Enemies in the House of Medicine — Complacency, Apathy, & Hostility

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The ERISA Squirrel Law — 'Are you fer it, or agin it?'

Mr. Conner, p. 2
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The ERISA Squirrel Law

For generations, this story has long been a fixture of folk politics in the South and may be apocryphal for all I know:

A Tennessee Congressman long ago found himself running for re-election in the midst of a local controversy over a proposed squirrel law.

The exact details of the squirrel law escape my memory but it had something to do with confining squirrel hunting to certain hours of the day, etc. The people in the candidate's congressional district appeared to be about evenly divided on the issue, a highly emotional one for proponents and opponents alike in that far simpler day.

That's about all the voters had on their minds when the Congressman began stumping for the fall election. He was naturally determined to avoid the subject like the plague.

He succeeded for a time, haranguing the multitudes on every subject under the sun — except the squirrel law. But near the close of his campaign, hecklers began appearing at his rallies demanding that he declare himself on the squirrel law, one way or the other—or, as they put it, "fer it or agin it?" Day after day, the hecklers returned with their taunts. The Congressman stood mute on the issue.

Even the few people who didn't care much one way or the other were getting restive: if their congressman couldn't make up his mind, maybe he should stay at home in Tennessee next term.

Finally, he could evade no longer. Rumors had been building for weeks that he was about to declare himself. On the fateful day came the usual challenge from the crowd assembled in the town square:

"That's all well and good, John, but how do you stand on the squirrel law? Are you fer it or agin it? That's all we want to know about."

Congressman John looked over the crowd of voters, figuring that here was a fairly representative sample of the 50-50 split on the issue. The air was charged with expectation as he adjusted his string tie, tossed back his silver mane, cleared his throat and began:

"Ladies and gentlemen, as a statesman I will not hedge or waffle. Someone once said at such a momentous juncture as this: 'All is lost save honor, and that hangs in the balance.' My personal honor and integrity, as you all know, are more important to me than my re-election. The times cry out for leadership and a courageous stand on principle and I will not shirk or shilly-shally. I must be true for there are those who trust me. I must be brave for there is much to dare. The great people of this great state know my sterling record of fearless faith as their public servant. For was it not I who struck the serpent from the eagle's nest in their behalf long, long ago? ...."

"THE SQUIRREL LAW, JOHN," came the insistent voice from the back of the crowd. "FER IT OR AGIN IT?" The crowd picked up the chant.

"Ah, yes, the squirrel law," the Congressman began. "No greater question has presented itself to the good people of our fair state since it was created. The squirrel law is as fundamental to the rights of a freedom-loving people as the Magna Carta; as basic to the liberties of our great citizenry as the Bill of Rights itself; as essential to the maintenance of the character and substance of our proud people as...."
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“I will not equivocate,” the congressman said, equivocating: “Some of my friends are for the squirrel law and some are against it. I want to say here and now that my record speaks loudly on this point — I’m for my friends; always have been, always will be. ‘This above all,’ the Bard said, ‘to thine own self be true.’ Thank you all and remember your faithful servant on election day.”

They did; he lost.

The swelling national controversy over Section 514 of the 1974 federal law, the Employee Retirement Income Security Act (ERISA), is a squirrel law in that some of medicine’s friends are for it and some are against it. At the risk of sounding like the fearless Congressman, I think both sides have persuasive cases.

This is the section that permits large employers to self-insure, as about two-thirds already have. The essential appeal is that the law permits self-insuring companies to escape state insurance laws and state taxes earmarked for pools to provide care for the uninsured.

The rush to self-insurance is the result of many forces, principal among them being the freedom it gives employers to write their own policies as a hedge against the rising cost of health care; and as an escape from the mandated state benefits legislators have been imposing on carriers — requiring coverage demanded by every special interest group in the land.

While many of these legislative mandates have been legitimate, some groups have succeeded in getting mandated coverage for in vitro fertilization, hair transplants, acupuncture and even, it is alleged, fees for Christian Science counseling. These and similar coverages are hard to the kind of medical necessity normally insured. Taken together, they add many millions to the health care bill.

Since the buck stops with those who pay the bills, many employers are jumping ship. Some states are howling mad that these escapees can dilute coverage with only their consciences as their guides. They have also insulated themselves against taxes designed to defray the costs of treating the medically indigent.

The exodus under Section 514 also undercut, perhaps fatally, many of the proposed health care reforms in Congress, along with AMA’s own grand design, Health Access America. Most of the bills in Congress are designed to build on existing insurance infrastructure that employers have been providing since World War II.

Since Medicare-Medicaid, the unwritten social contract has been that the private sector, business and industry, will cover working Americans and government will care for the old and at least some of the poor. But now spokesmen for the aged are saying that their constituents are once again paying as much-out-of-pocket for health care, in constant dollars, as they did before Medicare; Medicaid covers a smaller percentage of the poor with each passing year; and the private sector says it is being forced to curtail coverage and even to renege on pension plans because of spiraling health care overhead and as the target of much of the cost-shifting from other sectors.

All this is the result of many economic factors, including the cost-shifting from Medicare-Medicaid and other prudent buyers of health care. In other words, the social contract is in tatters. Everybody, it seems, wants that fellow behind the tree to pay and he has disappeared without a trace.

Section 514 has been around for 18 years but not until recently has the controversy over its social immunization reached critical mass.

Senator Dave Durenberger, Minnesota Republican, speaks for many in the state houses and a significant number in Congress when he says: “ERISA has become a shield behind which self-insured companies can avoid social responsibilities that others must bear.” He is one of the leaders of the ERISA reform movement.

Such is the state of the controversy at this time that it seems immaterial that employers were driven to self-insure by the Niagara of legislative mandates and by the massive cost-shifting that ultimately landed at their door. By going into business as their own self-insurer they are beyond most state insurance laws and can reduce coverage almost without restraint.

Several states have already filed for congressional waivers under the act, which is the only way to get straying employers back under the tent, short of repealing the section. Leaders of the state waiver movement are Florida, Minnesota and Vermont, all of which enacted health care reform this year, reform that would not work if the big employers stayed out. Oregon and California are preparing to file.

A lobbyist for the National Governors Association, Alicia Pelrine, says most states can’t move without an ERISA waiver. “We are caught between a rock and a hard place,” Ms. Pelrine says:

“On the one hand Congress wants to support incremental reforms in the states and on the other if business succeeds in killing any hope we might have, we
William Weld, Republican, favors its repeal.

Minnesota has had "HealthRight" in effect for a couple of months, an attempt to cover all the state’s uninsured and pay for the program by taxing health insurance. But unless it can tax the self-insureds — and only a congressional waiver would permit this — the state must rely solely on premium taxes imposed on private health plans sold primarily to businesses too small to self-insure and thus insulate themselves under ERISA. Since 60% of all workers in the state are covered by self-insured plans, the tax base is much too small.

One congressional plan mentioned by Senator Durenberger is legislation to permit states to impose a broader-based tax to pay for risk pools. But that concept may have been rendered moot by a May 27 federal court decision that self-insured companies and unions in New Jersey could not be subject to a 19% surcharge on hospital bills earmarked for the uninsured.

Section 514 exempted them, the court said. Until the order, which was stayed until New Jersey can think of something, self-insureds had paid 40% of the

Florida Gov. Lawton Chiles recent led a delegation of 17 governors to Washington to try to convince Congress and the White House that ERISA is making it virtually impossible for states to assist in health care reform. Since there is no authority in ERISA for waivers, Congress must legislate each one.

Florida’s recently enacted universal health plan depends heavily on Medicare, Medicaid and an ERISA waiver. Failure to get the latter, Gov. Chiles says, would vitiate key features of the bill he signed into law March 24.

The law would require employers, by the end of 1994, to provide workers with health benefit requirements in a state-designed package. If they fail to comply, the law provides that a state mandate then kicks in to force them to. But if self-insured firms escape under ERISA, it would be politically impossible to place all the load on smaller firms.

Hawaii has already won a congressional waiver for its employer mandate program. Massachusetts has a 1988 insurance mandate law but employers say they’ll sue if the state attempts to enforce it. And Gov.

can’t do anything but nibble around the edges.”

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<thead>
<tr>
<th>Male ages</th>
<th>$250,000</th>
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<td>25</td>
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<td>845</td>
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$737 million total raised for uncompensated care. If the decision stands, New Jersey officials say, the uncompensated health care plan will collapse.

Many states are watching the New Jersey ruling. If it survives, along with previous decisions that self-insured companies can reduce coverage as they please, all bets are off until Congress changes the law. IF it changes the law. Business groups are lobbying even more intensely than the governors to keep Section 514. They point to the fact that they were being crippled by mandated benefits, which had grown from fewer than 200 in the mid-1970s to almost 900 in 1990, according to the Blue Cross & Blue Shield Association. In the past two years alone, 116 new state laws were enacted.

In fact, business and industry argue through its national ERISA Industry Committee that "the reason you have the system of self-funded and ERISA plans in the first place is that states have done such a poor job of disciplining the medical system — states are captive of every special interest group that comes along."

President Bush has been on record as favoring the retention of 514. His health and welfare adviser, Gail Wilensky, formerly HCFA administrator, says that the Administration sympathizes with the states' problem but is concerned that amending the section would put big companies back under the intolerable load of insurance mandates.

One industry spokesman indicated repeal would be resisted until there is a comprehensive national health care reform law the business community can live with. To this, Durenberger responds that this would be the ideal solution, but comprehensive reform is not happening on the federal level but is on the state level — "So why are we standing in the way?"

The outlook in Washington, according to insiders, is that if states can show they can and will deliver truly universal coverage, they may qualify for a congressional waiver, but a repeal of Section 514 is less likely.

I said at the outset that it's a squirrel law issue. Some of our friends are for Section 514 and some are against it. We must go along with our friends.
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Complacency, Apathy, Hostility

Complacency and apathy have been the twin enemies of American medicine for many years. As I use the two words, they are not synonymous, although they do overlap. Complacency, to me, means the fat, dumb and happy belief that whatever the current excitement — no problem; things will work out.

Apathy is the mindset that is simply indifferent to what happens, good or bad.

In this connection, the other day a major national newspaper quoted a political scientist on the subject of Ross Perot’s amazing early popularity. Was it due to voter apathy?, the reporter asked.

Hell, no, the political scientist responded without a moment’s hesitation: this was voter hostility. He explained that the Perot followers were, for sundry reasons, disgusted with both parties, government itself and just about everything inside the Washington beltway.

This gives us another physician attitude that all of us have encountered — generalized, free-floating hostility. Our hostile physician takes a dim view of the entire landscape — politics, government, the bureaucracy, both parties, and organized medicine itself.

My social scientist credentials are suspect, but it is my guess that there is a progression that leads to this advanced state:

First, complacency — we’re in complete control of everything;

Second, apathy — when our complacency is shocked and devastated by a rude encounter with reality, leading to our conclusion that somebody fouled up somewhere; the situation is hopelessly out of control, and so we can turn our backs to the problem and forget it;

Third, hostility — we tried not to care because they’ve messed everything up but now they’ve really made us mad; a plague on all their houses.

The year I matriculated at the University of Alabama, 1948, was the year of the great Democratic split into Loyalists and Dixiecrats, a schism that has yet to heal entirely. Hostility abounded on all sides. The Dixiecrats accused the Loyalists of selling their souls to the national Democratic Party, which was seen as soiled and utterly corrupted by the great cities and the grimy industrial subculture of the Northeast.

Anybody who would make that pact with the devil was described tenderly as “a yellow dog Democrat,” so labeled because he would vote for even a yellow dog if the party asked him to. The Loyalists were not short on venom either; they accused the bolters of “leaving the party of our fathers” and, worse, of being closet Republicans. (That was the worst thing you could call a fellow Alabama politician in those days.)

Times have changed but hostilities remain, confirming the observation of Thomas Jefferson that if it’s tranquility in public affairs that you want, democracy is not for you — it has ever been contentious and brawling, he said, and always would be, almost by definition.

My point being, there is nothing new in either complacency, apathy or hostility. All have infected the tribes of man since they decided that if they were to survive they had to join together in some common purpose. Thus was government born. People have cussed it ever since.

Organized medicine seeks, through democratic channels, to define goals and interests that should
unite us. Obviously, common denominators fit no one precisely. We make accommodations to the necessity of unified action and purpose, just as did our ancestors when they came out of the caves. In any society or institution that seeks to do (Jefferson again) the greatest good to the greatest number, there is an inherent leveling of individualism.

For many years medicine enjoyed a special status in the political affairs of the nation. We had things pretty much our way — no sweat, no tears. That bred complacency. Then came Medicare-Medicaid, the first great repudiation of physician leadership. That brought apathy in its wake — We’re powerless, so let’s give up.

In more recent years, managed care, the sometimes crude ratcheting-down of Medicare, the avalanche of paper work, the hassle factor in general — all have combined to blow away apathy and complacency, perhaps, but to enthrone free-floating hostility, which has the same end result as apathy and complacency.

Unless anger is channeled, it is little better than defeatism. You can bellow like a bull in the doctors’ lounge or at a cocktail party, making the very heavens rattle with your rage, but if that’s the end of it, if you do nothing to contribute to remedial action, you have accomplished no more than the less demonstrative physician who sulks quietly in his tent.

Hostility, like atomic power, is destructive unless harnessed and directed to useful work. If all the physician anger in the country could be converted to effective horsepower, a force driving in one direction, we could be the most formidable segment in American life — particularly now, when all other factions are in such a state of total disarray.

And that force could be felt far beyond the health care issue. If America has indeed lost its way, as some of the crepe-hangers are saying, what group other than ours is better positioned — by virtue of our education, the esteem in which we are held as individuals, and our close daily contact with the people — to lead? Or at least to find the path.

Think about it: converting your anger into directed energy in behalf of organized medicine could, just possibly, open much wider horizons.

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Primary Causes of Medical Instability of Medicare Patients at Discharge
1990-1991

Robert G. Sherrill, Jr., M.D., M.A.
Hugh M. Hood, M.D.
Warren D. Everett, M.D., M.P.H.
Nadine Schiesz, R.N.
Joan Scott Lowe, R.N., M.P.H.
James F. DeLong, M.D.

ABSTRACT

Background

HCFA-sponsored Peer Review Organizations nationwide have been criticized by organized medicine, Medicare beneficiaries and interested Congressional parties for being punitive without exploiting educational opportunities garnered through their massive data collection capabilities. Until now this data has been poorly analyzed and has not been adequately utilized as a positive motivational tool.

Methods

HCFA has developed, with the cooperation of the medical community, six generic screens for Peer Review Organizations to utilize when evaluating quality care provided Medicare beneficiaries in an acute care setting. Through the sheer volume of cases seen, significant inpatient information can be obtained that cannot be duplicated in any other epidemiological endeavor. Line item discrepancies can be further studied through small-area-analysis to determine “who” as well as “what” may be the problem.

Results

By compiling and reviewing data in a systematic manner over two years (1990-1991), the Alabama Quality Assurance Foundation (AQAF) has singled out problems with patient medical stability at discharge as the predominant concern for care providers and reviewers alike.

Conclusions

Having determined the primary problem in rendering quality care in a Prospective Payment System to Medicare beneficiaries lies in premature discharges, subsequent small-area-analysis further narrows the focus of concerned individuals. Hopefully, practitioners and providers alike will act on their own initiative in correcting this problem. Follow-up review will be utilized to assure this self-corrective action.

GENERIC QUALITY SCREEN 2 STUDY

Medicare Inpatient Discharges
1990 Physician Advisor Initial and Final Decisions
Medical Stability of Patient at Discharge

PURPOSE OF STUDY

The Peer Review Organization's routine review of Alabama hospital Medicare discharges (inpatient) in 1990 suggests a high rate of patients who are medically unstable at discharge. Medical records and review documents have been examined to determine the situations and sources which led to the review decisions of medical instability at discharge. A follow-up study of 1991 review outcomes was also completed to validate the 1990 findings. A summary of

From the Department of Education, Quality and Research; Alabama Quality Assurance Foundation, Inc.
the study's outcome will be made available to physicians and providers as a means to improve quality of care by decreasing the rate of medically unstable discharges.

**Background Information**

Interventions by the Health Care Financing Administration (HCFA) to identify and remedy problems in quality of care for Medicare patients include routine screening of inpatient records for quality problems in seven categories (Generic Quality Screens):

- **GQS 1** Adequacy of Discharge Planning
- **GQS 2** Medical Stability of Patient at Discharge
- **GQS 3** Deaths
- **GQS 4** Bacteremia
- **GQS 5** Unscheduled Return to Surgery
- **GQS 6** Trauma Suffered in Hospital
- **GQS 7** Other Quality Problems Identified

In 1990, there was a total of 230,283 Medicare inpatient discharges from Alabama hospitals. Of these cases, 48,064 records were selected for review.

Review selections are made weekly from the tape of paid claims sent by the Fiscal Intermediary. A random sample is selected based on the Health Care Financing Administration mandated review categories - i.e., focused DRGs, readmissions, transfers, day and cost outliers, etc.

In Alabama, Generic Quality Screen (GQS) 2, Medical Stability of Patient at Discharge, has always ranked highest in number of problems identified by physician advisor initial review of quality of care. These suspected potential problems were then brought to the attention of the concerned practitioner or provider, allowing them the opportunity to respond, clarifying their care or supplementing the original chart's documentation. As a result, the majority of these "suspected" problems were adequately explained. Still, a significant minority of cases were confirmed quality problems in final review.

The following graph illustrates the predominance of GQS 2 problems found by the Alabama peer review organization (PRO) in initial 1990 review of Medicare inpatient discharges versus the number of 1990 physician advisor final review decisions.

The significant number of inpatient GQS 2 problems across the state presents a major problem area in

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**Medicare Inpatient Quality of Care Study**

HCFA Generic Quality Screens Comparison of 1990

Initial & Final Physician Advisor Decisions

Number of Quality Problems*

<table>
<thead>
<tr>
<th>Number of Quality Problems*</th>
<th>Initial PA Suspected Problems</th>
<th>Final PA Confirmed Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,400</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1,171</td>
<td></td>
<td></td>
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<tr>
<td>1,002</td>
<td></td>
<td></td>
</tr>
<tr>
<td>48,064</td>
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<tr>
<td>Duplicate cases in GQS 2 and 6: 170</td>
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</tr>
</tbody>
</table>

**Total # initial PA suspected problems** = 2,446 (5%)
**Total # final PA confirmed problems** = 387 (0.8%)

*Percent based on 1990 inpatient reviews = 48,064

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quality of care provided by hospitals/physicians to Medicare patients. The current rate of physician advisor (PA) initial review decisions on quality problems is cause for concern since the rate of problems indicates potential and real quality problems. In addition, the number of problems generates excessive cost to the review process. Problems with attending physician/provider documentation comprise the majority of quality problems.

To modify the predominance of quality problems in GQS 2, Alabama Quality Assurance Foundation, Inc., the Alabama PRO, has completed a thorough analysis of GQS 2 initial PA suspected problems based on 1990 completed reviews of Medicare inpatient discharges.

**METHODOLOGY OF THE STUDY**

The study is based on data profiles of review outcomes. The profiles provide summaries of hospitals, physicians and DRGs with GQS 2 problems suspected by 1990 initial PA review confirmed by final PA review. 1990 review data of Medicare inpatient discharges yields 1,171 GQS 2 initial PA suspected problems, or 2.44% of the total number of Medicare inpatient discharges (48,064) reviewed by the Foundation in 1990.

**STUDY POPULATION**

The Foundation examined 871 (74%) of the 1,171 records with GQS 2 initial PA suspected problems to validate and identify the specific quality problem(s) in each case. Of these, 166 cases were deemed final PA confirmed problems. The Foundation examined all 166 of these records for comparison of initial potential versus final confirmed GQS2 problems.

**Emergency Room Admissions**

The majority of initial PA suspected problem cases with GQS 2 problems were Emergency Room admissions (468 — 53.7% of the study population). There were 86 Emergency Room admission cases with final PA confirmed GQS2 problems (51.8% of the final PA confirmed cases). These rates compare favorably to that of the total inpatient Medicare population emergency room admissions in 1990 — 141,083 out of 230,283 discharges, or 61.3%.

**Length of Stay in Intensive Care/Coronary Care Units**

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lems, the patient spent time in an intensive or coronary care unit:

<table>
<thead>
<tr>
<th>Length of Stay in ICU/CCU</th>
<th>#/% Initial PA Suspected Cases</th>
<th>#/% Final PA Confirmed Cases</th>
</tr>
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<tbody>
<tr>
<td>1-5 Days</td>
<td>146 (17%)</td>
<td>32 (19%)</td>
</tr>
<tr>
<td>6-10 Days</td>
<td>49 (6%)</td>
<td>4 (2%)</td>
</tr>
<tr>
<td>11-15 Days</td>
<td>10 (1%)</td>
<td>3 (2%)</td>
</tr>
<tr>
<td>&gt;15 Days</td>
<td>13 (1%)</td>
<td>6 (4%)</td>
</tr>
<tr>
<td>Total</td>
<td>218 (25%)</td>
<td>45 (27%)</td>
</tr>
</tbody>
</table>

*Percents based on total number cases in sample = 871 initial and 166 final problems.

Premature Discharges, Prohibited Actions and Admission Denials

The graph below compares Physician Advisor review decisions of initial potential PA suspected and final PA confirmed problems. The initial suspected problems include 86 premature discharges, seven of which resulted in readmission to the same hospital within 31 days of discharge. This latter sequence of events is deemed, by HCFA mandate, a type of "Prohibited Action." If confirmed after further review, a level 3 Severity Quality Problem (see below) is automatically assigned. There were also seven admission denials for lack of medical necessity. The final confirmed problems include 24 premature discharges, 4 prohibited actions and 2 admission denials.

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1990 Medicare Inpatient Quality of Care Study

Results of the Study

GQS 2 Problems by Severity Level

Physician advisor review rates GQS problems by severity levels, defined as follows:

- **F** = PA finds no quality problem
- **1** = Confirmed quality problem without potential for significant adverse effects on the patient.
- **2** = Confirmed quality problem with the potential for significant adverse effects on the patient.
- **3** = Confirmed quality problem with significant adverse effects on the patient.

The majority of cases in the study sample were assigned Severity Level 1, which often involves a problem with inadequate documentation:

### RESULTS OF THE STUDY

GQS 2 Problems by Severity Level

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The majority of cases in the study sample were assigned Severity Level 1, which often involves a problem with inadequate documentation.
Top Five GQS 2 Problems

Analysis of the study sample of initial PA GQS2 case review (871 records) identified 1,676 initial PA suspected problems with medical instability of patient at discharge. These problems are ranked in descending order. Mismanagement of electrolytes is the most frequent cause of GQS 2 problems, followed by failure to follow up abnormal urinalysis/urine culture and sensitivity, vital signs, medication and drug level, and hemoglobin/hematocrit management problems.

1990 Medicare Inpatient Quality of Care Study
Top Five Generic Quality Screen 2 Problems
Initial PA Decisions

<table>
<thead>
<tr>
<th>Problem</th>
<th>Number of Cases</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electrolytes</td>
<td>270 (16%)</td>
<td></td>
</tr>
<tr>
<td>Urinalysis/Urine C&amp;S</td>
<td>224 (13%)</td>
<td></td>
</tr>
<tr>
<td>Vital Signs</td>
<td>217 (13%)</td>
<td></td>
</tr>
<tr>
<td>Medication &amp; Drug Level</td>
<td>193 (12%)</td>
<td></td>
</tr>
<tr>
<td>Hgb. &amp; Hct.</td>
<td>104 (6%)</td>
<td></td>
</tr>
</tbody>
</table>

Percent based on number of GQS Problems: 1,676
Some cases have more than one GQS problem.

