in intensive care for three weeks by the side of her almost brain dead 90 year old husband, insisting that everything possible be done, while the respirators and dialysis machines support some kind of "life" and Medicare is picking up the tab.

Someone from the university says that the medical schools are also in trouble: the government is changing the rules and is refusing to pay professional fees for some full time staff doctors, claiming that their services are already covered by their salaries and that in fact they are being paid twice. Many young investigators have their backs against the wall because their salaries depend entirely on grants, and as these are being cut their jobs are in jeopardy. "I spend most of my time writing grants," said one young faculty member, "because all the university cares about is that I bring in money, and without money there is no job." So he goes on "service" in his subspecialty for two months a year and in general medicine for one month, and except for a few lectures he spends the rest of the year doing research. Perhaps society can no longer afford such luxuries, one is tempted to reflect, especially after a conversation with a British subspecialist who does rounds 12 months a year on a general medical service, has three clinics a week, performs all the special procedures and biopsies himself without the help of an army of fellows in training—in fact he has none—yet somehow manages to carry out some research and edit a major journal.

Perhaps hard times blunt sensibilities, but in the same doctors' lounge one hears little sympathy for the recent hullabaloo about execution by injection. "What's all the fuss about, and what is the matter with those liberals?" asks an older doctor, "do they really think that hanging or the electric chair is more humane than being put to sleep with thiopental, potassium, and pancuronium?" And, "I have never found a psychiatrist who could convince me that society can rehabilitate mass murderers and child rapists, so why not put them to sleep and get rid of them once and for all!" But on the issue of doctors administering the lethal injections and serving as executioners, an issue recently aired at length in the journals, the consensus is that a trained technician should have no trouble finding a vein and that the disciples of the Hippocratic order have no business getting involved.

Plastic hearts . . .

Then comes up again the issue of spending millions on hopelessly ill individuals. A 7 month old baby with biliary atresia has so far had three operations, the parents are already committed to making monthly payments to the local hospital for years to come—yet it is determined that everything possible shall be done. A newspaper starts an appeal, within a few days the funds grow to $275 000. The baby is flown to Minnesota to get a new liver, but, anticlimatically, it cannot have its operation because at 5·5 kg it is unacceptably small. Not too small, however, was the premature baby girl weighing under 1000 g who developed renal insufficiency and was treated by haemodialysis, some feat, given that its blood volume is only 60 ml.

The doctors are also less than excited about the artificial heart. Not that it is not a remarkable achievement, something akin to walking on the moon, but in their present mood they murmur darkly about misuse of resources, misplaced priorities, and cost benefit ratios. The publicity too is annoying to some, the clinical details about respirators and chest tubes and chicken soup being used to correct the hyponatraemia. And who is to pay for all of this, now that it is no longer a matter of a few cows moaning in the night on the back elevator to the laboratory, or of an occasional scientific film being shown of these poor beasts suspended from the ceiling by hooks and chains and tape, their pupils dilated, their saliva drooling on the floor as they are being kept "alive."

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For now the recipient is a retired dentist with cardiomyopathy whose 280 g plastic and aluminium heart clicks away at 85 beats/min, the original organ having been taken out by a surgical team of 20 people in what was described as "almost a spiritual experience." The next day the patient is able to look out of the window and observe that, "It's a beautiful day outside"—but then the lungs fill up with fluid and the surgeons have to increase the rate to 95, then the lungs tear and need to be sewn up, the left ventricle cracks and has to be replaced, and so it goes on. "Patient suffers a minimal setback," announces the front page of the paper, and on page five we read how the patient had seizures, was reintubated, and has not yet regained consciousness. Dr Denton Cooley writes in that plastic hearts should remain experimental, but by day 17 the patient is able to stand up, though still intubated, and even the pragmatic *Wall Street Journal* is full of praise and thinks that do nothing politicians should get out of the way of innovators and pioneers.

. . . and pedlars

Now the time has come for rounds, the coffee has run out, and as the doctors are filtering out of the lounge a drug representative carries in his wares to display them in the middle of the room. He has a new cream to coat a rash, a new agent to coat a stomach ulcer, and a new drug to coat a doctor's brain. He has pamphlets, samples, pencils, flashlights, calendars, statuettes, room thermometers, and calculators. He has charts to show that macromycin achieves higher blood levels, kills more organisms, causes less renal failure. He works on the private doctors at the hospital, he keeps on good terms with the secretaries at the office, and he brings candy all year round and other goodies at Christmas to gain easy access to the doctor. Once admitted, he doggedly repeats the same litany on each visit: "Remember, only one tablet of macromycin a day, and higher blood levels. For depression try macromyl, our new decacyclic antidepressant. For diabetes, one tablet morning and evening, so simple. And don't forget our hormone. . . ."