In contrast, final PA confirmed review decisions on GQS2 problems rank medication management issues second after electrolytes as the most frequent cause of GQS2 problems.

1990 Medicare Inpatient Quality of Care Study
Top Five Generic Quality Screen 2 Problems
Final PA Decisions

<table>
<thead>
<tr>
<th>Problem</th>
<th>Number of Cases</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electrolytes</td>
<td>52 (15%)</td>
<td></td>
</tr>
<tr>
<td>Medication &amp; Drug Level</td>
<td>45 (13%)</td>
<td></td>
</tr>
<tr>
<td>Urinalysis/Urine C&amp;S</td>
<td>42 (12%)</td>
<td></td>
</tr>
<tr>
<td>Vital Signs</td>
<td>22 (6%)</td>
<td></td>
</tr>
<tr>
<td>Lack of Doc.</td>
<td>21 (6%)</td>
<td></td>
</tr>
</tbody>
</table>

Percent based on number of GQS 2 Problems: 345
in 166 cases.
Electrolyte Management Problems

The first graph illustrates the management of potassium (138 cases or 8% of all GQS 2 problems in the study sample) as the major type of electrolyte management problem in initial PA decisions. The second graph depicts analysis of electrolyte management problems found in final PA review decisions, with potassium as the leading type of quality problem:

Further analysis of initial PA suspected potassium management problems identifies low serum potassium level (83 cases) as the leading potassium management problem:

The following graph illustrates specific descriptions of initial PA decisions regarding potassium management problems. In 67 of the 138 potassium management problems, lack of inpatient follow-up is the source of the qual-
ity problem. Forty-two potassium problems were caused by inadequate documentation, and 34 abnormal potassium levels were not addressed by the attending physician.

1990 Medicare Inpatient Quality of Care Study
Potassium Management Problem Description
Initial PA Suspected Problems

Quality Problems with Urinalysis/Urine Culture and Sensitivity

The following two tables illustrate the type of quality problems encountered in management of urinalysis/urine culture and sensitivity in initial PA suspected and final PA confirmed review decisions. Initial review shows 224 problems, while final review, allowing practitioner/provider time for response, yields 42 confirmed problems with urinalysis/urine culture and sensitivity management:

<table>
<thead>
<tr>
<th>INITIAL PA SUSPECTED PROBLEMS, BEFORE REBUTTAL</th>
<th>Urinalysis/Urine C&amp;S</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abnormal urinalysis not addressed/ inadequate follow up</td>
<td>117</td>
<td></td>
</tr>
<tr>
<td>Urine C&amp;S not ordered when indicated (abnormal urinalysis, elevated temperature/WBC, etc.)</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>Abnormal urine C&amp;S not addressed/inadequate follow up</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Culture positive/no antibiotics given</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Urinalysis not ordered when indicated (elevated temperature/WBC, etc.)</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Urine C&amp;S ordered but not done</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Daily urinalysis without documentation of reason/overutilization</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Urinalysis ordered but not done</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Antibiotics given without urine C&amp;S</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>224</td>
<td></td>
</tr>
</tbody>
</table>
### Management of Vital Signs

The majority of quality problems encountered in vital signs management includes lack of documentation of vital signs; i.e., no graphic sheet, no vital signs recorded on graphic sheet, no vital signs recorded on last day of visit. The graph below summarizes the number of problems associated with management of blood pressure, temperature and pulse in initial and final PA review decisions.

#### 1990 Medicare Inpatient Quality of Care Study

**Vital Signs Mismanagement Problems**

<table>
<thead>
<tr>
<th>Vital Signs</th>
<th>Initial PA Decision</th>
<th>Final PA Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>92 (5%)</td>
<td>8 (2%)</td>
</tr>
<tr>
<td>Temperature</td>
<td>79 (4.5%)</td>
<td>11 (3%)</td>
</tr>
<tr>
<td>Pulse</td>
<td>48 (3%)</td>
<td>3 (1%)</td>
</tr>
<tr>
<td>Vital Signs</td>
<td>1 (0.1%)</td>
<td>0</td>
</tr>
</tbody>
</table>

Per cent based on total # GQS/2 Problems = 1,676 initial and 345 final PA decisions.

### 4. Medication Management Problems

a. Of 147 initial PA decisions concerning quality problems associated with medication management, 24 involve issues with administration of antibiotics. Administration of potassium supplements is the second greatest
The graph below ranks the medications connected with management problems in descending order of frequency as identified by initial PA review:

![Graph showing medication management problems]

b. Final PA review ranks medication management problems second highest to electrolytes. The following graph summarizes the type of medication problem identified in descending order of occurrence:

![Graph showing medication management problems]

Final PA Review Decisions: 345 problems in 166 cases with final confirmed GQS 2 problems.
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DISCUSSION

In both initial suspected and final PA confirmed GQS2 problems, the principal source of quality problem is the attending physician. The source of quality problem identified in the study sample is shown in the graph below.

![Graph showing source of quality problem](image)

The following table classifies the top DRGs associated with quality problems in the study sample of initial PA suspected and final PA confirmed GQS2 problems:

<table>
<thead>
<tr>
<th>1990 Top 6 DRGs with Initial/Final PA Confirmed GQS2 Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INITIAL PA REVIEW DECISION</strong></td>
</tr>
<tr>
<td>DRG</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>127</td>
</tr>
<tr>
<td>416</td>
</tr>
<tr>
<td>089</td>
</tr>
<tr>
<td>296</td>
</tr>
<tr>
<td>182</td>
</tr>
<tr>
<td>014</td>
</tr>
<tr>
<td>TOTAL</td>
</tr>
</tbody>
</table>

(Percents based on number of 1990 reviews per DRG).
Analysis of the incidence of GQS 2 problems can also be performed by Hospital Market Area (HMA) in the state of Alabama. There are 99 Hospital Market Areas in the state, each of which is composed of a grouping of patient zip codes based on the publication Small Area Analysis of Variation in Utilization and Outcomes for Hospital Care among Medicare Beneficiaries. Volume II: Zip Code Composition of Hospital Market Areas. Future investigation of GQS 2 problems by HMA is a possible research tool for expanded analysis of quality of care problems in the state.

FOLLOW-UP STUDY OF 1991 REVIEW DECISIONS ON GQS 2

To validate the patterns found in the study based on 1990 review decisions, a follow-up study of 1991 review decisions on initial PA suspected and final PA confirmed GQS 2 problems was performed. In 1991, a total of 41,265 reviews were completed from a universe of 184,701 Medicare inpatient discharges. Initial PA review identified 1,893 potential GQS 2 problems (4.6% of completed reviews), while final PA review confirmed 348 cases with GQS 2 problems (0.84% of completed reviews).

Medicare Inpatient Quality of Care Study
HCFA Generic Quality Screens Comparison of 1991
Initial & Final Physician Advisor Decisions

The Foundation examined a random sample of 500 (26%) of the 1,893 records with initial PA suspected GQS 2 problems identified by reviews between May 5, 1991 and December 31, 1991. Of these cases, 138 were final PA confirmed GQS 2 problems. Twenty-one (21) of the 500 cases examined were premature discharges, 5 prohibited actions and 9 admission denials.

Results of the Follow-up Study

As in 1990 review decisions, most cases from the 1991 study sample of 500 initial PA suspected GQS 2 problems were assigned an overall Severity Level of 1, which usually involves problems with inadequate documenta-
The following graph illustrates the number of GQS 2 problems by Severity Level:

**Overall Severity Level**
_for 1991 Reviews with GQS2 Problems_

![Graph showing severity levels and case counts for GQS2 problems]

Initial PA Suspected Problems  Final PA Confirmed Problems

*Percent based on number 1991 reviews with problems: 500 (initial) & 138 (final).

The top five GQS 2 problems identified by 1991 PA review decisions are ranked in the table below in descending order of occurrence. The list of top five problems with medical stability at discharge identified in 1991 almost mirrors the 1990 review results, with the exception of problem number five in final PA decisions. Lack of Documentation was the number five GQS 2 problem in 1990, while Chest X-ray management was rated fifth in 1991.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PROBLEM</td>
<td># CASES</td>
<td>PERCENT</td>
</tr>
<tr>
<td>Electrolytes</td>
<td>132</td>
<td>19.0%</td>
</tr>
<tr>
<td>Urinalysis/Urine C&amp;S</td>
<td>90</td>
<td>12.9%</td>
</tr>
<tr>
<td>Medication Management</td>
<td>87</td>
<td>12.5%</td>
</tr>
<tr>
<td>Vital Signs</td>
<td>75</td>
<td>19.0%</td>
</tr>
<tr>
<td>Chest X-ray/Hgb. &amp; Hct.</td>
<td>51/51</td>
<td>7.3%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>486</td>
<td>69.8%</td>
</tr>
</tbody>
</table>

(Percents are based on number of GQS 2 problems - initial PA suspected = 696 out of 500 cases; final PA confirmed = 202 out of 138 cases).
Potassium was again the number one electrolyte management problem in 1991, as shown in the graph below:

As found in the 1990 study, the principal source of quality problem identified by 1991 review is the attending physician, followed by the provider.
Generic Quality Screen 2 problems in the 1991 study sample are classified by DRG in the following graph. The top three-DRGs with the highest incidence of GQS 2 problems in 1991 were DRG 127 (Heart Failure and Shock), DRG 089 (Simple Pneumonia and Pleurisy with CC) and 296 (Nutritional and Miscellaneous Metabolic Disorders with CC).

**COMMENTS**

This study focuses on pattern analysis of quality problems identified by the Alabama PRO. In general, 1991 physician review decisions reflect 1990 decisions in patterns of care by overall severity level, type of problem, source of problem and DRG. In 1990, the *New England Journal of Medicine* published an article which affirmed, “Interventions attempted by the PROs to remedy severe problems in quality were for the most part unsuccessful.” The punitive approach of sanctions against physicians/providers with quality problems has often resulted in animosity toward the Medicare program by physicians and providers.

HCFA is directing PROs to a less punitive, more educational orientation method to improve quality of care. This approach, pattern analysis, consists of statistical breakdown of patterns of care on a state-wide, rather than an individual basis. General memorandums, articles and workshops on the results of such studies will be accessible to all providers/physicians in the state. The educational material and manner of the information dispersed are intended to motivate physicians and hospitals to take action on their own for optimum quality of care, in lieu of following direct requirements from the PRO.

Suggested methods to eliminate quality of care problems identified in the study will be presented at Provider Outreach Meetings and other workshops to reduce the state-wide occurrence of quality problems. Educational intervention should prove a more practical strategy to enhance quality of care given to Medicare beneficiaries. Ongoing small area analysis may be used to verify this claim.

The present study reveals lack of documentation about patient follow-up before and after discharge and inadequate documentation of known causes for abnormal diagnostic findings as the primary cause of quality problems. Educational intervention will provide specific guidelines regarding documentation of quality of care based on this study.

As Kardos states in his article, “Failure to Document,” “The failure to adequately document events in the written clinical record is the major reason for letters of inquiry from Peer Review
Organizations (PROs)....Although at present there are no guaranteed ways to avoid error, a systematic approach that is followed consistently will reduce the frequency of such errors of omission to a very small percentage....Peer review should reward good care, help improve care when necessary, educate other physicians when such education is necessary, and take remedial action only when educational attempts have failed.”

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A GREAT WAY TO SERVE
The First Five Minutes:

by Judy Marston

Today's popular saying is true: "You never have a second chance to make a first impression." Whether you're a physician, a member of a medical office staff, or a medical auxiliary volunteer, the first impression you make on others is lasting and difficult to change.

Within 30 to 60 seconds of meeting you, people begin forming negative or positive impressions of you and your work. Within the first five minutes they most likely have decided whether or not they want to invest any more of their valuable time getting to know you any better.

How do you want others to perceive you? Friendly? Sleek and sophisticated? Professional? Competent? Do you adequately project that impression through your actions, your words and the visual image of your office or yourself?

Studies done at UCLA by Albert Mehrabian showed that 58% of first impressions are non-verbal; 38% are how you use your voice; and only 12% are made by the actual words you say. So if your non-verbal messages are sending negative signals, you'll have a lot of talking to do to project a positive and professional image.

What are some of the non-verbal messages we send to others in the first five minutes? There are eight main methods, or characteristics. Some can be changed, some cannot. Let's look at the first four characteristics that someone notices about us:

- Race: What color is your skin?
- Sex: Are you male or female?
- Age: Are you older or younger than expected by the people who meet you? If you are in the general age range that they expected, your age will not be noticed.
- Size: Are you extremely tall or short? Are you abnormally heavy or thin?

No matter what type of impression you hope to project, there is nothing you can change about yourself on this list other than your weight. (Some say there is one other characteristic that can be changed, but it is very painful and quite expensive!) But what about the second four characteristics that others notice? These four are open to change:

- Grooming: How well do you take care of yourself? Are you neat and well put together? Check your hair, your nails, your personal hygiene, your shoes.
- Clothing: Are you dressed appropriately for the type of position you hold or the work you do? Do you dress to enhance your body type and build? It's not how much you spend on your clothes that counts. It's knowing what to wear and what to buy.
- Body Language: You can spot a winner a mile away. Just look at the body language. It's happiness and confidence in the walk, the stance, the smile. You can also spot the losers. It's slouch, droop and sag. The entire body looks defeated.
- Handshake: Is your handshake firm and confident? How do you feel when you shake hands with a "dead fish" or a wimp? Most professional and confident people portray composure and control when they offer their hand first, slip it firmly into the other person's, then shake it two or three times.

You can project more confidence in yourself and the business or volunteer work that you do by being aware of these second four characteristics. Evaluate
you yourself as objectively as possible, then pick the areas in which you would like to improve. Have your friends or co-workers help you in making a decision on what changes you can implement. Keep in mind that negative impressions are formed three times as quickly as positive impressions. Most people know almost immediately whether they dislike something or someone. It takes a little longer to react positively.

Fair or not, first impressions send definite messages about you and your capabilities. Take the steps you need to project yourself more positively within the first five minutes.

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<thead>
<tr>
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<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
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<tr>
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<tr>
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Impairment in a physician’s practice may be a result of substance/alcohol abuse or mental or emotional disorders. The American Medical Association recognized a significant impairment problem among physicians in a letter to its members earlier this year.

The incidence is similar to that seen in other professionals, including professional athletes and those individuals working in the public media. In years past, often these illnesses were viewed by colleagues and the public as untreatable or “moral issues” and a danger to society.

Many times, the sick physician was ignored and allowed to practice as his illness progressed resulting in multiple complications. A few states began to recognize this dilemma and in the late 1970s began to do something about it. The Medical Association of the State of Alabama was a leader in this volunteer effort. The selfless efforts of several MASA physicians resulted in the Impaired Physicians Program and the development of the Alabama Impaired Physicians Committee (AIPC) in 1988.

This action set the stage for a full-time program and the appointment of a full-time Medical Director on Oct. 1, 1991. MASA recognized the need to assist its colleagues to acknowledge their illness prior to impact upon their medical practice, family disruption and other legal complications including disciplinary actions by the Licensing Board, hospital credentialing committees, and malpractice litigation.

Chemical addiction to mood-altering substances, including alcohol, is associated with a conspiracy of silence and may result in death from multiple causes. One unfortunate incident was that of a prominent surgeon in a metropolitan area of Alabama who was rumored to have a problem with alcohol. On a clear evening, with no traffic around, he was alone in his car and drove it into a tree resulting in his death. One year previously, he had asked for assistance for his alcohol problem. His plea for help went unheeded.

The Physicians Recovery Network (PRN) is now available to assist physicians in the event that they reach out for help. PRN response to physicians and their families is confidential and respects their anonymity.

The Physicians Recovery Network is available to assist in the resolution of frivolous complaints rendered to the Alabama Board of Medical Examiners (ABME) or to MASA concerning physicians. A referral is illustrated in the following example.

A 39-year-old specialist was reported to ABME by a local business that he was intoxicated and acting in a belligerent manner. ABME referred the complaint to PRN. A confidential and discreet investigation revealed the complaint to be unsubstantiated. The situation was resolved without involvement by the regulatory Board. A time-consuming and unnecessary investigation by the regulatory Board with potential exposure to the public was avoided.

PRN assists impaired physicians prior to disciplinary actions by hospital administration. Advocacy for the impaired physician is paramount. Returning the physician to a productive practice is one of the goals, as is demonstrated in the following case of an Alabama physician.

A 42-year-old internist was discovered by the hospital staff to be under the influence of chemicals while working in the emergency room. He was brought before the hospital administrator and the hospital attorney with the intent to revoke his hospital privileges immediately. PRN was notified and within hours responded with a meeting in the hospital administrator’s office. The impaired physician was permitted evaluation by a treatment provider approved by the AIPC, subsequently treated, and has returned in recovery as a productive physician on the staff. PRN was able to begin to develop a re-entry advocacy position during the initial intervention in the administrator’s office. The confidentiality of his
illness remains intact, with no involvement of regulatory Boards or insurance carriers.

Protection of the public prior to demonstrable impairment in a physician’s practice is a primary concern to PRN. Self-administration of mood-altering chemicals intravenously has the realistic and urgent potential for impairment in professional performance.

A 42-year-old family practitioner in Alabama was referred for self-administration of intravenous opiates. An immediate investigation resulted in the indication for intervention. The physician was noted to be severely impaired, was immediately referred to an approved treatment provider, and is currently in treatment. He is expected to make a full recovery and return to active practice in his community free of the dependency on mood-altering chemicals. There was no evidence of injury to any of his patients. This brief case history illustrates that experienced physicians on the AIPC offer the sick physician the best chance of prompt, discreet investigation, intervention and recommendation for evaluation.

The confidential nature of the PRN enables colleagues to assist a physician without fear of reprisal from regulatory Boards, hospitals or colleagues within his office. For example:

A 46-year-old Alabama internist was referred by his colleagues after he had appeared in his office during working hours on several occasions with alcohol on his breath. The physician’s behavior was associated with marital discord with potential injury to his reputation in the community. Referral for evaluation out of the state resulted in the diagnosis of alcohol abuse but not the disease of alcoholism. He recognized his dilemma and was able to stop drinking on his own recognizance and to put his professional and personal life back in order simultaneously maintaining confidentiality. He is currently a leading physician in his community.

The AIPC directs the policies and procedures of the Physicians Recovery Network.

There are 14 members representing different specialties, all with a special interest in helping physicians who may be becoming impaired. Through the PRN, their expertise is available to the ABME. PRN saves the ABME time and expense through the confidential network established. The efforts by PRN avoids the necessity of investigative efforts by the Board, appearances at meetings of the Credentials Committee or other recurrent disciplinary actions. ABME member’s time can thus be utilized more efficiently.

The ABME provides for out of state physician applicants for Alabama medical license who have a history of substance abuse or emotional or psychiatric illness, to be evaluated by PRN during the application process. The availability of the AIPC and PRN provides expertise to the ABME through the confidential network established with other state impaired physician programs. These advocacy efforts avoid the necessity of out-of-state investigative efforts by regulatory Boards and potential disciplinary actions. Two illustrations of this process follow:

A 40-year-old out-of-state physician with a history of chemical dependency to intravenous opiates had been in recovery for five years. A confidential communication to the state impaired physicians program documented his recovery status. PRN then provided advocacy for his Alabama license. He is currently practicing in Alabama, compliant to his new PRN advocacy recovery contract.

A 37-year-old out-of-state physician indicated treatment for addiction on his initial application for an Alabama license to practice medicine. Confidential communication with the Medical Director of his state impaired physicians program revealed poorly documented recovery and relapse behavior. Prior to PRN developing an advocacy position for his Alabama application, he has agreed to undergo an evaluation by an AIPC approved treatment facility. The results of the evaluation will be included in his Alabama license application process and be made available to the ABME. As a result, Alabama citizens will be assured of a physician compliant in his recovery program.

The Medical Association of the State of Alabama is one of the few states with a full-time impaired physicians program. The program also provides guidance to hospital impaired physician committees and the education of hospital staffs and employees, structured support groups, family assistance, and with permission, liaison to hospital credentialing committees and insurance companies. The benefits of the program are readily evident. Perhaps the outstanding benefit is that the patient is assured of a competent physician. The process grants immunity to referring sources. This encourages early referral of possible impairment.

Alabama has a system in place to provide evaluation of physician complaints prior to impairment in professional care. The process provides evaluation for the sick physician without fear of reprisal. The PRN system provides safe harbor for physicians from unnecessary harassment. Other states should take note.
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- Advocacy
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The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control. A lower initial starting dosage of 120 mg/day may be warranted in some patients (e.g., the elderly, patients of small stature). Dosages above 240 mg daily should be administered in divided doses. Calan SR should be administered with food.

†Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

Verapamil should be administered cautiously to patients with impaired renal function.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see Warnings), hypotension (systolic pressure < 90 mm Hg), or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control mild heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be induced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction past the accessory pathway bypassing the AV node, producing a very rapid venous reentry or venricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension have been seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function in severe dysfunction use about 30% of the normal dose or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdose. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction, and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitals toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Diuretries should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lidium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbachol concentrations during combined use. Risperidone may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may potentiote the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions:

Constipation (7.3%), dizziness (3.3%), nausea (2%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1%), dyspnea (1%), bradycardia. HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1%), flushing (0.8%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: ankle paresthesia, atroventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, dysphagia or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, preathesia, psychotic symptoms, shakiness, somnolence, anarthria and rash, exanthema, hair loss, hyperkereatosis, muscles, sweating, ticura, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, special menopause, impotence.

References:

Health Access America

The AMA's bold and farsighted policy positions on health care reform are must reading for physicians who are concerned, as all should be, with the survival of American Medicine as we know it.

Dr. Morris, p. 6

Physician, Heal Thyself

The first step in the recovery of an impaired physician, whether it's you or a colleague, is to face the problem -- that is the sine qua non of recovery.

Drs. West and Summer, p.25
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Physicians Recovery Network

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SEP 28 1992

Alabama Medicine, The Journal of MASA / 1
On first hearing the sad news that John Murphy Chenault, M.D., had died July 23, it occurred to me that so many Alabama physicians now in practice may never have heard of him, to say nothing of his contributions to medicine and the cause of medicine.

After all, Doctor Chenault’s eight-year tenure of the Board of Censors ended in 1975, almost two decades ago, as did his pivotal participation in the historic revolution of the AMA pragmatists in the late 60s and early 70s.

Although Dr. Chenault devoted his entire practice lifetime to Decatur, Alabama, his impact was national if not international. After all, as someone has said, the Sermon on the Mount was not delivered at the corner of Hollywood and Vine. Nor, for that matter, was the little Greek island city of Cos in the Southeast Aegean itself the center of the known world in the sixth century B.C. when Hippocrates located, for all time, the moral bedrock of medical practice. Wisdom knows no geography.

It was Dr. Chenault’s presence at the creation of the modern AMA that I will recount in this memorial to a man better described by a prominent Decatur attorney as “a great man... a leader and advocate of everything good and worthwhile.”

In the mid-1960s, after being rolled over by the Lyndon Johnson’s Medicare-Medicaid steamroller, AMA morale reached perhaps the lowest level in its history, a predicament well described by Frank Champion in his history, The AMA and U.S. Health Policy Since 1940:

“No organization can undergo what the AMA underwent and remain the same. It had battled a generally hostile press, two Presidents of the United States and three Congresses — and lost. It had taken an uncompromising stand upon a major health issue, laid its principles on the line and committed its resources — only to fail. People were weary of physicians calling programs they did not like ‘socialism’ and looked unsympathetically on the AMA’s inability to develop an alternative plan for the care of the elderly needy until it was too late.

“The size of the final vote on Medicare, almost three to one in the House of Representatives, underscored a disjunction that had opened between the AMA and society.

“Outwardly, the association appeared unscathed. No was calling for resignations; no one was looking for a scapegoat. Nevertheless, feelings of disenchantedment and unrest were running through the House of Delegates. With the enactment of Medicare and Medicaid, medical policy-making — a lot of it, anyway — moved to Washington, and AMA needed ways to deal with the new center of power....”

The hard-core pragmatists knew that, but they also knew there was, in the conservative organization, a massive inertia that would resist radical transformation from an AMA concerned mainly with medical standards and the dissemination of scientific information to a political powerhouse. The palace coup began with a shift of power to AMPAC and to the philosophy of political clout.

Although there were earlier skirmishes, the revolution began in earnest with the dismissal of Executive Vice President F.J.L.(Bing) Blasingame in 1968. Dr. Blasingame was seen by the reform Trustees as a
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benevolent despot at best; at worst, a barrier to all necessary change.

He must have seen the handwriting on the wall with the new posture of AMPAC, which had established regional field offices beyond his direct control. At the June 1968 meeting of the House of Delegates, two of the Blasingame "head of the table" group on the Board of Trustees were defeated for re-election. At the same time, two physicians closely identified with AMPAC were elected to the Board — John F. Kernodle, M.D., and Alabama's Dr. Chemault.

The reformists didn't cotton to Dr. Blasingame's self-image as the permanent president of the AMA and the Board as his docile advisory committee. As one physician recalled of the period, Dr. Blasingame saw himself as being to organized medicine what George Meany was to labor — the head man who, directly or indirectly, made all policy.

Both the AMPAC Board of Directors and the Board of Trustees met the following September in Chicago. Out of these meetings came an invitation for Dr. Blasingame to resign. When he refused, he was dismissed but not without much doubt and soul-searching even among the pragmatists. He was a friendly man, with many supporters; his avuncular style suited many physicians.

Dr. Blasingame always said thereafter that he had been unhorsed by AMPAC but it was much more involved than that. Tough to the very end, he accepted an invitation to address the House of Delegates in December. In that address, he posed a question that some still believe remains unanswered:

After expressing his "amazement, regret and sadness," he asked the Delegates, "How can a dichotomy not be avoided in matters of medical service and research on the one hand and legislative and political [matters] on the other?"

His immediate successor was Earnest B. Howard, M.D., the AMA assistant executive vice president, who agreed to accept what was first intended to be an interim appointment. Dr. Howard understood his place as an instrument of the Board, although he was far from a puppet.

He was a pragmatist, but not a crusader. The next year the Board removed "acting" from his title. As if in direct answer to Dr. Blasingame's question to the House of Delegates, a new department was created under Dr. Howard's command and at his suggestion — the Division of Public Affairs, which would be responsible for AMA's relations with the federal government.

Dr. Howard let few occasions pass in the ensuing years when he did not make it known that he considered his successor to be one of the two assistant executive vice presidents he appointed in the summer of 1969 — Richard S. Wilbur, M.D., grandson of an AMA President and nephew of the immediate past president. The directors of the non-scientific divisions thereafter reported to Dr. Wilbur, an attractive, able man who had risen to the chairmanship of the California Medical Association.

Dr. Howard had no authority to appoint Dr. Wilbur as his successor, but he actively campaigned for him as he approached the age of 65, having announced well in advance he would serve no longer beyond that time. As 1973 ended, the AMA began to concern itself with Dr. Howard's replacement.

That was the principal business when the Board of Trustees met in Washington March 14-17, 1974. A search committee had started with 70 names, which were winnowed down to 26, then 12 and finally the five presented to the Board: Merlin K. Duval, M.D., dean of the University of Arizona College of Medicine and a former Assistant Secretary at HEW (now HHS); Charles C. Edwards, M.D., at the time Assistant Secretary of Health and formerly director of the AMA's division of socio-economic activities; Robert B. Hunter, M.D., a member of the Board; James H. Sammons, M.D., the chairman of the Board; and, of course, Dr. Wilbur.

Before proceeding with written ballots, the board adopted ground rules, which included: the order that trustees under consideration would absent themselves from the meetings and would be ineligible to vote as long as they remained under consideration; the five candidates would be voted on simultaneously, the candidate with the fewest votes being dropped before the next ballot; a two-thirds majority would be required for the final decision — ten votes out of 15 if all were present, nine out of 13 or 14, depending on the absence of Hunter or Sammons or both.

The first ballots eliminated all but Drs. Sammons and Wilbur. Dr. Hunter returned to the room and to the voting on these two. There followed a succession of 7-7 votes, according to Mr. Campion's history, "the deadlock lasting to the end of the day and exhausting all present." In all, 14 ballots were taken.

The rest of the story is in dispute. By the time the Board went back into executive session two days later, some minds had apparently changed. According to Mr. Campion's sources, Trustee Russell B. Roth, M.D., had told Trustee Max H. Parrott, M.D., at dinner the previous evening that he was going to switch his support to Dr. Sammons because he was now con-
vinced that Dr. Wilbur could not win.

According to Campion's history, Trustee Donald E. Wood, M.D., closely allied with Drs. Sammons and Parrot, went to Dr. Chenault and said he would withdraw as a candidate as vice chairman of the board and back Dr. Chenault for that post if Dr. Chenault would switch to Dr. Sammons.

Dr. Chenault's widow, Belle, who was in Washington at the time of the fateful meeting, says this is totally wrong: her husband had supported Dr. Sammons all along, she says. In any case, on the 15th ballot Dr. Sammons prevailed by the necessary two-thirds majority, 9-5.

Feelings ran so high over the outcome, that a motion to make Dr. Sammons's victory officially unanimous, a routine gesture in the AMA, failed.

Dr. Chenault was, in fact, elected the new vice chairman of the Board but not because of a quid-pro-quo, Belle stoutly maintains.*

The rest, as they say in football, is history. Still, one question raised during this turbulent period may remain unanswered to this day, some say — the question put to the House of Delegates by the ousted Dr. Howard in December 1968:

"How can a dichotomy be avoided in matters of medical service and research on the one hand and legislative and political [matters] on the other?"

Some younger Alabama physicians may view the AMA as a clubby group of good old boys without qualms or doubts. A visit to an annual meeting of the House of Delegates would quickly disabuse anyone of that notion.

Dr. Chenault was deeply involved in the soul-searching at the very dawn of the new era of AMA. There were no easy answers to everything then, and there certainly aren't in 1992.

*Belle Chenault has been a major force in medical affairs in her right. She served as President of the AMA Auxiliary, 1969-70; she was the first Auxiliary representative to the AMPAC Board, on which she served from January 1970 to December 1979. In her honor the AMA Auxiliary established the Belle Chenault Award for Political Participation. Small wonder that her late husband often described her as his No. 1 adviser.

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Albama Medicine, The Journal of MASA / 5
Health Access America

Many physicians, in Alabama as elsewhere in the country, appear to know little of AMA’s proactive position on health care reform, as embodied in its comprehensive Health Access America. The original document was released more than two years ago, after years of work, and refined in subsequent meetings of the House of Delegates.

For that reason, we are devoting a substantial portion of Alabama Medicine this month to what could be called a mini-residency on organized medicine’s position as it is still evolving.

On the following pages you will find two recent reports of the AMA Board of Trustees — 1. Report QQ submitted to the House of Delegates last December, itself incorporating refinements previously directed by the House; and 2. Report DD of the Board, submitted to the House at the annual meeting this past June. (Additional refinements were directed by the Delegates at that meeting and will be incorporated into the Board’s report to the House in December.)

Health care reform is an immensely complicated and hazardous undertaking. It is also highly fluid. Accordingly, AMA’s position is an organic, ongoing process, responding to the welter of bills already before Congress as well as ideas being publicly debated.

What you are about to read are not bills. They are policy positions enunciating what U.S. physicians believe to be the standards against which all reform bills introduced in Congress must be judged if the great institution of American medicine is to be preserved. Obviously, this remains open-ended. As the situation changes, our positions will be further refined.

In a subsequent issue, we will print the Alabama adaptation of Health Access America. Both the AMA position paper, as it existed at the time, and the Alabama one were approved by the MASA College of Counsellors and House of Delegates at our April meeting.

Please take the time to read these pages. Otherwise, you will have no idea where we are. You will see that organized medicine has been manning the barricades to protect the American health care system in a highly volatile time fraught with great danger to patient care and private practice.

The next Congress will likely set the stage for American health care well into the next century.
EXECUTIVE SUMMARY

This report presents key Health Access America refinements which will supplement and strengthen the HAA proposal as the national debate on health care reform intensifies. Recommendations in the report are based on the Board's own deliberations as well as discussions with the Councils on Medical Service and Legislation, and the recommendations of the Board/Council Task Force appointed by the Chairman of the Board at the October Board meeting.

The report recommends that all Americans should have defined health care coverage; calls for a broader commitment than ever before of the medical profession to respond to the needs of the poor and near poor; establishes a bold commitment of the medical profession to make fee information available to patients to empower them to make more informed market-based health care decisions; and makes a direct challenge to the government to allow professionalism to serve as the needed restraint on unbridled entrepreneurialism.

The report strongly favors market-based forces, along with an appropriate government role, over a centrally-controlled, budget-driven, government-run system.

REPORT OF THE BOARD OF TRUSTEES

Report: QQ

Subject: Health Access America Refinements

Report: QQ (I-91)

Presented by: Joseph T. Painter, M.D., Chairman
Referred to: Reference Committee A

The AMA believes that recent events underscore the AMA position that the American people want action on health care system reform. During the year-and-a-half since the introduction of Health Access America, the AMA has been a leading proponent of health care reform. When the proposal was announced in March 1990, the AMA noted it was committed to the process of debate and negotiation, and that it was essential for a national dialogue to address health care reform in this nation. Since that time, over 30 health care reform bills have been introduced in the Congress, and the intensity of the national debate has steadily increased. The AMA has forthrightly discussed with the Administration and with the Congress the urgent need for health care system reform, based upon the strengths of the current private/public partnership for health care delivery. Health Access America specifically lays out a program for comprehensive reform. Even as strong, willing and generous as this nation is, the legitimate competing calls upon this nation's treasury require that more effective measures be proposed to both constrain the rate of increasing health care costs and assure solid value in medical services. The emphasis must be on what is best for the patient.

The Board has extensively reviewed and discussed ways to refine and strengthen the Health Access America proposal. The Board believes that the actions described in this report, which are based upon its own deliberations as well as discussions with the Councils on Medical Service and Legislation, and the recommendations of a Board/Council Task Force appointed by the Chairman of the Board at the October Board meeting, will strengthen the Health Access America proposal. This Task Force is comprised of representatives from the Councils on Medical Service, Legislation, and Long Range Planning, along with Board representatives Dr. Lonnie Bristow, who chairs the Task Force, and Dr. John Seward. The Council representatives on the Task Force are: Dr. Perry Lambird and Dr. T. Reginald Harris, from CMS; Dr. John Nelson and Dr. Ted Lewers from COL; and Dr. John K. Scott and Dr. C. Burns Roehrig from CLRPD.

The wonders of modern medicine provide great benefits to the American people, but they carry significant costs. In a nation spending $666 billion per year for health care and still having 13% to 15% of its population uninsured, the rate of increasing costs obviously is a valid concern in considerations of extending coverage to the uninsured. The core question is whether this nation is getting full value for its health expenditures. Cost containment, as long as it does not compromise the access to quality care for the 8570 of Americans with coverage, is an appropriate avenue to make resources available to the uninsured.
There are really only two general approaches to achieving cost restraint: (1) a government-run, regulatory, budget-driven, centrally controlled system, or (2) a system based on enhanced market forces, with patients empowered with information and incentives to make economical utilization and related health care decisions based on each individual's personal priorities, and with the medical profession empowered to assure professionalism.

This report to the House supplements and presents proposed enhancements to HAA based on attentive listening to all sides of the health care system reform debate. It recommends approval by the House of policy which: approves universal coverage for all Americans as a national goal; calls for a broader commitment than ever before of the medical profession to respond to the needs of the poor and near poor; establishes a bold commitment of the medical profession to make fee information available to patients to empower them to make more informed market-based health care decisions; and makes a direct challenge to the government to allow professionalism to serve as the needed restraint on unbridled entrepreneurialism. The Board believes these changes are timely, appropriate and essential to the AMA continuing to fill a leadership role in helping the American people to better understand the implications of decisions they will be making in the coming months and years. These changes are pivotal to a system which focuses on what is best for the patient.

The way to bring about universal coverage for all Americans is through a national health policy, not through a nationalized health care system. Particularly in a time of burgeoning national debt, a national health insurance plan that calls for massive restructuring with responsibilities shifting to federal or state governments for financing health care services is neither desirable nor realistic. Health Access America, however, provides a framework for universal coverage. The American people want choice, value, and quality in their health care system. The trust for such care should not be transferred to the federal government, with its monumental deficit, the interest on which is a greater proportion of federal spending than is health care spending. The average annual increase (1980-1990) of the percent of the federal budget going to pay net interest on the deficit is greater than the increase for health care, Social Security, or national defense. All health care funds should not be entrusted to the federal government, where they, like the Social Security "surplus," could become subject to helping to fund the deficit. It is preferable to have the checks and balances of the competitive market influencing our opportunities for medical advancement, provision of quality care, medical education, and scientific research, rather than entrusting such precious values to a governmental monopsony where the nation's total health care financing is removed from the private sector and becomes subject in a governmentally controlled system to competing demands of defense, housing, education and other demands. The economic control of supply/demand forces by the government would result in artificial cutbacks in the supply or volume of medical services available and price controls on those services. Accordingly, the continuing advance of medical science against the frontiers of disease and disability, which many Americans take for granted, could fall victim to other governmental priorities, such as foreign affairs or the need for domestic bailouts, such as the savings and loan crisis.

It would be ironic at a time of the collapse of state-centered command and control economies around the world to institute such a system for medical care delivery in the United States. There is no question that we need substantial health care reform in this country. Such health care reform, however, should not jeopardize the access and quality of health care provided to the majority of people in this nation, and should have as its central focus the question: what is best for the patient?

All of this, as noted in the original HAA proposal, is not to say there is no proper role for government. The profession recognizes that greater reliance on market forces is not a total health care reform solution. A government role in providing for a fair market system and in protecting those who have inadequate resources will be essential. In general, the market will be enhanced if insurance is directed toward helping patients with expensive, long term and emergency conditions for which personal budgeting is not practical and away from routine, low cost, discretionary medical services.

Core Principles and Specific Health Access America Refinements

As the Board and its Task Force have reviewed specific refinements for strengthening Health Access America, it became evident that not only specific refinements but also a list of core principles against which such approaches and the variety of health care proposals could be measured would be very helpful. Thus, the remainder of this report lays out for recom-
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**INDICATIONS AND USAGE**  For the relief of moderate to moderately severe pain. CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone. WARNINGS: Respiratory Depression. At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression. Head Injury and Increased Intracranial Pressure. The respiratory depressant effects of narcotics, and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury or other intracranial lesions or in intracranial hypertension. Furthermore, narcotics produce additive respiratory depression with other depressants including alcohol, sedatives, hypnotics, general anesthetics, phenothiazines, and other CNS depressants.

Acute Abdominal Conditions. Administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions. PRECAUTIONS: Special Risk Patients. VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, respiratory depression, Addison's disease, prostatic hypertrophy or partial urinary obstruction. Cough Reflex. Hydrocodone suppresses the cough reflex, as well as other reflexes. Caution should be exercised when VICODIN/VICODIN ES Tablets are used in patients with a history of chronic constipation or in patients with a history of adverse reactions to hydrocodone. The concurrent use of anticholinergic agents with hydrocodone may produce additive effects. Usage in Pregnancy. Teratogenic Effects. Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Nonteratogenic Effects. Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stooling, sneezing, yawning, vomiting, and fever. Labor and Delivery. Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used. Nursing Mothers. It is not known whether the drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. Pediatric Use. Safety and effectiveness in children have not been established. ADVERSE REACTIONS. The most frequently observed adverse reactions include light headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include: Central Nervous System: Drowsiness, mental confusion, lethargy, impairment of mental and physical performance, anxiety, fear, depression, psychic and mood changes. Gastrointestinal System: Anorexia, nausea, vomiting, constipation, diarrhea. Other Systems: Local reactions at the site of injection include redness, pain, and induration. Allergic reactions: Anaphylaxis has been reported. Cardiac: Elevation of blood pressure and tachycardia. Pulmonary: Increased respiratory rate and depth. Other Reactions: Insomnia, dizziness, headache, anorexia, nausea, vomiting, vertigo, drowsiness, dry mouth, sweating, increased sweating, increased salivation, feeling of warmth, hypotension, hypertension, orthostatic hypotension, flushing, syncope, tachycardia, myocardial ischemia, respiratory depression, paradoxical excitement, hallucinations, paranoia, and pruritus. CNS: Confusion, drowsiness, nervousness, restlessness, agitation, anxiety, hypomania, dysphoria, hallucinations, seizures, irritability, emotional lability, myoclonus, hallucinations, paranoia, coma, sleep disturbances, insomnia, hypnosis, respiratory depression, severe respiratory depression, intracranial pressure, and fever. Dermatological System: Blistering, urticaria, dermatitis, rash, pruritus, sweating, angioneurotic edema, photosensitivity, increased sweating, increased salivation, xerostomia, flushing, sweating, conjunctivitis, rhinitis, and impotence. Hematopoietic: Hemolytic anemia, agranulocytosis, and aplastic anemia. Endocrine and Metabolic: Impairment of glucose tolerance, changes in thyroid, and adrenocortical function. The incidence of hypoglycemic reactions has been reported. Other: Increased appetite, weight gain, respiratory depression, respiratory arrest, pulmonary edema, subdural hematoma, convulsions, status epilepticus, hyperpyrexia, AST or ALT elevations, rash, urticaria, and angioedema. Overdose. Severe overdosage, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoproteinemia, coma, and respiratory depression may also occur. Early symptoms following a potentially hepatotoxic overdose may include: jaundice, vomiting, diarrhea, and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post ingestion. Hydrocodone Sign and Symptoms. Severe overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume), Cheyne-Stokes respiration, cyanosis, extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradyarrhythmia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.
mended policy approval such core principles (Section I) and specific refinements to Health Access America (Section II).

RECOMMENDATION
The Board of Trustees recommends that the following core principles and specific HAA refinements be adopted as policy and that the remainder of this report be filed:

Section I. Core Principles
1. All Americans should have defined health care coverage.
2. Universal health care should be provided through a private sector/public sector partnership that builds upon the strengths of our current health care system.
3. Government programs should enhance our current employment-based system and provide coverage or assistance to those outside that system who are unable to provide coverage for themselves and their families.
4. Greater reliance on market forces, with patients empowered with understandable fee/price information and incentives to make prudent choices, and with the medical profession empowered to enforce ethical and clinical standards which continue to place patients' interests first, is clearly a more effective and preferable approach to cost containment than is a government-run, budget-driven, centrally controlled health care system.
5. Patients should have freedom of choice of physician and/or system of health care delivery. Where the system of care places restrictions on patient choice, such restrictions must be clearly identified to the individual prior to their selection of that system.
6. Physicians' clinical judgments should be subject to professional peer review to maintain and enhance the quality of care delivered to patients. When in conformance with standards and practice parameters developed by and acceptable to the profession, such clinical judgments should not be subject to third-party payor challenges. Medical societies should be empowered to operate programs for the review of patient complaints about fees, services, etc.
7. A pluralistic delivery system is essential. Such a system should be enhanced through governmental action to apply the same rules of competition to all competitors, including insurance carriers and self-insureds.
8. Physicians should retain the freedom to choose their method of earning a living (fee-for-service, salary, capitation, etc.).
9. Physicians should retain the right to charge their patients their usual fee that is fair, irrespective of insurance/coverage arrangements between the patient and the insurors. (This right may be limited by contractual agreement.) An accompanying responsibility of the physician is to provide to the patient adequate fee information prior to the provision of the service. In circumstances where it is not feasible to provide fee information ahead of time, fairness in application of market-based principles demands such fees be subject, upon complaint, to expedited professional review as to appropriateness.
10. Health insurance market reform is essential, particularly for the small business market, and community rating, elimination of preexisting conditions, guaranteed renewability, limits on premium increases, portability and continuity are critical elements to assuring universal coverage.
11. The AMA should achieve the right to negotiate for physicians program payment and the other conditions in government health entitlement programs, where legislative and/or administrative restrictions are unilaterally applied to physicians' freedom to set their own fees. Any such fee restrictions should be limited to those patients who cannot reasonably afford to pay the difference between the physician fees and government reimbursement levels. In the private sector, where insurance arrangements for thousands of patients are increasingly controlled by single third-party payers, physicians should have the ability to negotiate collectively on behalf of their patients and themselves.
12. Single-payor systems are not in the best interests of patients, physicians or the health care of this nation and should be strenuously resisted.

Section II. Policy Recommendations for Health Access America Refinements
(Appendix II contains a chart form a brief summary comparison of the proposed refinements with the original HAA points. Appendix III contains a brief summary of the group affected, objective and approach of the refinements.)

A. Patient/Physician/Employer/Employee/Labor

Provisions to (1) encourage cost-conscious utilization of health services and (2) provide revenue to fund expanded access

1. Tax cap - band of tax deductibility

Alabama Medicine, The Journal of MASA / 11
An employer/employee tax cap is recommended where an employer's tax deduction for health benefit premiums would have an appropriate ceiling (e.g., 133% - 150%) relative to the costs in that geographic area of the AMA minimum benefits plan. Maximum deduction for a benefit payment schedule (indemnity) plan or an HMO premium would be the actuarial equivalent. Optional benefit provision for unlimited physician office visits and hospital days or other benefit or coverage, at an added cost to the employee, would not trigger application of this tax limitation on insurance deductibility on the employer. (The AMA's minimum benefit plan was approved by the House of Delegates at A-90 in BOT Report KK, Policy Compendium 1990 Supplement. 56.002S. A copy of this plan is set out for information in Appendix I.)

Employer-paid health insurance premium/self-insurance amounts which exceed the cap would be considered taxable income to the employee. (CBO has estimated that a tax cap at $250/month for family coverage and $100/month for individual coverage would raise revenue an average $12 billion per year over a 5-year period.) Any amounts paid out of pocket by the employee would be tax deductible by the employee, with removal of the existing 7.5% on adjusted gross income tax code threshold for such deductibility. Current tax laws regarding cafeteria plans should be modified to allow an employee to roll over amounts not used toward a deductible/copay into a tax-preferenced account.

2. Health IRA/Flexible Benefit Account
Endorse an IRA for health care purposes (other limited, defined purposes could be included) which would encompass the concepts of utilization of pre-tax dollars, tax-free accumulations, and non-penalized withdrawals for health care and other limited purposes. Emphasis should be placed on utilization of such funds during retirement or disability (for example, premiums for supplemental coverage during working years would not be deductible).

Fairness in fees charged, value for services, professionalism, and insurance portability/continuity

1. Fee Information to Patients
In order to facilitate cost-conscious, informed market-based decisionmaking in health care, physicians, hospitals, pharmacies, durable medical equipment suppliers, and other health care providers would be required to make information readily available to consumers on fees/prices charged for frequently provided services, procedures, and products, prior to the provision of such services, procedures, and products.

There would be a similar requirement that insurers make available in a standard format to enrollees and prospective enrollees information on the amount of payment provided toward each type of service identified in the required minimum benefits package.

2. Assistance to indigent
For persons below 200% of the state-adjusted poverty level, the benefit payment schedule (indemnity) or UCR-based amount, whichever is applicable, would constitute payment in full. Such a provision should not preclude a nominal point-of-service payment.

3. Fee Review
Federal and/or state legislation would authorize medical societies to operate programs for the review of patient complaints about fees, services, etc. Such programs would be specifically authorized to arbitrate a fee or portion thereof as appropriate and to mediate voluntary agreements. A review mechanism including the state medical society and the AMA Council on Ethical and Judicial Affairs would also be authorized.