At the teaching hospital he is seen constantly hanging around the residence talking to the house officers. A special effort is required when a drug comes up for consideration by the formulary committee. Then he has to work on the staff members and department chiefs, sending reprints and calendars, bringing in applications forms, all filled in and ready for signature and submission to the committee. "By the way we also have an educational programme, you know," he says, "and for the next grand rounds we can offer you a list of speakers to choose from, including doctors so-and-so from New York and Philadelphia who have done pioneering work on macromycin in rats. Of course, you don't have to mention our name, it's all part of our educational programme." And there is also Dr X, who happens to be passing through town and could speak at noon next week, and they will take care of it all and bring the slides and the projector and the soft drinks and the submarine sandwiches. And then there is the occasional lavish trip to a remote country, so sunny and irresistible that one will for ever feel guilty for not using macromycin.

Now it seems that some doctors have even felt guilty for not putting in more pacemakers. So at least it looked to a team of investigators who claimed that they found much graft and considerable illegal practices. But competition is intense in this $800 million a year industry, and to have doctors insert a $3500 pacemaker some salesmen have offered incentives, kickbacks, consulting salaries, vacations at Aspen or Las Vegas, as well as letting them keep the rebate allowed for replacing the device. Some 25 000 pacemakers are claimed to be inserted unnecessarily each year, and there is talk of filing felony charges for defrauding Medicare. But more altruistic people have set up pacemaker societies and even hope to recover the devices from the dead and give them to the needy, though probably in less developed countries.

Product liability laws

Meanwhile the papers abound with medical breakthroughs—lasers for sicklers with retinopathy, monoclonal antibodies for immunodeficiency states, microsurgery for spinal tumours, new regimens for rheumatoid arthritis, and wonderful surgeons who stitch back limbs avulsed on hay rides. All infectious diseases may be eliminated by the year 2007, at least in developed countries, somebody claims; and there are techniques to extract leukaemic cells but return the healthy blood to the patient. Even obesity may become curable, now that receptors governing appetite have been discovered in the hypothalamus and elsewhere in the brain. But preventive medicine has been less successful, a consumer group finds, charging that a particular brand of tuberculin test has caused much "risk and mental anguish" by yielding too many false positive results. And television sponsored screening tests for occult blood in the stool ran into a snag at the post office, at least in the warmer states, when the stench from the envelopes containing specimens smeared on cardboard slides eventually necessitated a re-evaluation of the programme.

Also in need of re-evaluation are product liability laws, because at least 50 000 people are claiming billions of dollars in damages from manufacturing companies for being exposed to asbestos some 30 years ago or more. The companies claim that nothing was known at the time about the harmful effects of asbestos and even feel that they are being penalised for helping win the war, because at the time asbestos was used in the shipyards. Two large companies in excellent financial shape have filed for bankruptcy to avoid suits amounting to many billions of dollars, and many think that some federal compensation mechanism might be preferable to the present litigiousness. The victims, moreover, usually fare poorly because the cases drag on for years and the lawyers get most of the money anyway, working as they do on a contingency fee basis. There is even an organisation of trial lawyers whose agents are said to be scouring the country looking for potential clients. Here again comes up the issue of how much a society can afford, and one newspaper suggested the need to somehow limit product liability if the economy is not to be submerged in a sea of litigation.

Finally, at a time when one's middleaged colleagues are dropping dead right and left from heart attacks, one report indicates that most deaths from ischaemic heart disease occur on Saturdays, not on Mondays as was earlier suggested. This has been interpreted as suggesting that for some people the home environment may indeed be more stressful than the environment at work. But exercise may prevent heart attacks. So at the gym old Joey kills two birds with one stone by playing squash: it may increase his longevity, and it also keeps the old lady out of his hair for a few blissful hours during the afternoon.

Is there any link between blepharospasm and keratitis sicca in the elderly?

Blepharospasm is due to contraction of the orbicularis oculi muscle and may be voluntary or involuntary. When involuntary it is usually caused by ocular pain or irritation and photophobia. In the elderly blepharospasm is sometimes primary, or "essential," because of unwanted spontaneous firing of facial nerve impulses. Keratoconjunctivitis sicca is a chronic inflammation of the cornea and conjunctiva due to an inadequate tear film, seen in its most severe form associated with rheumatoid arthritis as Sjögren's syndrome. The lack of tears causes punctate corneal epithelial loss, and, as the cornea is very sensitive to pain, this is painful. The dry eye may therefore cause blepharospasm on account of pain. Paradoxically, although closure of the eyelids is essentially protective, blepharospasm tends to make the cornea more dry as it inhibits the normal blink reflex that spreads the tears over the corneal surface. Treatment is directed towards keeping the eye moist with frequent instillations of artificial tear solutions. If the blepharospasm is essential then it may be reduced by section of the upper branches of the facial nerve.—BRIAN HARCOURT, consultant ophthalmic surgeon, Leeds.