4. Portability/Continuity
Once covered through employment, an employee who leaves that employment would be guaranteed the minimum benefits coverage, with no waiting period or preexisting condition limitation, at a new employer without any rate increase for said coverage (other than due to geographic location) to the employer or employee due to health condition. The new employer must provide at least the AMA minimum benefits/insurance and offer the same range of benefits/insurance available to other employees. Only one deductible could apply in the same year. (Existing HAA provisions address periods of unemployment, by recommending that employers be required to pay the same share of premium for COBRA continuation coverage for up to four months, and that persons who lose group coverage should also have access to risk pool coverage, at standard group rates, with premium assistance for the needy.)

B. Insurance/Business
Make mandated employer insurance more affordable, particularly for small business. Provisions apply to both self-insureds and insurance policies. (Additional provisions such as preemption of
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Applicants must be board certified or meet all requirements for board candidacy in one of the above specialties.

BONUS ELIGIBILITY: In addition to meeting all criteria for appointment as a medical corps officer in the US Army Reserve, Bonus Test applicants must be civilians and if prior service, discharged before 28 April 1989.

BONUS AMOUNTS: The test offers $10,000 bonus for each year of affiliation with the Selected Reserve of the Army, up to a maximum of 3 years. Physicians must choose 1, 2, or 3 years of affiliation at time of application. Bonuses will be paid annually at the beginning of each year of agreed affiliation.

TEST PARAMETERS: The design of the test stipulates that bonuses be offered in certain geographic areas. To qualify, applicants must reside within those areas at the time of accession.

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state-mandated benefits and elimination of the ERISA preemption are in the current HAA proposal.)

1. Premiums charged to small business shall be no more than a small percentage higher than the per capita average across all the group insurance sold in the same or an actuarially equivalent community for the same benefit package during the preceding three months. Open enrollment would be required. (Community rating.)

2. Every insurer would be mandated to offer one policy with the exact required minimum benefits (no more, no less), with a benefit payment schedule (indemnity) version, a UCR version, and a prepaid version. This requirement would not restrict the offering of additional policies.

3. Reinsurance pool covering individual carrier/selfinsurers costs beyond a designated amount (e.g., $25,000) per insured person for the mandated minimum benefits policy. Carriers and self-insureds would be required to participate/underwrite the reinsurance pool.

4. In complying with the employer mandate to provide basic benefit coverage, the employer would have to offer the employee the options, where available, of a benefit payment schedule (indemnity) version, a UCR revision, and a pre-paid version.

Reduce administrative costs

1. Federal law would mandate the use by all insurers and self-insurers of the uniform claim form (i.e., the AMA form, HCFA 1500), and a standardized format for electronic claims. (Based on existing AMA policy, AMA Policy Compendium (1990 Edition), 56.022, and 56.003S.)

2. Support federal and state legislation regulating the conduct of utilization and managed care (i.e., managed cost/access to benefits) programs by all payors, so as to reduce the "hassle quotient" and the costs of varied and conflicting managed care requirements, claims procedures, review practices and disclosure policies. (Based on existing AMA policy, BOT M, I-90, AMA Policy Compendium (1990 Edition), 56.007S.)

3. Recognize appropriateness of payment delay, pending peer-to-peer review, for services outside of parameters that are acceptable to the profession. (Based on existing AMA policy, CMS Rep. D, A-89, AMA Policy Compendium (1990 Edition), 93.012.)

C. Government

Make costs more predictable: reduce cost shift: protect indigents from costs.

1. In order to remove the Medicare program from the continuing Congressional budgetary pressures, all Medicare funds (including replacement taxes for current general revenue funding of Part B) would be placed in trust funds to be administered by a federal reserve board type agency which would be independent of the Congressional budgetary process. (Any periodic tax changes to increase revenues would need to be approved by Congress.) (Based on existing AMA policy, Report MM, A-86, AMA Policy Compendium 1990 Edition, 65.058.) (This provision is not intended to imply support for extension of this concept to a central board that would also cover the private sector.)

2. In the Medicare program, which has legislative and regulatory restrictions on the right of physicians to set their own fees along with the authority to establish the conversion factor, the Medicare program would be required to negotiate the payment schedule conversion factor with the AMA, the national organization with the largest physician membership. State laws would be specifically preempted from addressing this or essentially related issues.

3. The tax rates to fund the trust fund would have to adequately reflect: demographic factors, inflation, technological advances, adequate access, geographic cost of practice differences, return on equity, capital development, labor and other practice costs, and professional liability costs.

4. There could be no charges beyond the negotiated rate for any Medicare beneficiary under 200% of the state-adjusted poverty level.

D. Minimum Benefits in Mandated Employer Insurance

The minimum benefit package already approved by the AMA House of Delegates as AMA policy (set out in Appendix I), which employers are required to provide, would have to be offered in three versions, where available (benefit payment schedule, UCR, and pre-paid) with the employee being entitled to select his or her choice. The requirement to offer three versions, where available, is new, and will enhance the provision of true indemnity policies, market-based choice and pluralism.

In all three versions, the employer, in accordance with the existing minimum benefits policy, shall be required to offer coverage for unlimited physician office visits and hospital days, at an added cost to the employee selecting this coverage. No policy provision in any version may contain a pre-existing condi-
tion exclusion from coverage (this is existing policy). The provision of choice in the small employer setting should not be troublesome, since rates for small employers will be on a community-rating basis, not experience rating.

In the benefit payment schedule (indemnity) version, the benefit payment schedule may be adjusted on a carrier-by-carrier or employer-by-employer basis, subject to the requirements that some payment amount be scheduled for each of the required benefits and that there be a $1,500 per individual and $3,000 per family out-of-pocket limit for incurred expenses for minimum benefits above the scheduled benefit payment amounts for such benefits. Neither premiums nor payments for benefits beyond the scope or intensity of the required minimum benefits shall be counted toward meeting the out-of-pocket maximum. (The individual and family benefits are the same as in the minimum benefits policy previously approved by the House, and set out in Appendix I.)

The pre-paid version must provide for at least the scope and intensity of services in the minimum benefit package and out-of-pocket limits and optional benefits noted above for the benefit payment schedule (indemnity) (which are the same as the minimum benefits policy previously approved by the House and set out in Appendix I.)

The previously approved minimum benefits plan reflects features, such as deductibles and copayments, contained in UCR-based plans.

APPENDIX I

The AMA Minimum Benefits Package
- Maternal and child care
- Pre- and post-natal care
- Pregnancy care including complications
- Delivery
- Immunizations and well-child care up to age 8, using American Academy of Pediatrics guidelines

Physician services
- Medically necessary services provided in inpatient and outpatient settings, up to 20 office visits per person per year
- Diagnostic and therapeutic services
- Medical or surgical treatment of illness or injury
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- Dental services
- Limited to repair necessitated by injury to sound teeth or jaw

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• Semiprivate room, board
• Nursing services
• Diagnostic services
• Drugs, oxygen, blood, biologicals, supplies, appliances, equipment
  • Operating, delivery and recovery room charges
  • Intensive, coronary and other medically necessary special types of care
• Dialysis
• Rehabilitation unit charges
• Care for pregnancy and complications
• Other medically necessary ancillary services

Home health services
• Medically necessary services prescribed by physician, up to 240 visits per person per year

• Physician services
• Services of nurses, aides and medical social workers under physician supervision
• Medical supplies, appliances
• Oxygen, blood, biologicals
• Durable medical equipment rental
• Ancillary services

Other
• Ambulance
• Skilled nursing facility, up to 180 days per person per year

Not covered
• Routine physicals, routine screening tests and exams
  • Detoxification
  • Sterilization, reverse of sterilization
  • Artificial insemination, family planning
  • Cosmetic surgery
  • Obesity treatment, weight loss programs
  • Custodial or domiciliary care
  • Eyeglasses, hearing aids
  • Orthopedic shoes
  • Orthodontic appliances
  • Hospice
  • Outpatient prescription and non-prescription drugs
  • Outpatient speech, occupational, physical therapy
  • Personal comfort items

Deductibles. The basic deductible is $350 per individual and $750 per family. There is no deductible on pre-natal and post-natal care of mother and infant, nor for well-child care and immunizations up to age 8.

Co-payments. The insured individual generally pays 20 percent except as follows:
  • First $1,000 of services, after deductible 30%
  • Additional services, except as otherwise provided 20%
  • Inpatient room and board 30%
  • Outpatient facility services 30%
  • $25 emergency room co-payment per visit, after deductible
  • There is no co-payment on pre- and post-natal care of mother and infant, nor for well-child care and immunizations up to age 8.

Out-of-pocket limits. Limits are set at $1,500 per individual and $3,000 per family. Deductible and co-payment amounts, but not premium payments, go toward meeting out-of-pocket expenses. Lifetime benefit limit per person is $1 million.

Other. As an optional benefit, employers are required to offer coverage for unlimited physician office visits and hospital days, at an added cost to the employee selecting this coverage.
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## APPENDIX II

### COMPARISON OF HEALTH ACCESS AMERICA PROPOSAL TO RECOMMENDED PROPOSAL ENHANCEMENTS

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<tr>
<th>CURRENT HEALTH ACCESS AMERICA PROPOSAL</th>
<th>RECOMMENDED HEALTH ACCESS AMERICA ENHANCEMENTS</th>
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<tr>
<td>1. Medicaid Reform</td>
<td>Refinement of employer-mandate to include the following specific provisions:</td>
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<td>Increase access by enacting major Medicaid reform to assure that in all states persons below poverty are eligible for a uniform set of adequate health care benefits.</td>
<td>(1) In complying with employer mandates, employers would be required to offer their employees options of a benefit payment schedule (indemnity) version, a UCR version, and a pre-paid version, where such versions exist;</td>
</tr>
<tr>
<td>2. Provision of Private Health Insurance</td>
<td>(2) Once covered through employment, employees and their families would be guaranteed coverage at a new employer (portability), with no waiting period, pre-existing limitations, or rate increases to the employer or employee (except based on geographic location), and only one deductible per year could apply. Unemployment periods addressed in current HAA proposal through COBRA extension and risk pools;</td>
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<td>Increase access by requiring employer provision of private health insurance to all full-time employees and their dependents, with tax incentives so that new and small firms can afford the cost of such coverage. Specific legislative reforms include: preempting state-mandated benefit laws to make basic coverage more affordable to small firms; expanding COBRA continuation coverage to require employers to pay (for up to four months) the same share of an employee’s health benefit premium that was paid prior to termination; eliminating provisions excluding pre-existing conditions from employee health benefit plans; and requiring access to pool coverage by small firms and individuals to assure access to minimum benefit policies at standard group rates.</td>
<td>(3) Premiums charged to small firms could be no more than a small percentage higher than per capita average in the community for the same benefit package (community rating), and open enrollment would be required;</td>
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<td>3. State level risk pools</td>
<td>(4) Reinsurance pool covering cost exposure of the insurer/self insured for the minimum benefits package beyond a designated amount (e.g., $25,000) per insured, with required participation in reinsurance pool; and</td>
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<tr>
<td>Increase access by creating state-level risk pools in all states.</td>
<td>(5) All private insurers would be required to offer one policy with the exact minimum benefit package in three different versions: benefit payment schedule (indemnity), UCR, and pre-paid, and employer required to provide whichever version employee selects.</td>
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<td>4. Medicare Reform</td>
<td>Medicare reform initiatives to maintain access to care for the elderly are:</td>
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<td>Maintain access and reduce costs for the elderly by enacting Medicare reform. Medicare reform initiatives, to avoid the future bankruptcy of the program, would create a pre-funded program to be paid by individual and employer tax contributions during the working years. All persons age 65 years and over would be entitled to a voucher for purchase in the private sector of a comprehensive health insurance policy meeting federal standards.</td>
<td>(1) Place all Medicare funds in trust funds, to be administered by an independent federal reserve board-type agency. The AMA would negotiate with this agency the conversion factor for Medicare physician services; and</td>
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<td></td>
<td>(2) Permit balance billing with the limitation that no fees could be charged beyond the negotiated rate for Medicare beneficiaries under 200% of poverty.</td>
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1 The "---" sign in the Health Access American enhancement column indicates that there is no addition recommended to the current position.
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<thead>
<tr>
<th>CURRENT HEALTH ACCESS AMERICA PROPOSAL</th>
<th>RECOMMENDED HEALTH ACCESS AMERICA ENHANCEMENTS</th>
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<tr>
<td><strong>5. Long-term Care Coverage</strong></td>
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<td>Increase access and reduce costs for the elderly by enacting necessary legislation to finance expanded long-term care (LTC) coverage.</td>
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<td>This reform includes expanding financing for LTC through expansion of private sector coverage (encouraged by tax incentives and an asset protection program) and providing Medicaid coverage for those below poverty.</td>
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<td><strong>6. Tort System Reform</strong></td>
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<tr>
<td>Reduce health care costs through professional liability reform.</td>
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<td><strong>7. Professional Parameters &amp; Quality Assurance</strong></td>
<td>Recognize appropriateness of payment delay, pending peer-to-peer review, for services outside of professionally developed and accepted parameters.</td>
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<td>Maintain quality and reduce costs through development of professional practice parameters.</td>
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<td><strong>8. Tax Treatment of Health Care Benefits</strong></td>
<td>Specific tax caps on health care benefits, for employees and employers, as follows:</td>
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<td>Reduce health care costs through altering the tax treatment of employee health care benefits.</td>
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<td>Reform includes the following tax incentives to encourage individuals to make economical insurance choices: (1) placing a limit on the amount of employer provided health insurance that is tax-exempt to the employee; and (2) providing tax-exempt rebates to employees who select health insurance plans with premiums less than their employers' contribution to more expensive plans.</td>
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<td><strong>9. Patient Responsibility</strong></td>
<td>(1) To encourage cost-conscious decisions by patients, &quot;fee disclosure&quot; provision that would require physicians, hospitals, pharmacies, durable medical equipment suppliers, and other health care providers to make charge information for frequently provided services, procedures, and products readily available to consumers, prior to provision of the service, procedure, or product. Similar requirement proposed for insurers regarding release of information on the amount of payment provided for covered services; and</td>
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<tr>
<td>Reduce costs by encouraging cost-conscious decisions by patients.</td>
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<td>If insurance companies, employers, and government programs provide patients information, prior to service, regarding the amount insurance/program will cover, patients are more likely to make cost-conscious choices.</td>
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<tr>
<td><strong>10. Innovative Insurance Underwriting</strong></td>
<td>(2) Endorse the concept of individual &quot;health IRA&quot;/flexible benefit accounts that would encompass the general concepts of utilization of pre-tax dollars, tax-free accumulations, and non-penalized withdrawals, with an emphasis on utilization of such funds during retirement or disability.</td>
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<td>Reduce costs by seeking innovation in insurance underwriting, including new approaches to creating larger risk spreading groups and reinsurance.</td>
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<td><strong>11. Federal Support for Medical Education, Research, &amp; NIH</strong></td>
<td>Basic insurance underwriting reforms include: community rating of premiums charged to small firms, with mandatory open enrollment and no preexisting condition limitations; required reinsurance for the minimum benefits package, portability, and continuity.</td>
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<td>Maintain quality through expanded federal support for medical education, research, and the National Institutes of Health.</td>
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<td><strong>12. Health Promotion &amp; Disease Prevention</strong></td>
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<td>Maintain quality and reduce costs through increased health promotion and disease prevention efforts.</td>
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<tr>
<td>CURRENT HEALTH ACCESS AMERICA PROPOSAL</td>
<td>RECOMMENDED HEALTH ACCESS AMERICA ENHANCEMENTS</td>
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<tr>
<td>14. State-Mandated Health Benefit Laws</td>
<td>Reduce costs and increase access by repealing or overriding state-mandated benefit laws.</td>
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<tr>
<td>15. Administrative Costs and Paperwork</td>
<td>Reduce costs by reducing administrative costs and paperwork.</td>
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<tr>
<td>16. Voluntary Care and Ethical Practice</td>
<td>Maintain quality and access through encouraging physicians to practice in accordance with the highest ethical standards and to provide voluntary care. Reform includes continued AMA efforts to encourage physicians to: provide health care without charge or at reduced rates for persons who are without health insurance and cannot afford health care; and to inform patients of the benefits, risks, and estimated costs of treatment.</td>
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<td>Specific provisions to reduce administrative costs: (1) Federal legislation to mandate the use of uniform claim form (i.e., HCFA 1500) by all insurers and self-insurers, and a standardized format for electronic claims; and (2) Support for national legislation regulating the conduct of all managed care (i.e., managed cost/access to benefits) programs.</td>
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<td>(1) Provision to provide assistance to the indigent in paying for health care. For persons below 200% of poverty, the benefit payment schedule or UCR-based amount, whichever is applicable, would constitute payment in full, while allowing for a nominal point-of-service payment; and (2) Pursue federal legislation to authorize local medical societies to operate programs to review patient complaints about fees or services and to arbitrate or mediate fees accordingly.</td>
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REPORT OF THE BOARD OF TRUSTEES
Report: DD (A-92)

Subject: Health Access America
Presented by: Joseph T. Painter, MD, Chairman
Referred to: Reference Committee A
            (William S. Weil, M.D., Chair)

At the 1991 Interim Meeting, the House of Delegates adopted Substitute Resolution 119, which called on the AMA to consider appropriate means of support for states’ efforts to implement various parts of the Health Access America proposal. The resolution also called on the AMA to: coordinate Health Access America support activities with the respective state medical associations; continue to evaluate state and other approaches to developing a basic benefits package; and seek legislation to repeal or amend ERISA provisions that preempt state-mandated employer health plans.

Also at the 1991 Interim Meeting, the House adopted Board of Trustees Report QQ. That report presented core principles on health care reform and recommended specific policy refinements to Health Access America to strengthen AMA’s leadership and advocacy role in the national health care reform efforts. In adopting Report QQ the House also requested that the AMA: examine the cost of implementing Health Access America; address the issues of escalating hospital charges, drug and device costs, and the marketing of new technologies before adequate clinical trials; and develop additional specific cost containment provisions for the Health Access America proposal.

This report updates the House of Delegates on AMA initiatives to support states’ efforts on Health Access America and notes that an estimate of Health Access America implementation costs, prepared by Lewin-ICF, Inc., is now contained in the updated HAA Booklet which will be provided to all members of the House. The report also recommends additional AMA policies to strengthen the cost-containment aspects of Health Access America, particularly building upon the very important market forces policy established by the House in approving Board of Trustees Report QQ (1-91).

CONTROLLING HOSPITAL, DRUG, AND DEVICE COSTS

The Board of Trustees has prepared a separate report before the House of Delegates at this meeting on the “Cost of Prescription Drugs.” That report reviews several AMA efforts, as well as those of the private and public sector, to control escalating drug prices. Legislative proposals have been introduced in the Congress, such as S 2000 (introduced by Senator Pryor, D-Ark.), that would restrict increases in the price of pharmaceuticals. The Board will continue to monitor and take action on this legislation as appropriate.

Consistent with current policy to promote true market forces and cost-conscious decisionmaking in health care, the AMA has also urged all hospitals to make available to the attending staff, the hospital’s housestaff, and medical students permitted to work in that hospital, a list of commonly requested diagnostic tests and prescribed medications with their corresponding charges. (Policy 155.990, AMA Policy Compendium, 1992 Edition) Board of Trustees Report QQ (1-91), as adopted, recommended AMA support for a requirement that physicians, hospitals, pharmacies, durable medical equipment suppliers, and other health care providers make available to consumers information on their fees/prices for frequently provided services prior to the provision of service.

The Board believes that fee release guidelines should be developed to assist hospitals, pharmacies, and medical equipment suppliers in implementing this aspect of HAA as adopted in Report QQ. (Guidelines for the provision of physician fee information to the public have already been developed by the Council on Medical Service.) Consideration will be given to developing these fee disclosure guidelines with the American Hospital Association, the Pharmaceutical Manufacturers Association, and other health-related organizations as appropriate.

MARKETING NEW TECHNOLOGIES

Current AMA policy directly addresses the issue of promoting/marketing new health care technologies. Policy 480.990 (AMA Policy Compendium, 1992 Edition) states, in part, “Manufacturers and suppliers of health care technologies should ensure that promotional material and marketing strategies provide accurate and balanced information regarding the risks, benefits, and uses of products to be used in health care.” However, the Board believes that the rapid proliferation and aggressive marketing of new technologies—especially in relation to the impact of such activities on overall health care expenditures—is a key concern that merits further study. The Board, in conjunction with the Board/Council Task Force on Health System Reform and the relevant AMA councils and committees, will continue to analyze this.
issue and develop recommendations for consideration by the House as appropriate.

**ERISA MODIFICATION**

The AMA has developed legislation to modify the current ERISA provisions that preempt state regulation of employer-provided health plans. The AMA will continue to advocate such legislation to amend or repeal the ERISA preemption of state laws to allow for more rational and competitive regulation of self-insured health benefit plans.

**HEALTH ACCESS AMERICA AND THE FEDERATION**

In late 1990, the AMA established a Federation Advisory Committee on Health Access America (HAA). The Committee, comprised of Federation executives, has continued to meet every several months to obtain federation staff input into HAA policy and related programmatic activities. In follow-up to this initiative and other related support activities, a majority of state medical associations, and a number of specialty and county societies, have taken positions in support of the HAA reform proposal.

The AMA also has pursued activities that provide direct financial assistance and support to the Federation on health system reform issues. For example, in 1991 the Association provided 14 funding grants to state and county medical societies to support their communication efforts with targeted audiences on health reform and the HM proposal. A publication will be distributed to the Federation in mid-1992 that describes the results of these grant projects. In addition, the AMA continues to provide informational, legislative, and advocacy assistance to individual medical societies in dealing with state-level reform initiatives.

Efforts are also underway to develop an intensified 1992 Federation Outreach Campaign on HAA that will improve coordination of HAA support activities with state medical associations and enhance communication on health reform throughout the Federation. Upcoming discussions of the Federation Advisory Committee will consider key action items for inclusion in this campaign to support states’ efforts to implement various parts of the HAA proposal.

To support HAA policy on professionalism and negotiations, the AMA has petitioned the FTC, and other agencies of the Federal government, to change their interpretation of the anti-trust laws in order to permit the profession to engage in broader self-regulation, including fee review, and to negotiate collectively with third party payors over medical policy and reimbursement.

**HEALTH ACCESS AMERICA - MINIMUM BENEFITS**

As part of the Association’s overall efforts to strengthen the HM policy base, the Board also has evaluated state and other approaches to developing a minimum health benefits package. The AMA’s current minimum benefit plan, as approved by the House of Delegates in Board of Trustees Report KK (A-90) and reconfirmed by the House in Board of Trustees Report QQ 1-91 (Policy 165.960, AMA Policy Compendium, 1992 Edition), has provided the Association with a leadership position in health care reform discussions. This minimum benefit plan continues to represent a reasonable approach for a phased-in requirement of employment coverage in the private sector. However, the Board, along with the Board/Council Task Force on Health System Reform, believes that the existing minimum benefits plan should be refined to reflect the emphasis on enhancement of market forces as a cost containment mechanism, and on an enhanced use of personal health IRAs in constraining escalating health care expenditures. The specific proposed refinements to the AMA minimum benefits plan are discussed later in this report under Health Access America Policy Refinements.” The Board notes that the existing AMA minimum benefits package provides favored coverage provisions (i.e., no deductible or co-payments) for prenatal and post-natal care of mother and infant, and for well-child care and immunizations up to age eight. However, the Board believes that it is desirable to take another look at the implications of possibly including a broader range of preventive services in the minimum benefit package and will ask the Board/Council Task Force to do this and make recommendations to the Board for a report at the 1992 Interim Meeting.

**HEALTH ACCESS AMERICA - COMMUNICATION ACTIVITIES**

In 1992, the AMA will give increased, campaign-style attention to promotion of HAA, particularly the important market forces element of Board of Trustees Report QQ (1-91). Among other activities will be editorial board visits; communication with physicians and others through such vehicles as American Medical Television and Member Matters, JAMA articles, congressional testimony, targeted advertising, promotional videos, preparation of a slide/script pre-
HEALTH ACCESS AMERICA
IMPLEMENTATION COSTS

The international consulting firm of Lewin-ICF, Inc., has developed for the AMA comprehensive cost estimates of the Health Access America proposal that reflect the recent policy enhancements approved by the House of Delegates in Board of Trustees Report QQ (1-91). These estimates are contained in the updated HAA Booklet which will be provided to all members of the House and otherwise be widely distributed. These estimates include: (1) the overall "direct" cost of HM implementation; and (2) the impact of HM implementation on moderating the growth in national health care expenditures.

HAA POLICY REFINEMENTS

The Board, in conjunction with the Board-Council Task Force on Health System Reform and relevant AMA councils, has reviewed and discussed ways to further strengthen the cost-containment and other aspects of the HAA proposal.

The Board believes that the proposed recommendations presented in this report to the House will strengthen the existing HM policy base on cost-containment and will help position the AMA to counter less desirable solutions to the cost issue offered by some health reform advocates. The recommended HAA policy enhancements should also help promote the AMA's continued leadership role in the health care reform debate.

Employer Required Insurance

Employers who fail to comply with the employer mandate should be subject to a penalty and to payment for incurred health expenses of an employee or family member to the extent such expenses would be covered by the required minimum benefits policy.

Cost Containment

Several key HM policy refinements addressing the cost containment issue are recommended for House approval in this report. These refinements build upon the commitment to market forces in Board of Trustees Report QQ (1-91) and seek to provide the patient even more incentives to become a cost-conscious utilizer of health services.

a. The essence of the first refinement is to strengthen the potential use of Health IRAs and other tax-preferenced plans. This refinement would provide that where employers and employee voluntarily agree to increase the deductible beyond that specified in the AMA minimum benefits plan, tax incentives should be provided to encourage contributions to Health IRAs or similar tax-preferred plans.

The Board believes that this HAA modification can have a very important cost containment effect by bringing market forces to bear on utilization and price decisions of patients and of physicians and health care providers and by substantially lessening the number of claims submitted for insurance processing.

b. The second cost-containment approach is a cap on the premium cost exposure for small employers. Refundable tax credits would make up the difference between such capped amounts and actual premium costs. (This approach is similar to that provided for in the successful Hawaii program.)

c. The third cost containment recommendation suggests the use of incentives for health insurers/self-insurers to switch to uniform electronic billing with a uniform format, within a designated period of time.

d. The fourth cost containment recommendation relates to managed care. The Board believes, consistent with the policy adopted in Board of Trustees Report QQ (1-91) regarding requirement of three versions of the minimum benefits policy—benefit payment schedule, UCR, and prepaid, that the AMA should adopt a set of key principles on managed care to supplement existing AMA policy on this issue. These principles will help to promote physician and patient understanding of the managed care concept—especially as it is becoming increasingly popular in the health benefit market and in health care reform debates and legislative/administration proposals. These key principles are set out in the recommendations in this report. The Board believes that managed care programs which satisfy these principles do represent one valid approach to cost containment in a pluralistic, market-driven system.

CONCLUSION

The Board believes that Health Access America has enabled the Association to provide a leadership role and to be at the forefront of health care reform efforts in this country. The Board believes that the recommendations presented herein will strengthen our HAA proposal.

RECOMMENDATIONS

The Board of Trustees recommends that:

1. The AMA seek to have discussions with the
American Hospital Association, the Pharmaceutical Manufacturers Association, and other relevant national organizations regarding development of guidelines for the release of price information on hospital charges, drugs, and medical devices to physicians and the public.

2. The AMA analyze the impact of marketing new technologies before adequate clinical trials on overall health care expenditure growth and develop recommendations, as appropriate, to address the effect of such marketing activities on rising health expenditures.

3. The AMA adopt the following policy modifications to Health Access America:

a. Employer Required Insurance

Employers who fail to provide the required coverage shall be subject to a penalty and to payment for eligible health care costs incurred by an employee or dependent.

b. Health I.R.A./Tax-Preferred Plans

When employers and employees reach a voluntary agreement to increase the deductible beyond the AMA minimum benefits plan, tax incentives should be provided to encourage contributions to Health IRAs or similar tax-preferred plans.

c. Special Assistance to Small Employers

Small employers shall receive a refundable tax credit for premium amounts for the required minimum benefits policy which exceed a designated percentage of payroll/wages and before-tax income.

d. Uniform Electronic Billing

Health insurers shall be provided incentives to switch to uniform electronic billing in a uniform format within a designated period of time.

e. Managed Care

Managed care is an acceptable approach to health benefits management when it is part of a pluralistic system and when it comports to the following key principles, which are intended to supplement existing AMA policy on managed care:

1. Managed care programs should compete openly and equally in the health care market with other delivery systems. Individual preferences should be the sole determinants of growth in any mode of delivery (i.e., managed care vs. any other mode of delivery). Public policy should be neutral.

2. Reimbursement under managed care programs should be easy to administer, promote quality health care, occur in a timely fashion, and be viewed as fair by all concerned parties.

3. Managed care programs should disclose—in simple and understandable terms—the nature of any cost control mechanisms and other review procedures and policies to actual or potential beneficiaries.

4. Patient access to necessary medical care should not be limited by financial incentives to physicians or others.

5. Utilization review under managed care programs should be based on open and consistent review criteria that are acceptable to and have been developed in concert with the medical profession. Physicians (with background appropriate to the care under review) should have the ultimate responsibility for determining the necessity and quality of care.

6. Legislation should be enacted relative to managed care programs that would allow broader physician negotiation regarding quality of care, adequacy of payment rates, and other appropriate provisions of managed care programs.

7. Standardization and methods of accreditation for managed care programs should be pursued.

e. Part-Time Workers

All employers shall be required to provide their part-time workers with an insurance voucher, equal to a designated percentage of the worker’s gross pay. The voucher would be redeemable toward the purchase of a private sector health insurance policy, meeting the standards of the AMA minimum benefit plan, for the worker and his/her family.

4. The Board of Trustees continue to analyze additional cost containment options for possible inclusion in Health Access America as appropriate.

5. The remainder of this report be filed.

Fiscal Note: Within budgeted amounts.
Physician Heal Thyself
(and Thy Colleagues)

James E. West, M.D* and Gerald L. Summer, M.D.**

As physicians, we are uncomfortable discussing our own shortcomings which may be perceived as failure. We are trained to be omnipotent, omnipresent and omniscient. As a result, many physicians do not want to take a look at impairment in themselves or in their colleagues. We worked hard to get where we are, and the last thing we can acknowledge is the suggestion that we are not doing our job well. No one is comfortable telling an aged colleague that it is time to retire. And no one wants to tell a sick physician that he may have an illness that could interfere with patient care. The most common illness in physicians leading to impairment is substance abuse including alcohol. We need to confront our limitations in the disease of chemical dependency and the reasons for our unwillingness to confront ourselves and our colleagues when the disease is suspect.

The Physicians Recovery Network receives information from several sources. These referrals are carefully evaluated as to their validity. If indicated, the referral is discreetly investigated, usually beginning with a member of the Alabama Impaired Physicians Committee. The response elicited from physicians when a possibility of impairment exists in a colleague varies widely. Many are surprised but genuinely concerned and candidly offer help. Some say they simply do not want to become involved. Others may react defensively, bringing to mind the words of Herbert Spencer:

“There is a principle which is a bar against all information, which is proof against all arguments, and which cannot fail to keep a man in everlasting ignorance — that principle is contempt prior to investigation.”

Contempt for the presence or absence of an illness is a reflection of an educational deficit. The disease of chemical dependency received little if any instructional time in medical school. We are all vulnerable to our defense mechanisms when we know little about a subject.

One of the most perplexing things about chemical dependency, especially alcoholism, is that many physicians socially drink alcohol without difficulty. And for the true social drinker it is inconceivable that a person could not control how much or when they drink. Most do not understand that for the problem drinking individual, willpower is no more effective than it is for a person with diarrhea. We have difficulty in relating how intoxication at social events has anything to do with professional performance. The behavior observed at social events or during hospital rounds reveal little of what really goes on with the physician’s life events throughout the day. Consequences as the result of substance abuse, such as marital discord, attempts at hospital romance, driving while intoxicated or other arrest, changing practice location, and inappropriate angry outbursts all suggest involvement with mood altering chemicals. As the disease progresses, it may manifest in changing practice characteristics to accommodate chemical use, such as separating from partnerships, or geographical change in location or failure to meet hospital committee responsibilities. What we need to realize with physicians is that professional performance, in the hospital and the office, is the last thing to be affected as a result of the abuse of alcohol, opiates, benzodiazepines, or other sedative or stimulant drugs.

Physicians have availability for drugs much more than any other group in America. The instance of alcoholism among physicians is similar to that of the general population.

However, involvement of prescription sedative drugs and opiates may be higher. Physicians are

*president-elect of MASA
**director of PRN, MASA
trained to administer drugs and they have little difficulty in obtaining drugs for self-administration. The insidiousness of the problem may begin with an occasional use of office samples progressing to writing prescriptions for themselves or family members. Even when drugs are stolen from other physicians, hospitals, or writing fraudulent prescriptions, the sick physician fails to understand his dilemma. Colleagues are rarely aware of these behaviors until the disease is far advanced.

Drug tolerance or taking more drugs to achieve the desired effect, develops as physicians continue to self-prescribe. They learn to balance the drugs they take—stimulants (uppers) and sedatives (downers)—to allay obvious sleepiness or tremor and keep up the desired outside appearance. If this balance is not achieved, symptoms of drug abuse such as mood swings or lethargy at meetings may be attributed to lack of sleep when on call or other stresses of practice. The using physician does not acknowledge an effect upon professional performance. His denial, the unconscious distortion of the facts, allows his disease to progress. The cunning and baffling aspect of his illness is that he is unable to spontaneously reach out for help. He simply does not see the need for it. Colleagues must penetrate their own denial and realize that "waiting for more information" before offering help may allow the disease to progress. We need to put aside our unfounded personal fears and be willing to reach out to help our colleagues.

Medical education places value in making professional decisions and diagnoses based on accumulated facts and experience. Unfortunately, medical education in substance abuse is limited. Thus, most physicians rely on a limited expertise in the evaluation of symptoms and signs of chemical dependency. An uneasy feeling develops with the possibility that a colleague may be a "substance abuser." It is sometimes easier to avoid the question of unusual behavior in other physicians. The idea develops that someone else should take care of the problem. An equally disastrous idea is that there is no problem, or that "if he doesn't take care of himself, he is going to have a problem." These attitudes originate from insufficient education in the disease concept of addiction. The Medical Association of the State of Alabama has recognized this dilemma, and through the Physicians Recovery Network, efforts have begun with educational presentations to the University of Alabama at Birmingham and the University of South Alabama hospitals, local medical societies and participation with liability insurance company seminars.

What physicians need to realize is that this is not a disease of "weakness," or lack of willpower. The unwillingness to admit weakness or ask for help are prominent symptoms of this disease. The disease is not a "moral problem" nor does it discriminate against religion, race, gender, or social standing in the community. All are vulnerable—physicians perhaps more so. The surgeon or family practitioner from outside appearances may appear successful while inwardly be ravaged by addiction. The family will be the first to be affected. Family and friends may deny the problem and unconsciously protect him for fear of endangering his practice or social status by admitting there is a problem. Denial and fear prevent them from acknowledging a problem which is the first stage in its resolution. They hope that he may "slow down his drinking and get better." The reality is that substance abusing physicians rarely recognize their problem and do not have the faculties to spontaneously resolve it.

Physicians frequently deny their feelings beginning in medical school. The onset of addiction increases their denial. They feel immune from the disease even when they generate consuming efforts to hide their drug use. Even financial disaster cannot be related to their drug use. Fear of loss of self esteem, and the unfounded fear of loss of professional practice, precludes the need to seek outside evaluation and treatment. Blaming others for "bad breaks" is common. "The administrator overreacted and did not follow the bylaws." "The nurses were being vindictive when they reported me." "My ex-wife spreads all the rumors about me." When colleagues fully and honestly accept subtle aspects of the disease, the willingness to help spontaneously develops.

The fear that prematurely referring a suspected colleague may adversely affect his practice or standing in the community is valid and needs to be addressed. If in fact the physician is in trouble, early intervention by the Physicians Recovery Network prevents later public investigation by regulatory Boards. If the physician does not have a problem, a confidential investigation by the Physicians Recovery Network is closed with no word mentioned to anyone. Either way, both the public and the physician are protected. Another concern expressed has been that a competitive or vindictive physician may falsely accuse a colleague. Accusations, whether anonymous or not, never warrant an action against a doctor. All reasonable referrals to the Physicians Recovery Network are discreetly and confidentially investigated.

When colleagues understand there will be symp-
toms and signs in a physician prior to the disease process obviously impacting on professional performance, an intervention can avoid consequences by state regulatory Boards.

Regulatory Boards, because of time restraints, may invoke disciplinary measures for the reported offense, but be unaware of the extent of the physician's substance abuse. Members of licensing Boards may need to act as investigator, judge, jury, and executioner, often causing a cautious and conservative approach to investigating complaints in order to meet due process requirements. Licensing Board usually include physicians who may be less willing than more impartial evaluators to enforce evaluation and treatment for a problem as serious as substance abuse. This action may result in progression of the disease and recurrent need for disciplinary action.

However, physician members of regulatory Boards are becoming more open minded and oriented to the disease concept and offer the best chance for the sick physician to enter into the evaluation he needs. Non-physician members of regulatory Boards may tend to be more punitive and view symptoms of the illness as indication for punishment through loss of license or other restriction. Physicians need to evaluation symptoms of illness in other physicians. For example, a urine drug screen positive for mood altering chemicals needs to be evaluated by a knowledgeable physician. It follows then that involvement of the Physicians Recovery Network early in the referring process offers the sick physician the best chance for confidential treatment and re-entry into medical practice.

Hospitals are increasingly spurred on to identify impaired physicians as liability risks. Revocation of hospital privileges and reports to the National Practitioners Data Bank have occurred prior to evaluating an impaired physicians illness. Lawsuits involving impaired physicians are projected to increase dramatically in the 1990's. Quality care issues are requiring hospitals to develop systems to monitor signs that suggest impairment in physician performance and to monitor those physicians in recovery. The Medical Association's Alabama

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Impaired Physicians Committee’ and the Physicians Recovery Network have the expertise to assist hospitals in the identification, investigation, evaluation, and advocacy monitoring for impaired physicians to avoid legal entanglement. The Physicians Recovery Network process is consistent with the remarks of the American Medical Association President John L. Clowe, M.D.:

“We need to do all that we can to show that we can keep our own house clean — through peer review, the development of practice parameters, self-regulation — because it is the only hope for preserving our professional autonomy.”

Am I my brother’s keeper? The answer to the question is yes. Rather than protecting each other, physicians must be willing and honest to reach out and help each other. Being human, physicians need help in chemical dependency as often as their patients do. To objectively identify unusual behavior in our colleagues needing a positive change is no different from the objective evaluation indicated for melena, hemoptysis, or gall bladder colic. The motivation to help our impaired colleagues will come through open mindedness and education rather than be stimulated through liability risks, hospital administration, the public media, or the legislature. Through education, antiquated attitudes are changing and being replaced by a sincere desire to help. Our patients receive the highest quality health care available in the world. Physicians deserve the same quality for themselves. Physician, heal thy colleague.

References
5. Summer, M.D., G.L. Personal experience.

INFORMATION FOR AUTHORS CONCERNING MANUSCRIPTS

Manuscripts from member physicians should be typewritten, double spaced on white paper 8 1/2 x 11 inches with adequate margins. Two copies should be submitted. Authority for approval of all contributions rests with the Editor. Alabama Medicine reserves the right to edit any material submitted. The publishers accept no responsibility for opinions expressed by contributors.

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Patients who are treated as individuals are much less likely to sue a physician over a perceived inadequacy in care than are patients who are treated impersonally.

First impressions of a physician, his office and his staff begin forming within 30-60 seconds of a patient’s arrival.

Within the first 3-6 minutes most patients have decided whether or not they will receive satisfactory treatment.

Exactly what goes into determining the attitude of a patient towards the treatment that is received from the doctor and his staff? Two important factors need to be considered: first impressions and patient rapport.

FIRST IMPRESSIONS

When patients visit a physician for the first time, they usually come through the recommendation of a family member, another patient or a friend. Before patients even meet their physician they will be influenced by a minimum of six other factors that will determine their attitude towards the treatment they receive. What are some of those factors?

• Initial Contact - the telephone: How are your patients treated when they place that first call? Politeness and concern on the part of your operator as well as voice tone, grammar, and familiarity with office set-up is of utmost importance. So is a good working knowledge of your phone system.

• Location of Office: Is the office easily accessible and well-marked? Is there adequate parking space close at hand? When entering the building, are there clear signs directing patients to the reception area?

• Attractiveness of the Building: Is the building up-to-date and attractive from the outside? Are repairs made frequently and upkeep maintained? Check especially to see the condition of your main entry doors. Is brass kept polished? Glass shined? Weather stripping nailed in place? Does it reflect pride? If so, it reflects pride in the work carried on inside.

• Reception Room: Whether or not it is actually true, if a reception room is out of date with shag carpeting, plastic covered chairs, yellowing shades and year-old magazines, it will appear that the methods used by the physician are also old and out of date. Paint your walls with new decorator colors, check for good lighting, replace old and worn-out furniture. Watch the traffic flow to see if patients and staff move in and out of the room smoothly and easily. Is the TV too loud? Do you want to use a TV at all?

• Receptionists and Front Desk Personnel: These are the first “live impressions” that a new patient sees. Are they projecting competence and professionalism? Are they genuinely concerned about your patient’s well-being? Because the average patient interacts with three to five practice employees before ever seeing the physician, the way employees treat the patient may play a larger role in building a good impression than the professionalism and skills of the physician himself.

• Are receptionists well-groomed and professionally dressed? Do they take time to look everyone in the eye as they speak? Patients should be greeting immediately when they arrive at the reception desk. The goal of the employees who work in a professional and
caring office is to make patients feel as though they are the most important person who stepping into the office that day.

- Medical Assistants: People's names are music to their ears. Are your patients called to examining rooms with individuality and respect, or are they herded back like cattle? Caring staff members recognize each person as that person's name is called and they respect patient's privacy as they walk down the hall. Asking personal questions in front of other patients appears insensitive and uncaring. Personal questions are best asked in private.

PATIENT RAPPORT
Good patient skills are crucial for practice employees. One reason is that bad patient skills can quickly ruin a practice's reputation. Studies show that patients who are happy with the treatment they receive tell an average of three other people. Patients who are unhappy tell an average of 11 other people.

Building rapport with patients helps them feel that the treatment and services they receive are worthwhile. It also makes it more likely that patients will return to the office in the future.

An additional benefit of building good rapport is that it helps employees feel better about their work and themselves. They can go home after a busy day feeling like they treated people as numbers, or they can go home feeling that they can go home knowing that they treated those individuals with dignity and respect. In the first case the employee will feel tired and overwhelmed; in the second case they will feel a sense of accomplishment, professionalism and pride.

TEN TIPS TO BUILD PATIENT RAPPORT
1. Smile a lot
2. Look people in the eye
3. Pay attention to your grooming
4. Be sincerely interested in others
5. Lean forward when someone is talking to you
6. Touch patients when they need reassurance
7. Develop a soothing, but authoritative, voice
8. Have something interesting to say
9. Remember something personal about your patient
10. Make every patient feel important

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Alcohol is America’s #1 drug problem. The problem in medical families is the same as nonmedical families.

10-15% of physicians will be impaired at some time in their professional career, usually secondary to substance abuse.

One out of four American families is affected by alcohol-related problems.

Driving with any alcoholic concentration presents an increased hazard. More than 8,000 15-24 year olds die in alcohol-related highway crashes each year.

Alcohol use during pregnancy is one of the major causes of birth defects. There is no known safe dose of alcohol during pregnancy.

Mixing alcohol with prescription medication causes more problems than either drug alone. Physicians are five times as likely to take sedatives and minor tranquilizers without medical supervision.

Fear of public exposure creates secrecy and isolation. This allows the disease to progress.

Women use more psychoactive drugs. This may place them at high risk of physical or psychological impairment when alcohol is consumed.

Physician impairment from substance abuse is nearly always manifest in the home before it is evident in the office.

Impaired physicians almost never spontaneously reach out for help. Addiction to mood altering substances is impossible to self treat.

Here are a few positive facts to consider:

There is help. Recovery from substance abuse in physicians is probably better than in nonprofessionals. The same is true for medical families.

A confidential referral to PRN allays fear of public exposure to licensing boards, hospitals and insurance companies.

A confidential call to PRN can start the recovery process.

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Advance Notice - Call for Papers
The Medical Association of the State of Alabama

Ninth Invitational Scientific Symposium
Saturday, January 30, 1993 - 9 AM to 4 PM
Edna Merle Carraway Convention Center, Birmingham

Purpose of the Program - This program is designed to allow Alabama physicians to share with their colleagues current research efforts and professional concerns. Topics selected will cover a wide range of medical interests.

Program Format - The program will be structured from the papers submitted by Alabama physicians. Registrants will receive copies of all papers.

Paper Selection - Papers will be selected using the following criteria and procedures:
1. The subject matter should be of interest to physicians in a number of specialties. Emphasis should be on medical problems which may be encountered by primary care physicians.
2. This is a program designed for and presented by Alabama physicians, so current local research efforts and professional concerns will be given top consideration.
3. The paper should be one that can be adequately outlined and covered in 20 minutes with additional time for questions. Selectees will be expected to prepare suitable written materials to be used with the presentation for the study and use of attendees.
4. On the final review of papers, members of the MASA Council on Medical Education will select topics from a variety of specialties and physician interests to offer a balanced program of general interest.

Symposium Timetable
August 15 to November 1, 1992 - Call for abstracts
November 1, 1992 - Final date for abstracts to be received
Early November 1992 - Review of abstracts by the Council on Medical Education and final selection of papers
November 1992 - January 1993 Announcement of selections, publicity and promotion of Symposium
January 30, 1993 - Program in Birmingham

Symposium Topics - to acquaint potential presenters with the kinds of subjects that might be suitable, the speaker and topics at the 1992 Symposium are listed below.
Carl J. Sanfelippo, MD - Testis Cancer - A Curable Cancer; Robert Y. Kim, MD - Two Patterns of Epidural Spinal Cord Compression; Merle M. Salter, MD - Conservative Surgery and Radiation Breast Cancer; Robert P. Carraway, MD - Role of Autologous Platelet; Frank D. Sutton, MD - Asthma Management; Martin S. Cogen, MD - Botulinum Toxin Therapy of Eye Muscle Disorders; Norman B. Halpert, MD - Proliferation and Availability of Laparoscopic Cholecystectomy in Alabama; Betty W. Vaughn, MD - Diversity of Maternity Care in a Multi-County Area; Charles Svensson, MD - Pelvic Inflammatory Disease During Pregnancy; W. Foster Eich, MD - Redskins: A Review of Infectious Red Rashes; Elizabeth A. Hochuli, MD - Respiratory Problems of Textile Workers; Christopher W. Old, MD - Congestive Heart Failure vs. Nephrotic Edema; Donald Gordon, MD - New Aspects of Cardiology

Abstracts - Abstracts of proposed paper (200-300 words, doubled spaced) should be sent to the Council on Medical Education

Submission of Papers - Interested presenters should send abstracts to the MASA Council on Medical Education P.O. Box 1900, Montgomery, AL 36102 no later than November 1, 1992
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-- Dr. Morris, p. 8

Health Care 2000?

-- Mr. Conner, p. 2
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Health Care 2000?

I was asked recently to give a talk on what medicine would be like in the year 2000.

Any attempt to make such a fearless forecast would necessarily begin with a sub-prediction: what kind of health care reform legislation will finally emerge from Congress? Neither I nor anyone else, however learned, has even an educated guess on that. But there are other problems as well.

When anyone is tempted to foresee the future, he or she should give pause to reflect on the way some highly sophisticated computer models are tested for their powers of forecasting.

After appropriate experimental software is loaded in the mightiest computers, they are tested for their forecasting ability by going backward in time to determine if, from old data, they could have predicted what has already occurred. The worst grade to be given such systems is this: "Failed to predict the past."

I am not a prophet, computerized or otherwise. Like most mortals, I have rather consistently failed to predict the past. Most things that have already occurred surprised me, as they surprised most experts.

And in predicting the past, you have the advantage of hindsight. In the rear-view mirror we can see all the forces that shaped history, including forces that might have been invisible when that history was being made. Looking at the future, and strain as we might to factor in everything that could possibly affect the course of events, we are inevitably going to omit one or more of the more important forces.

Some factors that may seem so trivial in 1992 as not to warrant inclusion could easily emerge as the most significant in the next seven or eight years. If the navigator of an aircraft leaving Atlanta and heading west makes an error of 1 degree of arc, that is well within tolerance if his objective is Birmingham. If, however, the plane is headed to Sydney, Australia, a one-degree error might land it in Antarctica. Small errors over time and space compound themselves.

In medicine, there is simply no way of knowing what forces — social, economic, political, technological and so on — will be present as the year 2000 arrives. Even things we think we know cannot be projected with any confidence. Following are some random musings on the subject:

First of all, the population is aging. With every passing year, a smaller and smaller ratio of workers supports, directly or indirectly, those who are retired, chronically ill, disabled, etc.

That process is already producing much inter-generational conflict; the working population of 1992 increasingly resents the involuntary support of older generations. For many of them Social Security and Medicare taxes exceed income taxes. Also, the premium for the health insurance they buy is inflated by the cost-shifting from losses sustained by providers in treating the aged and ailing and by third parties in underwriting them.

If we are tempted to criticize yuppies who opt for health care plans, PPO and HMO, that filter out the old and the sick ("skimming," it is sometimes called, or "cherry picking"), they respond that they have already paid their civic rent in other cost shifting, including Social Security and Medicare taxes. Since man is an economic animal, as the theoreticians say, this behavior is normal and predictable. Whether or not it is moral is a question I would leave to moralists.

Increasingly, business and industry are doing something similar under the federal ERISA: they are
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self-insuring and thus removing themselves from state insurance laws, mandated benefits, etc. They thus attempt to restrict their exposure to their own worker population, which tends to be younger and healthier than the state average. When they were buying health insurance on the open market, they were paying part of the burden of the older and sicker population.

But, as some consultants are noting, they may run but they can’t hide: they still assume some of the cost-shifting load from hospitals and other providers, who must pass on portions of their losses from treating the old and the medically indigent. There is no real way to opt out of the system entirely, try as they might. And the ERISA escape route may soon be closed, under pressure from states.

One of the effects of this “risk-avoidance” behavior is to leave higher-risk patients in other plans, resulting in that demon of the insurance actuaries, “adverse selection.” An adversely selected pool of patients often results in bankruptcy of the plan. To be insurable, risks must be spread broadly.

To force the young and healthy back under the big tent, some states are moving toward requiring insurers to have one statewide premium as if everyone belongs to the same group. In effect, this would force the young back into a more cross-sectional group. When that happens, they or their employer must increase premium payments because of increased overall risks. At this juncture, large employers are attracted by ERISA’s siren song.

The AMA has joined governors and others in lobbying Congress to close the ERISA back door. But the enforced togetherness that opponents of the ERISA option are trying to impose would thus impact, one way or another, on able-bodied workers once again. Either they pay more out of their own pockets to insure older or sicker people or their employer does and passes the increase on to the employees in the form of raises not given. In this and many other ways, the cost-shifting buck stops with younger and healthier Americans. And they aren’t happy now that they have figured it all out.

The total burden of this cost-shifting to the younger and healthier, already heavy, will become more onerous over the next seven years. Even now, this generation is said to be the first in American history that has not been better off than the preceding one. They are beginning to understand how they are being victimized by the seniors in other ways — exorbitant cost of housing that contains, well hidden, all the excesses in spending and credit that characterized the rule of their elders. The national debt, too, concerns them more than older Americans. They will have to pay it. Indeed, they are already paying it.

They are beginning to dig in their heels — and who is to blame them? Even so, this increasing resistance could mean a reversal of present trends toward providing the best medical care for those who are sustained by government entitlements at state and federal levels.

And such demographic pressures could not come at a worse time for the embattled working population. Even as they become the target for cost-shifting, their wherewithal is shrinking. Fortune magazine (8/24/92, p.62) documents an alarming trend:

“The great American Job Machine, which once routinely churned out millions of high-wage jobs and still produces the highest standard of living in the industrialized world, is shifting gears — downward. Solid middle class jobs, the kind that allow a single worker to be the family breadwinner, have been disappearing in record numbers and are being replaced more often than not by lower wage jobs, many of them astonishingly inadequate. This change hit the factory floors in the 1970s. Though U.S. manufacturers have since bounced back in the global competition, their ability to generate an abundance of good jobs hasn’t. Now the same ugly trend is devastating the service sector as well.

“Suddenly millions of Americans worry not merely about staying employed, but about staying employed in jobs that will support anything close to their current standard of living.

“That’s why, though the present unemployment rate of 7.8% is well below the 10.8% peak it reached in the recession of the early 1980s, the general level of economic anxiety in the country has climbed to unprecedented heights, as poll after poll attests. Declining incomes, or the fear of future declines, also explain why, as consumers, Americans are sitting on the sidelines, forestalling a more robust recovery.”

In 22 charts and graphs Fortune documents the accumulated impact of the way American business has been “dumbing down” jobs — dividing complex operations into many simple, unchallenging tasks that “even the dumbest production worker can handle.” One consequence has been that many industries offer no wage premium for academic performance in high school, thus removing one of the incentives for educational achievement. Some 98% of employers don’t even bother to review the academic transcripts of high schoolers, believing their course work to be irrelevant. Management guru Tom Peters says business executives’ demands for school reform should be dismissed as “just a cop-out for their own shortcomings.”
So anyway you slice it, the "working well population" is far less able to shoulder health care cost-shifts from the general population than at any time in the last several decades.

Other scary pressures are building. The uninsured, the underserved, the elderly—all are saying they want some kind of subsidized health care. But politicians have found out that appeasing this group means alienating other groups—those now working, with less to show for it than their fathers, who will be paying taxes and voting a long time.

They know the bill for any kind of national health care plan will be handed to them. And they are already overburdened by national debt, personal debt, S&L bailouts, reduced real personal income and the rest.

Even as the young are increasing their resistance to being the ultimate cost-shifter, winds of desperation, generated by other elements of the public, by business, industry and government, are rattling the windows and shaking the walls of medicine. Since those who will ultimately pay are saying "not me," both the public and private sector feel they have no choice but to compress and restrict utilization.

It might be said that "The Health Care Crisis" has become our permanent Hurricane Andrew. If the eye has passed, I haven't noticed.

Rationing of health care, already a reality even though most Americans still refuse to look at it, will intensify as a public issue. You need look no further than Oregon to realize the quagmires we will enter as we attempt to decide who shall be served by finite resources.

In fact, this is the big imponderable, the big question mark. How we resolve the resource-allocation problems will, to a very large extent, be the principal shaper of health care in the year 2000. It will determine what technology comes into common use, because all the wizardry in the world cannot generate the cash to pay for it.

We have had a preview of some of the national debates on resource allocation for high technology: major portions of the scientific community have vigorously denounced the disproportionate support of "big science." Such incredibly expensive projects as the super-conductor super-collider, a space station, the hypersonic airliner, the human genome project—all have come under fire for hogging resources that could be better used for the "smaller" sciences, including the sciences of human disease, with more predictable payoffs in humanitarian terms.

Going back a few years, we had our first baptism in this kind of relative value argument in President Kennedy's race to put a man on the moon and give the Russians their comeuppance. How could we, people demanded, spend all that money for such a grandstand act without visible benefit to suffering humanity?

More recently, folks have been asking, bitterly, how could we send up that Hubble space telescope, with all its expensive production and deployment, when people are dying of cancer and heart disease? How dare we even think of a Martian landing when thousands are dying of AIDS; when genetic defects still mar the lives of many of the population; when the old scourges such as TB and STD are reappearing; when other causes of human misery and suffering show no sign of being eliminated, either by low technology or high technology?

The year 2000 is unpredictable because the coming debates over allocation of resources will not only dominate the health care actions in Congress but in the legislatures, city councils and town halls; in corporate boardrooms and even in mom & pop businesses. How these questions are resolved will, in large measure, determine the end product of health care delivery.

While technology can be incredibly expensive, it can also save money over the long haul. Properly conceived and positioned, the highest technology is often cost-effective. But it is difficult to prove negatives—
the expensive, long-term care avoided by early diagnosis and treatment; the lives not lost; the crippling that does not occur; the deformed child not sustained at public expense in a dismal lifetime existence.

I do not believe that health care can be compartmentalized and pondered apart from the environment in which it exists. Those of us within the health care system tend to think only of how the system pie is sliced. Those on the outside see the whole of health care as only one slice in a much larger and much different pie.

Stated another way, all elements of health care are connected internally to each other, but the collective cost of the whole system is also chained to other national priorities and obligations. Health care is only one element—a large and vital one, to be sure, but still only one element—in the decaying economy of this country.

There will be wonders aplenty in Health Care 2000. Of that I have no doubt. I could easily, if recklessly, extrapolate some current trends and predict, for example, how physicians in rural areas will be as close to high-tech medicine as their metropolitan colleagues through the miracles of modern communication—fiber-optics, satellite downlinks and uplinks; how imaging and lasers will continue to transform surgery as molecular biology transforms medicine; and so on.

But the overriding question of who will pay for all of this and how will it be prioritized in competition with other demands counsels me to keep such predictions to myself. No one knows where the money will come from, campaign platforms notwithstanding.

In other words, nothing in health care exists in isolation these days. Everything is connected to everything else, because the nation does not have, and will not have, enough money to pay for everything for everybody. Politicians who tell us we have only to eliminate most of the administrative overhead of government or private insurance companies to spread the medical wealth to everyone are either ignorant, trying to hoodwink us, or both. Squeeze all the water out of the present system and you will still have massive unmet demands.

Health care must continue to bear part of the burden of the national deficit and will be similarly constrained by the absolute necessity of reducing the astonishing national debt of $4 trillion. That unbelievable sum is starkly emblematic of the dismaying fact that in less than a generation the United States has changed from the world’s greatest creditor nation to the greatest debtor nation.

And the key to real and lasting economic recovery lies in quantum jumps in the quality of American public school education. We have the greatest system of universities in the Western world, virtually all agree, but we are at the bottom in grades 1 through 12. This imbalance is a prescription for disaster in future competition in world markets. All of health care is tied to that imbalance, which will cost billions to correct.

National defense will remain a high-cost item. The collapse of the Soviet Empire did not end man’s inhumanity to man. Indeed, there is more fighting on more fronts today than before the Soviet Union gave up the ghost. And one-fifth of the human race still lives under a brutal communist regime, mainland China.

The so-called peace dividend never happened and it won’t happen. As the need for massive forces is reduced somewhat, the cost of modern armaments skyrockets, leaving few net savings to divert to other needs.

If all this gloom and doom seems to leave little hope for qualitative and quantitative improvements in health care, there are many countervailing forces at work. One of the most cheerful, to me, is the expansion of women physicians in the ranks of medicine. The entering class in all U.S. medical schools in 1991 was 40% female. In some medical schools, women students were almost three-fourths of the beginning classes.

Admitting a personal bias, I believe that this massive infusion of womanhood into health care can only be regarded as one of the most promising developments. Call me a male-chauvinist pig if you like, but I believe there is no male substitute for the caring and compassion a woman is born with. This may change the human face of medicine more than all the sophisticated computers and other high-technology combined. And I welcome it.

What will health care be like in the year 2000? I can only point to some of the factors in the equation. Beyond guessing that it will be largely more of the same that we have in 1992, I can’t see the future. We are living in a time-warp in which quantum jumps have become commonplace and exponential change the order of the day. But we are also living in an unprecedented revenue crunch.

One measure of the gravity of the health care crisis is the ominous fact cited by Dr. Lundberg in JAMA — total U.S. expenditures on health care are now beginning to double at intervals of less than five years. Doubling in five years. To me that is awesome, and it underscores all the interconnected problems I have cited.

If forced to predict, in one word, what U.S. health care will be like in the year 2000, I would say, because I am an irrepressible optimist, “better.” But if you call to demand that I explain how, my secretary may tell you I’m out to lunch. I don’t know.

Until I learn to predict the past more accurately, I’ll leave the future to others.
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Health Access Alabama

Last month we devoted 17 pages of Alabama Medicine to a full presentation of AMA's Health Access America, first released more than two years ago, refined at virtually every meeting of the House of Delegates since then, and still being modified as circumstances warrant.

I hope you studied this document, for it is the touchstone of organized medicine for measuring the worth of the many health care reform proposals already introduced in Congress, and the even greater number certain to come in the next Congress.

But states, it is often said, are the best laboratories for testing new approaches. The AMA has encouraged its state societies to explore initiatives at this level while the AMA labors to shape national opinion in Washington.

Many states are already well advanced in their attempts to address the problems of the medically indigent and related issues. Too often, however, politicians have attempted to imposed their own reckless agendas, with disastrous potential.

It was this foreseen danger, along with other considerations, that prompted both AMA and MASA to offer pro-active policy positions in advance of such political overkill, which was predicted.

I am proud to say that Alabama's hat is already in the ring. Following you will find the Alabama application of Health Access America, tailored to what we believe are the needs of Alabamians. Some of these needs are identical to those that have been identified nationally. Others are either unique to this state or to other states similarly situated —relatively large populations of the medically needy adversely coupled with very limited state economic resources.

In the last century, and in all the decades of this century, our predecessors played a significant —often ground-breaking— role in advancing the health of our people. There is still a great unmet need inside out borders.

The document on the following pages, which was adopted by the College of Counsellors and House of Delegates in April, attempts to address these problems. Like the national Health Access America, it is not fixed in time. As circumstances warrant, it too may be refined. In fact, one of my reasons for printing it here is solicit your comments.

A considerable amount of deliberation and debate by the Board of Censors went into the forging of this document. But 5,000 heads out there may be better than 15. Read it, reflect on it, and let me hear your ideas for improving it.

This is an immensely complex subject; we need all the brainpower we can muster, in Alabama as in the nation.

[See page 11 for the Report of the Board of Censors, which was approved by the College of Counsellors and House of Delegates at the annual meeting in April.]
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Health Access Alabama

(Approved by the College of Counsellors & House of Delegates, April 1992)

Report of the Board of Censors

Report: D-92
Subject: Access to health care
Presented by: James E. West, M.D., Chairman
Referred to: Reference Committee A

The Board of Censors has studied the report of MASA's Health Access Task Force and the AMA's Health Access America, as modified by Report QQ of the AMA Board of Trustees. The Board voted to endorse the report of MASA's Health Access Task Force (see below). The Board also voted to endorse the concept of the AMA's Health Access America, with its sixteen points, as long as it does not conflict with the report of MASA's Health Access Task Force...
The Board of Censors refers the following reports to the College of Counsellors and House of Delegates:

Report of MASA's Health Access Task Force

Subject: Medicaid revision and uncompensated health care
Presented by: William J. Terry, M.D., Chairman

The Problem of Access

The measure of a state or nation's greatness should be gauged by factors other than just gross national products, corporate bottom lines, and the consumer price index. For as the personal health of a citizenry goes, so goes the true wealth of the state. And measured in those terms, it can be said that the health of Alabama is not what it should be. Too many of our citizens are shut out of the health care delivery system, and ironically, this at a time when the capabilities of medicine have historically never been greater.

Clearly, for too many Alabamians, ready, affordable access to the health care they need is seriously lacking. As many as 800,000 of our citizens don't have health insurance and are not covered in some way by a governmental program such as Medicaid or Medicare. For these Alabamians, staying healthy and living life to the fullest is, if not an impossibility, at least a stiff challenge. Society can do no greater service than to formulate a means to bring these people under some umbrella of coverage that will give them access to a basic package of services designed to help them maintain their good health. That is the impetus behind this report.

The Current Situation

The creation of the Medicare and Medicaid programs in the 1960's promised affordable, universal access to care for the elderly, disabled, and many of those below the poverty level who could not afford healthcare. That promise has never been completely fulfilled, and today millions of Americans, and thousands of Alabamians, simply fall through the cracks. These people frequently receive no care, or must depend on emergency rooms or services donated by private physicians for the care they do receive. Little or no preventive care is received, problems worsen, and the quality of life is diminished.

Alabama citizens who lack access to health care include:

• The uninsured working poor—defined as those earning incomes below the Federal Poverty Level, but who don't qualify for Medicaid coverage either because they aren't in one of the categorically entitled groups or because their income exceeds the cutoff limit. These people include non-pregnant women, many teenagers and adult males.

• The underinsured working poor—defined as those who have some coverage, but whose family dependents are not covered.

• The uninsured poor—defined as those who are unemployed and who do not qualify for Medicaid or Medicare, and who can't afford private insurance.

• Children who aren't covered by private insurance or Medicaid.

• Those individuals who are considered by insurance companies to be "medically uninsurable" because of health conditions which are usually chronic and complex.

• Those who can afford medical care but who do not access it — frequently a lack of education about personal health wellness will keep a person who needs care from seeking it, or from taking advantage of preventive measures to forestall more serious medical complications which could have been avoided. Also, many of these people elect not to purchase health insurance in order to obtain other necessities of life.

• Those who lack convenient physical access to health care givers — including people living in towns without physicians, hospitals, health support personnel, or needed medical specialists (such as obstetri-
Description: Yohimbine is a 3a-15a-20b-hydroxy Yohimbin-16α-carboxylic acid methyl ester. The alkaloid is found in Rubiaceae and related trees. Also in Rauwolfia Serpentina (L) Bent. Yohimbine is an indolalkyamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/212 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks prejunctional alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of shorter duration. Yohimbine’s peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to α2-adrenergic blockade which may theoretically result in increased penile flow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it, however no adequate studies are at hand to quantify this effect in terms of Yohimbine dosage.

Indications: Yoccon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient’s sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardiovascular patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the CNS and produces a complex pattern of responses in lower doses than required to produce peripheral α-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug. Also dizziness, headache, skin flushing reported when used orally.1,2

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence. 1,2 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasionally side effects reported with this dosage are nausea, dizziness, or nervousness. In the event of side effects dosage to be reduced to 1 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.3

Dosage: Oral tablets of Yoccon® 1/12 gr. 5.4 mg in bottles of 100’s NDC 53159-001-01 and 1000’s NDC 53159-001-10.

References:
Rev. 1/85

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ing health services to the poor. This responsibility should be shared by all of the citizens of Alabama.

A proposal to improve access to health care for the State's poor:

1) Develop a "Basic Health Benefits Package" which will be available to all Alabamians.

A comprehensive package of healthcare benefits should be made available which emphasizes prevention, early diagnosis and treatment, inpatient and outpatient care, and long-term care. The "Basic Benefits Package" should be available without pre-existing condition exclusions to individuals or experience ratings to larger groups. Emphasis through this benefits package will be on quality of life with compassionate medical care, rather than extending life at all costs. All State and Federal health care programs should, where possible, provide, at a minimum, this basic comprehensive package of benefits. Private insurance companies will also be encouraged to provide this package to their subscribers at a reduced price. A more extensive health benefits plan would be available to those who wish to pay additional premiums. The "Basic Benefits Package" should include:

Physicians Services
Office Visits (20 annually)
In-patient visits
Diagnostic and Therapeutic Services
Laboratory and X-Ray Services

Preventive Services
Maternity Services — pre- and post-natal care and delivery
Family Planning Services
Child Health Services — well child and minor illness
Immunizations
Chronic Illness Services — clinical, drugs and follow-up
Treatment and follow-up of communicable diseases
Laboratory and other diagnostic services

Dental Services
Injury/medically related only

Out-Patient Care
Emergency Services
Diagnostic/Therapeutic Services
Surgical Services
Lab and X-Ray Services

In-Patient Care
Hospital (45 days annually)
Diagnostic Therapeutic Services
Surgical Services
Delivery Services
Intensive care, coronary care and other specialized services

In-Home Services
Home Health Skilled — nursing, social work, physical therapy, occupational therapy, speech therapy and other therapies Home Health Skilled — services which are medically authorized and under physician supervision

Others
Ambulance — Emergency and non-emergency Skilled Nursing Facility (180 days annually)

Not covered
Reverse of sterilization
Artificial insemination
Cosmetic surgery
Obesity treatment, weight loss programs
Custodial or domiciliary care
Eyeglasses, hearing aids
Orthodontic appliances
Personal comfort items

2) Medicaid Reform

A. Raise the Medicaid Eligibility Level to increase the number of persons who are covered under the system.

Many Alabamians who are not covered by private insurance or Medicare would be eligible to receive Medicaid health coverage if their income level falls below 100% of the Federal Poverty Level.

Since 1986, when Congress first allowed states to delink eligibility for Medicaid from eligibility for cash assistance, states have aggressively expanded Medicaid coverage of pregnant women and children. The Omnibus Reconciliation Act of 1986 (OBRA-86) gave states the option to raise income eligibility for pregnant women and children to age five up to 100 percent of the federal poverty level. Alabama could seek special approval to cover additional groups under Medicaid providing they would be delinked from cash payments for human services benefits.

Currently, Alabama Medicaid extends to only a very small number of the uninsureds and underinsureds in the state. Virtually all the programs offered by Medicaid are mandated by the Federal Government, and are tied to some form of categorical public assistance. Many low income and poor people are outside the system. Medicaid reform would be required in order to allow states to cover additional groups under the program. Budget restraints are driving the level of services now being offered, and until Medicaid is sufficiently funded, there will be little change in the number of persons served.

Recognizing the substantial costs of Medicaid expansion, some phased-in approach would be necessary. Medicaid benefits would be basically the same
as those suggested for the “Basic Benefits Package,” and would include prescription drug coverage.

B. Increase Medicaid reimbursement rates to encourage physicians to treat Medicaid patients and to make hospitals, especially those in rural Alabama, more viable.

A number of studies have shown that the biggest impediment to physicians treating Medicaid cases is low reimbursement. Although this is the primary disincentive to take Medicaid patients, the burden of paperwork, slowness of payment, and the necessity to submit some claims more than once because of procedural mistakes are also daunting obstacles. We commend the efforts of the state Medicaid agency to streamline the system and make it more user-friendly for physicians and their staffs. Although reimbursement rates for some services have been improved, current payments to physicians for many services and procedures remain too low, often at or below costs.

There has not been an across-the-board increase for physicians since 1981, and these reimbursement levels were established using 1979 data. Rates must be raised, at least to Medicare levels, if more physicians are to be encouraged to participate.

3) **Require employers to provide health insurance for their full time employees and the dependents of those employees.**

Alabama employers should provide insurance coverage which is at least equal to the “Basic Benefits Package” described above. Employers could purchase insurance on the open market or provide it through a self-insured program or trust. This should include a copay by employees which may be small for the “Basic Benefits Package” or larger for a more extensive health care plan. If so desired, employees should be able to purchase their own policies with appropriate reimbursement from their employers. If an employee is covered under their spouse’s insurance plan, then the money earmarked for that employee’s “Basic Benefits Package” can be used to eliminate any co-pay on the spouse’s policy, or even to possibly upgrade it to a plan with more extensive coverage.

Companies which can demonstrate that they do not have the resources or income to pay for such coverage would receive assistance from the State to buy into the “Basic Benefits Plan.” Tax incentives must be provided and risk pools created so that new and small businesses can afford this plan. To make the transition manageable for all businesses, the program should be phased-in over 5-7 years.

4) **Create a state-level risk pool.**

A state risk pool is a legislatively created insurance program that can be funded in a variety of ways, including state tax revenues and insurance company contributions.

Small employers should have access to such a risk pool so that they can acquire coverage for their employees. Premium assistance from the state would be provided for those persons not covered through employment, Medicaid, Medicare, or other insurance, and who are between 100 percent and 200 percent of the poverty level.

5) **Take additional steps to increase access to health care for Alabamians.**

Many other approaches, can be taken to increase access to health care for not only the poor, but for all Alabamians. We further recommend that the following action be taken:

- Mandate school-based public health education for junior and senior high schoolers emphasizing wellness and healthy lifestyles (tobacco, alcohol, and drug free); personal responsibility for one’s own health; sex education stressing abstinence for the non-sexually active and protection for those who are active; and other prevention measures. An educated public knows to seek health care when it’s needed.

- Create State sponsored scholarships for medical students, nurses, physician’s assistants and allied health personnel who agree to practice in rural areas for a specified length of time.

- Continue to support the Physicians’ Alabama Opportunity Fair, to assist small Alabama towns with physician recruiting.

- Create a similar fair to assist in the recruiting of allied health personnel such as nurses, emergency medical personnel, physicians assistants, laboratory technologists, etc.

- Institute public information programs to educate patients about the need for early recognition of medical problems, and to encourage them to seek medical attention for those problems before they worsen. This can be done through MASA, the Health Department, the Cooperative Extension Service, and the Alabama Rural Health Association.

- Equalize Medicare payment levels to urban and rural physicians and hospitals.

- Develop information programs aimed at Alabama students to encourage them to pursue medical and other health-related careers in the state.

- The Alabama legislature should continue supporting the Alabama Family Practice Rural Health Board, which is funding rural preceptors/preceptees, rural training sites for Medical Students and Residents, added training in obstetrics for family physicians, and provid.
ing general support for family residency programs.
- Establish a program to subsidize the medical liability premiums of obstetricians in rural areas.
- Address transportation problems in rural areas, especially among the elderly and disabled.
- Encourage cooperative educational ventures between communities and the medical schools of the state.
- Increase support for trauma care in order to preserve existing trauma centers and expand into areas where trauma care is inadequate. We recommend supporting state and federal legislation strengthening and stabilizing Alabama’s trauma care delivery system.

Conclusion
It is the position of the MASA Board of Censors that access to health care is the best guarantor of a healthy public. Surely, the highest form of government service is to provide for the well being, safety, and good health of its citizens. And just as surely, a system that provides its people with the kind of access this report recommends will not be inexpensive. This program will cost what it must cost. However, when it, or a similar program, is instituted, the vast majority of Alabamians who now lack access to comprehensive health care will be brought into the system.

As a state we have taken short cuts too often, and have over-relied on the public spirit of physicians and others to fill in the gaps in the system. Volunteerism alone will never fully fill the need for health care by our less fortunate, less prosperous citizens. We commend Alabama physicians who have made significant contributions in addressing indigent care, and further ask that each physician re-examine his/her personal commitment to solving this problem and take whatever measures on a local, state, and national level necessary to ensure basic medical care for all.

The solutions, whether those outlined above or others, must be pursued with a single-mindedness of purpose by government officials, businessmen, and leaders in organized medicine. The health of our fellow citizens and our state is at stake.

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Photorefractor for Detection of Treatable Eye Disorders in Preverbal Children

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Abstract

Abnormalities of the optical media or alignment of the eyes during the period of visual immaturity may produce pathologic changes in the brain resulting in the clinical entity of subnormal vision known as amblyopia. Efforts to prevent visual deterioration or restore normal acuity where amblyopia exists require early diagnosis and treatment. Although amblyopia affects between 1% and 5% of children, it is estimated that at most one-fourth of preschool children are screened for this major treatable eye disorder. Simultaneous photography of the corneal and fundus reflex from both eyes using an off-axis flash photorefractor appears to be a practical, efficient, and effective method of eye-screening in pre-verbal children. Previous studies of this modality have dealt with populations referred to ophthalmology centers. We report the results of a masked validation of a commercially available photorefractor in an unselected group of children between the ages of 6 months and 6 years. (Key words: amblyopia, vision screening, photorefractor).

Amblyopia ("lazy eye") is a serious and potentially blinding disease which affects 60,000 children annually in the United States.1 Research has shown that the critical period for binocular visual development begins shortly after birth and is most sensitive within the first months of life.2-4 Amblyopia is caused by abnormalities in the optical media such as corneal opacities and cataracts, high or unequal refractive errors, and misalignment of the visual axes which prevent simultaneous, well-focused images from reaching the fovea of each eye. The resultant neurocompensatory changes in the brain consist of maldevelopment of binocular cells in the lateral geniculate body and cerebral cortex. The earlier amblyopia can be detected, the easier the treatment and more favorable the visual outcome.5 When treatment of amblyopia is delayed until the child reaches school, the results are usually disappointing.6 Unfortunately, it is not feasible to perform complete ophthalmologic examinations on all infants and young children. Therefore, vision screening is recommended immediately after birth, at six months, and in the preschool years to identify children with eye disorders at an age when diagnosis and appropriate treatment will be beneficial.6 Numerous programs exist for screening school-age children, but the techniques are ineffective for the younger, pre-verbal child. Methods such as forced-choice preferential looking and stereograms have been developed for testing infants and toddlers, however, administration is complicated and time-consuming for most, and all require a motor response from the child for interpretation.7 Recently, a simplified photographic technique has been developed to document the ocular alignment, refraction, and clarity of the optical media. The system uses an off-axis flash photorefractor to capture reflexes and images from light that is refracted and reflected from the eyes. The test is rapid and easy to administer, and requires only that the subject be positioned properly with eyes open for a brief moment during flash exposure. A permanent film record results which can then be analyzed. A masked validation of one device
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which is being commercially marketed (Visiscreen 100, Vision Research Corp., Birmingham, AL) was undertaken at the Eye Foundation Hospital, Birmingham, AL.

Methods

The Visiscreen 100 consists of a 500-mm telephoto lens mounted on a 35-mm camera. An electronic strobe flash is below the lens and a light-emitting diode is above the lens. An internal battery power source is connected to an external charger. The photographic equipment is mounted on collapsible alignment bars and directed at a horizontal rectangular opening in a black screen with an attached headrest located 8 ft., 3 in. away (Fig. 1).

A total of 127 children between 6 months and 6 years of age were examined. Participants were recruited through newspaper advertisements for free pre-school vision screening. Demographic information and signed consent was obtained from the parents. The child was brought into a darkened room and after one minute had elapsed for pupil dilation, the child was positioned against the headrest and the photoshotgraph exposed. One technician at a time administered the test, and additional pictures were taken if it was suspected that the patient was not properly aligned. None of the technicians involved received more than two hours of instruction and practice with the equipment. Photographs were regularly obtained in less than two minutes per patient, and the technicians were unaware of the ocular status of the patients.

All patients subsequently underwent ophthalmologic evaluation consisting of assessment of fixation behavior, visual acuity measurement when possible, covertesting, and cycloplegic retinoscopy. The ophthalmologists performing the eye examinations were not aware of the photographic results.

The film (ASA 200) was commercially processed, and the photographs were evaluated by one of us (MSC), who was not present during the screening and was unaware of the ophthalmic examination results. The position of the corneal light reflex was used to determine ocular alignment, and the red fundus reflex was used to evaluate media clarity and refractive state of the eyes (Fig. 2). If the distance of the corneal light reflex measured from the limbus with calipers differed by one-half millimeter or more, strabismus was felt to exist (Fig. 3). Media opacities appeared as dark areas against the red reflex (Fig. 4). Emmetropia yielded a diffuse red reflex of varying hue based on the patient’s pigmentation. Refractive errors were identified when yellow crescents or fringes appeared in the red reflex of the pupil. A superior crescent was interpreted as hyperopia, an inferior crescent as myopia, and an oblique or irregular fringe as astigmatism. The size of the fringe as measured with calipers was compared to a template to estimate the degree of ametropia, and a comparison was made between the

Figure 1 Visiscreen - 100 in use.

Figure 2 Normal photograph showing symmetric position of corneal light reflex indicating normal binocular alignment, and diffuse red fundus reflex indicating absence of refractive error or media opacity.

Figure 3 Right esotropia. Note temporal displacement of corneal light reflex and lighter color of fundus reflex which comes from peripheral retina in deviating eye.
two eyes to assess anisometropia (Fig. 5).

Criteria for abnormal ocular status included hyperopia greater than 4 diopters, myopia greater than 5 diopters, astigmatism greater than 2 diopters, and anisometropia greater than 1 diopter. Any strabismus or media opacity was considered abnormal. The photographic technique was considered correct if it identified one significant abnormality, even though it may have missed another.

**Results**

A total of 127 patients participated in the study. Fourteen patients were eliminated because photographic analysis could not be performed. Thirteen of 14 were the result of incorrect patient positioning, and only one patient would not cooperate during photography. One-hundred and thirteen (89%) of the 127 children tested had analyzable photographs.
Ophthalmologic examination revealed abnormalities in 13 patients (12%), and no abnormality was noted in 100 patients. Of the 13 patients with abnormalities, 6 patients (46%) had refractive errors, 5 patients (38%) had strabismus, 1 patient (8%) had both a refractive error and strabismus, and 1 patient (8%) had a media opacity. The photographic technique was accurate in 105 (93%) of the 113 patients studied. Ninety-four (83%) were correctly identified as normal, while 11 (10%) were abnormal. There were 6 (5%) false-positives and 2 (2%) false-negatives. The 2 patients incorrectly classified as normal by the photographic technique were patients with very small-angle esotropia that resulted from successful strabismus surgery at an earlier age. The overall sensitivity of the photographic test was 85% and the specificity was 94%.

Discussion

Amblyopia is a major preventable cause of visual loss and accounts for 17% of monocular blindness. Furthermore, amblyopes are at greatly increased risk of bilateral blindness resulting from trauma or disease in the better eye. Efforts to decrease the incidence and impact of amblyopia depend on early detection and successful treatment of conditions which interfere with normal binocular vision. The American Academy of Pediatrics has recommended that vision screening become a routine part of child health supervision and has promoted appropriate guidelines for examination and referral. However, a recent study by Campbell and Charney indicated that only 24% of physicians surveyed reported use of an examination that was in full compliance with the recommendations, and almost half of all cases of amblyopia went undiagnosed until after the child reached 5 years of age. Clearly, there is a need for improved eye screening for infants and children before they reach school-age. The National Society to Prevent Blindness has recommended an eye examination or vision screening for every child immediately after birth, at six months of age, and in the preschool years from 3 to 5. The off-axis phoroptor may provide a simple, inexpensive, reliable method for performing this mass screening.

Our results are in agreement with previous studies of the off-axis photographic technique. However, previous studies have dealt with patients already within an ophthalmology setting, which accounts for a high reported incidence of abnormal ocular status. Our study yielded a high sensitivity and specificity in a non-referral population with an overall incidence of ocular abnormalities of 12%, a figure close to that of the general population.

Previous investigators have commented on the weakness of the photographic technique to detect with-the-rule (axis 180) astigmatism, and the difficulty detecting very small-angle strabismus. The latter point is emphasized by the 2 false-negatives in our study. However, significant against-the-rule astigmatism is uncommon, and many patients with microstrabismus have some degree of binocularity with no or only mild amblyopia.

The Visiscreen 100 off-axis photographic technique appears to be an effective tool for mass eye screening in pre-verbal children. The instrument is ideally suited to pediatricians, family practitioners, health departments and others involved in primary care of young children. It is the only system currently commercially available which provides reliable information without requiring highly-trained personnel or a motor response from the child. Additionally, the photographs are returned along with trained interpretation to become part of the child's permanent medical record. Results of this study support the belief that photographic screening of infants and young children should identify most ocular conditions predisposing to the development of amblyopia at an age when treatment can be most effective.

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The Americans With Disabilities Act

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Many primary care physicians in Alabama are involved in some way in industrial medicine; some are corporate medical directors and a few are practicing Occupational Medicine. Many perform preemployment physicals, treat work related injuries or are considered “company docs.” The recently enacted Americans with Disabilities Act (ADA) may affect many of these relationships.

The ADA addresses discrimination against the disabled in employment, housing, public accommodations, education, transportation, communication, recreation, health services and access to public services. Many of the ADA’s key provisions have their foundation in the Rehabilitation Act of 1973 which applies only to recipients of federal funds. Over a decade later, a legislative committee found that many disabled persons were still discriminated against. The ADA is intended to remedy this situation by expanding the scope of the previous legislation. Because the ADA is truly far-reaching in equality it has been called the Civil Rights Bill for the Disabled. The ADA was signed into law July 26, 1990. It will be administered through the EEOC under the provisions of the Civil Rights Act of 1964, by the Attorney General. The impact is legislatively graduated over several years, beginning in 1992.

For private businesses with fifteen or more employees, the ADA will:

1. Eliminate discrimination against people with disabilities in public services and public accommodations;
2. Encourage employers to make “reasonable accommodations” for qualified individuals with disabilities unless it would present an “undue hardship” to the employer;
3. Require new buses, trains and subways to be accessible;
4. See that transit and rail stations are accessible within twenty years; and
5. Ensure that phone services are accessible and compatible with non-voice devices.

There may be as many as forty-three million Americans with disabilities. It has been estimated that at least 8.2 million disabled Americans want to work, could work if given the opportunity, but cannot work because they are denied job opportunities. In the state of Alabama alone, there are 846,000 individuals with disabilities, at least 17% (144,000) are considered employable in the 16-53 age group.

The ADA is an attempt to prevent dependency. The main statutory provision aimed at achieving this purpose is found at Section 102(a) of the Act, which provides:

No covered entity shall discriminate against a qualified individual with a disability because of the disability of the individual in job applications and procedures, hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions and privileges of employment.

What is a “covered entity”? This term is defined by the Act to include any employer, employment agency, labor organization or joint labor-management committee. “Employer,” in turn, is generally defined as a person, or agent of such person, engaged in an industry affecting commerce who has 15 or more employees (25 or more for the period from the Act’s effective date, July 26, 1992 through July 25, 1994) for each working day in each of 20 or more calendar weeks in the current or preceding calendar year. The primary exception to this definition is the United States government, which is under other mandates with respect to nondiscrimination in employment of the disabled, including the Rehabilitation Act. In short, the broad scope of the term “covered entity” makes virtually every employer of 15 or more employees, including all private employers, subject to the ADA.

What does it mean to “discriminate”? The Civil Rights Act of 1964 left the determination of what types of conduct constitute discrimination up to the courts. The ADA does not leave this area undefined. It specifies seven types of conduct which violate the

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Act. These seven provisions, which are found at Section 102(b) of the Act, are likely the result of Congressional recognition of past failures and disputes in the civil rights arena and constitute an attempt to provide more specific and enforceable guidelines. Most of these provisions apply to employment and are not particularly important to the practicing physician.

The first type of conduct prohibited by the ADA is the limiting, segregation or classifying of a job applicant or employee in a way that adversely affects the opportunities or status of the person because of his or her disability. An example of this prohibited conduct would be the isolation of an HIV positive employee from his or her co-workers, which would further stigmatize the employee.

The second type of conduct prohibited by the ADA is participation in a contractual or other relationship that has the effect of discrimination. The problem that Congress intended to address by this provision is that of the employer who seeks to avoid compliance with the Act by contracting for its labor with union halls, temporary help agencies, etc., rather than employing its work force. Under this provision, an employer will not be able to insulate itself from liability by directing blame for violation of the ADA to the labor source. It would also be inappropriate for a company to contract with a physician to do prohibited preemployment screening in an attempt to shift the responsibility for its actions to the physician. Physicians must take care when considering requests to perform medical screening for third parties.

The third type of prohibited conduct is the utilization of standards, criteria or methods of administration that have the effect of discriminating based on disability or perpetuating such discrimination. The fourth type of prohibited conduct is the utilization of qualification standards, employment tests or other selection criteria that screen out or tend to screen out qualified individuals with a disability. This would be allowed if the test or selection criteria is shown to be job related and is consistent with business necessity. Like the third type of prohibited conduct, this provision also deals with employment practices that have a discriminatory effect, regardless of whether there is any discriminatory intent. However, the third type of prohibited conduct pertains generally to an employer’s standards, criteria or methods of administration, while the fourth type of prohibited conduct pertains specifically to the use of employment selection criteria that screen out or have the tendency to screen out a particular group of job applicants.

In addition, this fourth provision raises the critical issue of which party, the employer or the disabled worker, has the burden of proving whether or not the selection criteria in question is job related and consistent with business necessity. Among the factors that the EEOC states are to be considered in deciding whether a particular job function is an "essential function" are: The employer's judgment; written job descriptions; the amount of time on the job spent performing the function; the consequences of not requiring that the function be performed in that particular job; the terms of a collective bargaining agreement; and past or current work experiences.

It should also be noted that in establishing its "qualification standards" an employer may include a requirement that an individual not pose a "direct threat" to the health or safety of other individuals in the workplace. By regulation, the EEOC has provided a definition and interpretive guidance with respect to what constitutes a "direct threat." In general, "direct threat" means a significant risk of substantial harm to the health or safety of the individual or others that cannot be eliminated or reduced by reasonable accommodation. Determining whether an individual poses a significant risk of substantial harm to others must be done on a case by case basis. However, it is clear that an employer is not permitted to deny an employment opportunity to an individual with a disability merely because of a slightly increased risk. The risk must pose a high probability of substantial harm; a speculative or remote risk is insufficient.

Clearly these two provisions comprise the area in which physicians can be most influential in facilitating the implementation of this act. The development of consistent, functional job descriptions are essential if we are to assist employers in avoiding discrimination while maintaining a safe and healthy workplace.

The fifth type of conduct prohibited by the ADA is discriminating against a qualified individual because of the known disability of a person with whom the qualified individual has a relationship or association. One example of this type of prohibited conduct would be refusing to hire the mother of a disabled child for fear that she may miss work to care for her child. Another example, one which has gained recent national media attention, would be firing a qualified individual who has a premature child in fear of the increased cost of health insurance that the child may precipitate.

The sixth, and probably most controversial, prohibited conduct is not making reasonable accommodation for the known physical or mental limitations of
an otherwise qualified applicant or employee. Reasonable accommodation means making allowances for the person's disability so that they can do the job. An example would be to provide a mechanical lifting device for a wheelchair bound person to move heavy objects which they would otherwise be unable to carry. The employer must show that such accommodation would cause the company undue hardship. Denying employment opportunities to an otherwise qualified person with a disability is prohibited if such denial is based on the need to make reasonable accommodations. The consulting physician can be extremely helpful in the development of accommodations for the disabled.\(^2\)

The seventh and final type of prohibited conduct is failing to select and administer tests in the best way to ensure that the tests measure the skills and aptitude of the person with a disability and don't reflect the person's impairments.\(^2\) By including this very broad provision, Congress is apparently requiring employers to select the "best," not merely an appropriate, skill or aptitude test from among all alternatives. This may create a cause of action for a disabled individual to challenge the employer's judgment.

The ADA addresses certain important labor practices other than its key anti-discrimination ideas. These including medical exams and inquiries. For many years Occupational Medicine physicians have favored pre-placement medical evaluations. Under the ADA, preplacement evaluations will replace the traditional pre-employment exam. The important distinction here is that the medical evaluation is a part of the placement process and not an instrument of discrimination. Furthermore, a pre-placement examination focuses on a specific job and is not a global certification of employability as was often the case with pre-placement exams. Job offers may be conditional on passing post-offer medical examinations, if all applicants in the same job classification undergo similar examinations, the results are kept confidential and the information is not used to discriminate.\(^2\) However, physicians should encourage employers to consider alternative placement and job descriptions when dealing with the disabled.

Pre-employment inquiries about prior disabilities are prohibited in applications.\(^2\) Similarly, the EEOC has clarified that inquiries into an applicant's workers' compensation history are prohibited.\(^4\) An employer may, however, ask about an applicant's ability to do job-related functions.\(^2\) As noted by the EEOC, such inquiries must be narrowly tailored to avoid violating the general prohibition against pre-employment inquiries regarding disability.\(^6\) Physicians may make enquiries into the employee's history as they deem medically appropriate. The confidentiality of this information should be preserved if it has no bearing on the placement process. According to the American Occupational Medical Association code of ethical conduct:

"Physicians should treat as confidential whatever is learned about individuals served, releasing information only when required by law or by over-riding public health considerations, or to other physicians at the request of the individual according to traditional medical ethical practice; and should recognize that employers are entitled to counsel about the medical fitness of individuals in relation to work, but are not entitled to diagnose or details of a specific nature."

Unlike the general prohibitions, medical examinations and inquiries of those currently employed are permitted. However, the employer must be able to show that such examinations or inquiries are job-related and consistent with business necessity.\(^3,6\) Periodic health evaluations offered on a voluntary basis for the benefit of the employees are not so restricted.

The final substantive area covered by Title I of the ADA is found in Section 104, which deals with alcohol and drug use. There is widespread concern over the use of illegal drugs and the use of drugs in the workplace. The Act provides that the term "qualified individual with a disability" shall not include any employee or applicant who currently uses illegal drugs; The Act does not protect current users of illegal drugs. However, the Act does protect rehabilitated drug users.\(^2,6\) Pre-employment drug tests are not considered "medical examinations" under the Act; Pre-offer drug screens are allowed.

Alcoholics, on the other hand, are not excluded from the definition of "qualified individual with a disability." It appears that alcoholism is a protected disability. The Act makes it clear that an employer may require any user of drugs or alcohol to conform to the same standards as other employees with respect to working sober.\(^2\)

The ADA obviously creates complex and costly issues for employers. The social and economic importance of this act more than justifies the complexity and cost. The removal of all unfair prejudicial barriers to the disabled will increase the self worth, productivity, economic independence and quality of life of these individuals. This would increase the work force (and tax base) by at least eight million workers in the USA.\(^1\) In Alabama the increase would be roughly
144,000 otherwise qualified individuals. With the expected shrinking and aging of the work force in the coming decades, this would help offset the significant lack of qualified workers expected in the future. The cost of the dependency of the disabled is measured in billions of dollars. If only a fraction of this were spent on granting disabled persons their wish of independence and productivity the result would likely more than outweigh the price of accommodation.

The enforcement power is in the hands of the EEOC and the Attorney General. The questions of if and how they will enforce the act remain. Remedies for non-compliance may include forced hiring or reinstatement, back pay, and reimbursement for costs of litigation. Compensatory and punitive damages may be imposed where intentional discrimination is found. If a case involves a dispute about reasonable accommodation, compensatory damages may not be awarded to the charging party if an employer can demonstrate good faith efforts were made to provide accommodation. There is a $300,000 cap on punitive damages for companies with 500 or more employees, however there are currently two bills before congress to remove this cap. The magnitude of potential liability serves to emphasize the need for physicians to encourage prompt and thoughtful compliance among employers.

Business reaction, when business is even aware of the ADA, is often one of concern, resentment, and reluctance to comply. The practical ability of businesses to comply is also in question. The results of a survey published in the Birmingham News shows that of 100 businesses surveyed, only five had an idea what impact the ADA would have. Ninety had not even heard of the Act. Alabama physicians will play an important role in facilitating the understanding and enactment of this legislation in our state.

Initially employers may be opposed to this Act. Cost concerns make this understandable. Compliance with reasonable accommodation requirements will no doubt incur initial costs. There will be compliance problems and training needs that must be met. To insure compliance, meaningful job descriptions with performance expectations will need to be developed with increased training for those positions. A change of focus from "the job to be done" to performance and functional capacity is expected. Essential job functions, the right worker for the job and the right job for the worker, may identify improvements that can be made for the non-disabled worker. Employers need to be more aware of the needs of the workers. Focusing on ergonomic design and job safety will increase productivity and ultimately decrease costs. This act will redefine the role of the primary care physician. It may limit his actual usefulness in the industrial setting in many areas such as medical monitoring, placement or return to work exams if he is not aware of these new regulations. It will force more specific diagnoses and stronger compliance with confidentiality. The physician-management relationship may need to be redefined. The role of the physician is to return the individual to the greatest productivity possible and to evaluate the extent of impairment and predict recovery. These are important issues for the industry and the individual.

Copies of the ADA as well as information to assist employers with compliance may be obtained by calling the EEOC at 1-800-669-EEOC. Job Accommodation Network is an information and consulting service providing individualized accommodation solutions to inquiries about enabling people with disabilities to work. They may be reached at 1-800-DIAL-JAN. Additionally, the reader should feel free to contact any of the authors of this paper at 205-934-7303 for any additional information we may be able to provide.

ACKNOWLEDGEMENTS

The authors wish to thank the following persons for their support in the preparation of this manuscript: Elizabeth Murray; Brian G. Forrester, M.D., M.P.H.; and Timothy J. Key, M.D., M.P.H.

REFERENCES

Alabama physicians are primarily concerned with rendering the best medical care possible to their patients. However, physicians are not invincible to these same diseases. Chemical dependency to drugs and alcohol and mental and emotional disease impact in the medical practitioner the same as it does in non-professionals.

Physicians need evaluation and treatment early in their illness, prior to the disease impacting upon the professional care they render. These impaired physicians also need understanding and advocacy in recovery to enable them to return to productive professionals in the community. The Medical Association of the State of Alabama (MASA) has recognized this need by developing the Physicians Recovery Network (the Impaired Physicians Program of Alabama).

PRN offers education in the disease concept dealing with impairment in professional performance. Confidentiality assumes priority in PRN’s process of discreet investigation and evaluation which may lead to recommendation for a caring intervention. The process functions advantageously for consumer and practitioner protection in the following diagrammatic presentation:

---

### Safeguards of Impairment Programs

#### Safeguard Flow Sheet

<table>
<thead>
<tr>
<th>Function</th>
<th>Consumer Protection</th>
<th>Physician Protection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>Impairment recognized earlier (in practitioner himself, colleagues, and patients).</td>
<td>Prevents impairment by knowledge of risk factors.</td>
</tr>
<tr>
<td></td>
<td>Knowledgeable cadre’ of practitioners for intervention.</td>
<td>Impairment detected in early states and more easily treated.</td>
</tr>
<tr>
<td></td>
<td>Impaired practitioner recognized by consumer earlier.</td>
<td>Reputation not affected by the disease or recovery.</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>Freedom for the consumer to report suspicious acts without fear of reprisal or “ruining my practitioner’s reputation.”</td>
<td>Time of impairment shortened</td>
</tr>
<tr>
<td></td>
<td>Practitioners with problems free to “come out of the closet.”</td>
<td>Physician not grouped with morally deviant or incompetent peers</td>
</tr>
<tr>
<td></td>
<td>Early detection of dishonest or incompetent practitioners to receive legal sanctions.</td>
<td>Proper treatment.</td>
</tr>
<tr>
<td>Quality Control</td>
<td>Practitioner treated for specific problem by individual and institution knowledgeable and experienced in practitioner management.</td>
<td></td>
</tr>
</tbody>
</table>

*continued on page 29*
Principles

Principles and natural laws govern human growth and happiness — natural laws that are woven into the fabric of every civilized society throughout history and comprise the roots of every family and institution that has prospered.

The reality of such principles becomes obvious to anyone who thinks deeply and examines the cycle of social history. These principles surface time and time again, and the degree to which people in a society recognize and live in harmony with them moves them toward with survival and stability or disintegration and destruction.

One example is fairness, our of which our whole concept of equity and justice is developed. Others are integrity and honesty. They create the foundation of trust which is essential to cooperation and long-term personal and interpersonal growth.

Human dignity is the basic concept of the United States Declaration of Independence. The principle of potential teaches us that we can grow and develop and release more potential, develop more talents. Service teaches us to make a contribution.

Principles are not practices. Practices are situationally specific. Principles are deep, fundamental truths that have universal application.

Principles are guidelines for human conduct that are proven to have enduring, permanent values. They are fundamental. They are essentially unarguable because they are self-evident. Some may argue about how principles are defined, manifested or achieved, but there seems to be an innate consciousness and awareness that they exist.

When we value correct principles we have truth — a knowledge of things as they are.

Adapted from The Seven Habits of Highly Effective People by Stephen R. Covey, Simon & Schuster, New York, 1989.
<table>
<thead>
<tr>
<th>Function</th>
<th>Consumer Protection</th>
<th>Physician Protection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Involved monitors are experienced and cannot be diverted by practitioner or patient.</td>
<td>Continued help assured.</td>
</tr>
<tr>
<td></td>
<td>Problem resolved before harm done to consumer.</td>
<td>Problem handled before physician is aware of a problem.</td>
</tr>
<tr>
<td></td>
<td>May by referred to regulatory Board if practitioner fails to comply.</td>
<td>Physician does not compound legal and practice problems.</td>
</tr>
<tr>
<td>Hospital/Practitioner Assessment</td>
<td>All aspects of practitioner evaluated - will not return to practice if impaired or incompetent.</td>
<td>If not impaired, circumstances or crisis rectified and further problems avoided.</td>
</tr>
<tr>
<td>Treatment</td>
<td>If refused, ABME acts with stipulations upon return to practice.</td>
<td>Corrects problems.</td>
</tr>
<tr>
<td>Monitoring</td>
<td>Patient is assured the practitioner is being continually evaluated.</td>
<td>Promotes continued recovery.</td>
</tr>
<tr>
<td>Office of the Program and Alabama Impaired Physicians Cmte.</td>
<td>Rapid response to even questionable impairment.</td>
<td>Not affiliated with any specific hospital or treatment center.</td>
</tr>
<tr>
<td></td>
<td>Provides a practitioner who consumer can talk to with confidence and confidentiality.</td>
<td>Monitors treating physician and institution.</td>
</tr>
<tr>
<td></td>
<td>Ability to monitor outside legal restrictions.</td>
<td>Has no other purpose than to help the ill practitioner.</td>
</tr>
<tr>
<td></td>
<td>Experience and knowledgeable in specific area of practitioner impairment avoiding &quot;good ol' boy&quot; practitioner network.</td>
<td>Never isolated from help.</td>
</tr>
<tr>
<td></td>
<td>Continuity of care throughout geographic area of state.</td>
<td>Independent counseling.</td>
</tr>
<tr>
<td></td>
<td>Self-help telephone line maintained.</td>
<td>Re-entered safely.</td>
</tr>
<tr>
<td></td>
<td>Independent counseling.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Help on re-entry to hospitals and staff.</td>
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</tbody>
</table>

This flow sheet demonstrates the PRN functions that are available to Alabama physicians and patients. Presentation of this process is available for hospitals, county medical societies, medical auxiliaries, or other groups. PRN will respond promptly to your call to (205) 263-6441, 1-800-239-6272 or the Helpline at (205) 261-2044.

References

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<td>1,525</td>
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References:

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The Enabling Physician

-- Dr. Summer, p. 9
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Seven Stages of Reason

Like most Americans, I always look forward to a conclusion of the quadrennial silly season, otherwise known as our presidential campaign.

As this is written, neither the Republican nor the Democratic candidate has addressed the national debt or the annual deficit in anything remotely approaching a serious look at the central nightmare haunting this country. Although I had high hopes, I didn’t really expect much. Debt and economic stagnation are bad news. Politicians like to tell the American voter good news — that there are easy ways out of our unprecedented predicament. (There aren’t.) What voters want to hear is some simple way that $4 trillion in debt can be wished away in 90 days, the annual deficit reversed, and the flow of goodies from Washington restored, along with tax cuts.

Politicians are thus reaping what they have sowed. This is the line they have been feeding the voters so long, it is virtually impossible now to correct. A generation of lying to the people simply can’t be overcome in less than another generation, maybe longer. As the ancient Greek put it, we believe what we want to believe. Agreeable lies have staying power.

What really gets under my skin about all campaigns is the slavish fascination with polls. Every speech that candidates make are tailored to caress the voters in precisely the manner indicated by the latest numbers from out there. Politicians pander by referring to the “wisdom of the people,” when they know full well the rank & file is grossly uninformed on almost any complex issue. And that ignorance stems as much from past campaign attempts to gull and con the voters as it does from their intellectual laziness.

As if expecting this election year to be characterized by economic pablum, the National Council on Economic Education hired the Gallup Organization to find out just how much voters comprehend about elementary economics. Late last winter, a sample was asked such questions as: What does the federal reserve do? What happens to exports if the value of the dollar goes up? How is economic growth measured?

The findings, needless to say, were abysmal, but that’s not the worst of it. Americans are peculiarly opinionated, even militant, about issues they don’t begin to comprehend. Commenting on the Council’s findings, and comparing them with public expressions on economic matters, William B. Walstad, director of the National Center for Research in Economic Education at the University of Nebraska, said:

“Many people do not understand the meaning of basic economic terms. In contrast they have very strong opinions about things about which they have no underlying knowledge.”

And there is the crux of the matter. Nobody wants to make John Q an economist. But Americans’ basic understanding of the central problem of our time is so far behind that of the electorate of other industrialized nations of the West, one must seriously contemplate the possibility that we never will pull ourselves out of this deep, deep ravine. We won’t because the next political panderer coming down the pike will have
some nostrum that is absolutely guaranteed to retire the national debt without new taxes, and totally without pain — by simply declaring it null & void, perhaps.

Closely related is the economics of health care. When given a choice of free health care for all, Americans gleefully embrace the idea as no more than they deserve. Then, when it is explained that it’s not really free, some citizens begin to feel cheated. Since the pre-historic days when mankind was trading axes and animal hides in the caves, getting something for nothing has been a primal human craving.

A man who knows as much about public opinion and the sampling thereof as anyone in the land is Dan Yankelovich. He has been at it for three decades and is regarded as the dean of American pollsters.

Writing in Fortune, Mr. Yankelovich says politicians make a huge mistake when they look only at raw numbers. The public’s thinking on big issues always progresses through seven stages, he writes.

Because of its immediacy, he uses health care reform as his illustration of this progression. Here is a summary of the way he says the public mind works and will work on this issue:

**Stage 1. dawning awareness.** Here people become aware of an issue, launching it on its “long and tortuous journey toward public judgment.” A majority of the public is aware, in this stage, that health care costs are skyrocketing, but little else. Horror stories abound. The public learns of the great number of the uninsured. Even the insured feel threatened.

At this juncture, Mr. Yankelovich says, the public knows nothing of the specific drivers of rising health care costs: advances in technology; the high cost of caring for the increasing number of elderly and AIDS patients; rising administrative expenses. In this stage, “People glibly refer to the Canadian system but don’t know what it is.”

**Stage 2. greater urgency.** Health care reform is just now in this second stage, Mr. Yankelovich says. “The recession has many people terrified about job security, and much of this anxiety is channeled into worry about health care.... This concern is why almost four out of five Americans (79%) believe the health care system is in crisis. For now this sense of urgency is global and diffuse. The dominant sentiment is a pan-
icky appeal to 'Do something!'” Although the health care issue has been around for many years, only in the last year or so has it moved to the front burner.

Stage 3, discovering the choices. In this stage there is a creeping awareness of the choices and alternatives. On some issues, Mr. Yankelovich says, clear choices come in this stage. “But on most they do not. Some issues can fester for years before concrete, feasible choices appear.” This would be the next stage for the health care reform issue. The public begins to focus on the alternatives offered by leaders. Often the options presented are not the only ones and they may not be the best ones. But progress is being made in shaping rational public opinion; no longer is it simply a free-floating concern. Mr. Yankelovich:

“Health care is a particularly vivid example of the disorderly manner by which the public comes to focus on choices. Among leaders and experts, hardly a day passes without a new idea for coping with the crisis. But the public remains oblivious to most choices.

“Four choices have begun to swim into focus for the public, indicating the issue’s progress to the third stage of public opinion. The first relates to malpractice. People are learning about the debate to limit damages in malpractice suits. They are beginning to see the links between multi-million-dollar damage settlements, rising insurance rates for physicians, and the pressure on doctors to practice defensive (and unnecessarily expensive) medicine. This understanding neatly fits their preconceptions about greed as the driver of costs: The idea that lawyers are enriching themselves at the expense of the system is inherently credible.”

Other choices just looming on the horizon for voters at the stage are: prevention, as in anti-smoking campaigns, diets, exercise, etc.; the use of HMOs and other managed care plans; and, somewhat fuzzily, the idea that people must become more cost-conscious in the purchase of health care.

You would think that in stage 3 you have the beginnings of a maturing public opinion, but it doesn’t proceed in a straight line, as evidenced by, Stage 4, wishful thinking. This is where the public’s resistance to facing trade-offs begins. It is easy enough to get opinion polls showing people approve a cornucopia of improved and expanded services, Mr. Yankelovich writes. They will even say they could support a modest increase in taxes. “But saying this in a survey and accepting it in reality, are wholly different matters.” He continues:

“Mainly, though, the public erects its wishful-thinking barricade to public policy proposals because people feel excluded from decision-making on matters that affect their lives.... A significant part of the public’s resistance to facing reality reflects a perception that a serious disconnect separates today’s leaders from the voters.

“No issue illustrates this resistance better than health care. People start with the assumption that complete health care is a right, such as ‘everyone should have the right to get the best possible care — as good as the treatment a millionaire gets.’ 91% agreed to this proposition in a Harris poll. They think ‘health insurance should pay for any treatment that will save lives even if it costs $1 million to save a life (71%).’ Reinforcing the outlook is a gross misunderstanding of who pays the costs. People assume that they pay directly for 70% to 80% of their health care insurance, as they do for car insurance., while in reality they pay for only about 20% to 30%....”

It is in this stage that politicians begin to believe that the voters are ready to assume the consequences and the costs of changing the system. In that assumption, they are on shaky ground.

Stage 5, weighing the choices. In this stage voters must face alternatives that may challenge their most deeply held beliefs. Until now, the leaders and the media have done all the work of presenting choices. Now it is up to individuals, who must also understand the consequences of their choices. Conflicts of values occur, as in how heroic should measures be to keep elderly people alive for a few more days, weeks or months. Over the past five years, Mr. Yankelovich says, his own polling firm has found that the percentage of older Americans having doubts about whether anything and everything should be done for those near the end of life has risen from 40% to 64%. In other words, it is here that a painful choice between dollars and days begins to be made.

Stage 6, taking a stand intellectually, and Stage 7, making a responsible judgment morally and emotionally. These stages are linked, but different. “People are quicker to accept change in their minds than in their hearts.” We are ready to entertain the thought but not the deed. In Stage 7, “people’s first impulse is to put their own needs and desires ahead of ethical commitments. But once they have time to reflect on their choices, especially if the larger society provides moral support, the ethical dimension asserts itself, and people struggle to do the right thing, often suc-
No facet of the health care debate has reached either Stage 6 or Stage 7 level of resolution, Mr. Yankelovich says:

"But polls suggest that, under the impetus of a national debate, health care will move forward in virtually every stage. The public will learn that more than waste and greed are involved in driving costs higher (Stage 1). People's sense of urgency will grow less panicky and more tightly concentrated on controlling and reducing costs (Stage 2). Voters will focus particularly on choices entailing a larger role for government (Stage 3).

"Resistance will grow as people learn more about the options and the extent to which each involves higher costs and less choice for the individual. Resistance will focus particularly on options requiring employees to pay more, limiting technology, rationing health care and otherwise restricting choice and access (Stage 4).

"If the debate genuinely engages the voters, then the public, in Stage 5, should be ready to consider on their merits proposals for some degree of federal regulation of costs, for extending coverage to those who lack it, for curbing heroic measures in the last months of life. Even proposals for modest tax increases may receive a fair hearing.

"A few choices may even make their way to Stage 6. If the national debate is productive, Americans will support, at least intellectually, proposals for drastically reducing the incentives for malpractice lawyers to drive up settlement costs. They will also support proposals that emphasize prevention and that give incentives to individuals to take responsibility for their own health.

"It is too much, I suspect, to think that Americans can reach Stage 7 — the public judgment stage — on such a vexing issue in so short a time. But there may be some preliminary movement toward it. If so, it will take the form of an agonizing rethinking of complete health care as an inalienable right.

"People still support this right unqualifiedly, without thinking through its implications. Odds are that many years and many crises will have to pass before the American public fully accepts the need to ration, regulate, reform and even revolutionize health care in America so that it preserves some semblance of a right than a consumer good, without bankrupting the nation."

Reading Mr. Yankelovich's explanation of the stages of public opinion formation, you have probably figured out why it is that our politicians always prefer to ride an issue in Stage 1, eschewing the later stages. The explanation is obvious: they like to exploit popular passions in this raw, unformed state when the public will believe just about any pie-in-the-sky promise. As opinion matures, however, complexity is introduced, painless remedies become fatuous, and it's no place for the kind of "leader" who apes the style of the legendary figure in the French Revolution who is reputed to have said: "The crowds are in the street. I am their leader. I must follow them."

The health care issue, as I read Mr. Yankelovich, can be demagogued this year because it has just entered Stage 2. That may be impossible in 1996. By then, perhaps, people will want facts and figures, not rhetoric.

And perhaps by then — dare we hope? — the public will have learned something concrete about the American economy, to which the health care issue is strapped by chains of titanium.
Hard Cases, Bad Law

When the American College of Physicians recommended, in the Sept. 15 issue of Annals of Internal Medicine, a health care reform plan that embraced global budgeting of all health care expenditures in the country, I was disturbed by the news, as were many other ACP members.

When I read the full article I was even more upset. ACP proposed, in my name and the name of 77,000 other members of the College, that physicians and hospitals be herded into a global compound where assignment would be mandated for all patients, public and private, and fees would be fixed by some kind of national health care commission in cahoots with a vaguely described state regulatory agency.

This is all necessary, the authors said, to provide basically the same care for all Americans at the same price. The article, ostensibly the views of the ACP as a whole, goes far beyond other proposals that have been heard in Congress. The authors confessed as much: they had assembled their plan cafeteria-style by picking and choosing from ideas already on display.

I think that is called eclecticism, but whatever it is, the ACP plan would inevitably reduce, perhaps radically, the health care now benefiting 85% of the population. At the same time, ACP offers physicians as hostages to insure the efficient and economical operation of its universal health care plan when its failure seems foreordained.

I do not question the compassion of the authors; I question their wisdom. When you set about leveling the people, imposing uniformity on a heterogeneous population, you must necessarily bring down the many to benefit the few. That, to me, seems inescapable.

Such lowest common denominators did not produce the finest health care system in the world. That was accomplished through diversity, not lock-step conformity. I know of no better way to compromise the excellences of American health care than to place it in the custody of an all-knowing bureaucracy of the kind envisioned by the ACP authors.

What most distressed the four ACP members on the Board of Censors was that the ACP authors and other College officers would impose on all physicians the very kind of arbitrary, Olympian decision-making we fear most from adoption of any health care reform act. This was our greatest fear when Medicare was enacted a quarter-century ago.

Given the constraints of an enfeebled national economy and crushing debt, public and private, severe rationing will result from such a plan as ACP's authors have offered. Congress would set the goals. Washington fears nothing like it fears the word "rationing."

We saw that in the Bush Administration's refusal to grant waivers for Oregon to implement a state plan that would approach medical care by a cost-effective test, one frankly designed to guarantee more bang for the buck. It is, first and last, a rationing plan. In an election year, the Administration was panicked by the very word.

I happen to believe that the Oregon plan, now in abeyance, is a worthy experiment. But it is still that,
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Austerity in all areas of American life seems to be on the horizon. We cannot continue to borrow from our grandchildren, whom we have already saddled with a national debt of $4 trillion. To feed the fiction of annual budget-making, the government has slashed Medicare year after year. We haven’t learned how to handle this program or Medicaid intelligently, but the ACP authors seem confident that the failures already experienced can be remedied if we simply throw everything into a giant cauldron and mix well. I do not share the confidence of the chefs.

But if the radical experiment is attempted, the physician should retain the freedom to vote with his feet, an option ACP would deny him.

The rising cost of health care, coupled with the still increasing ranks of the uninsured, is an all but unparalleled national problem. No one denies that. Lawyers have a saying, I seem to recall, that “hard cases make bad law.” ACP has, in effect, looked at the hard case and concluded that the best course of action is to expand the mess and see what happens.

I respectfully dissent from that reckless advocacy of bad law.
The Enabling Physician

Gerald L. Summer, M.D.
Physicians Recovery Network

[See Cover]

The medical profession has been given an image to protect. It is an image of infallibility, omnipotence and prestige. These expectations, at times unrealistic, subject the profession to public scrutiny and in recent years increasing criticism. The result is that, when threatened by public disclosure, the medical profession has traditionally banded together to protect its own from anything that could tarnish the public image. As a result, colleagues unwittingly become enablers.

Inherent in the definition of enabling behavior is that which allows the chemically dependent person to avoid the consequences of his/her abnormal drinking or drug use. Denial of the existence of the problem actually supports chemical abuse. The failure of physicians to recognize colleagues with clear addictive behavior is attributed to many factors: (1) the failure of medical education to adequately address chemical dependency in the curriculum, (2) a physician’s inability to accept alcoholism as a disease, (3) considering the disease from a moralistic perspective, (4) fear of reprisal, (5) fear of litigation, (6) physician-peer conflict, and (7) simply not wanting to get involved.

These factors qualify as enabling behavior. Colleagues also enable by considering serious consequences, such as a DUI or evidence of chemical use in the professional work place, as isolated events requiring no further attention.

An antiquated attitude is that one has to “hit bottom” before recovery can begin. Not infrequently, “bottom” may be loss of license or death. 10%-15% of physicians are expected to be impaired at some period in their professional career. In addition, one study suggests that alcoholism is prevalent in approximately 25% of patients admitted to hospitals. Is it possible that through inadequate education physicians may enable both their colleagues and patients? All physicians need to reevaluate their knowledge in the recognition of chemical dependency in their colleagues and patients similarly to continuing medical education for other diseases.

An encouraging attitude is emerging that early recognition, evaluation and treatment of chemical dependency in physicians is possible with a successful recovery rate of 90%. The Physicians Recovery Network was developed to provide an opportunity for the impaired physician to get help earlier in the progression of the illness and prior to the illness impacting on patient care. Honesty, open-mindedness and willingness to acknowledge chemical dependent behavior in our colleagues will come through continued educational efforts in the disease concept.

The following first-person account of one impaired physician reveals that, in his long and tortuous journey, there were many enablers who, unwittingly and perhaps innocently in their own minds, failed to recognize his disease and his desperation.

References
Dr. Anonymous Tells His Story

This is the true story of an Alabama physician who miraculously survived the disease of chemical dependency associated with multiple complications. His history demonstrates how our lack of knowledge in the disease concept of addiction allows it to progress. It is also a success story because, through proper treatment, Dr. A. has returned to a productive individual serving his community.

Gerald L. Summer, M.D.
Medical Director
Physicians Recovery Network

My name is Dr. A, and I am an alcoholic and addict. I appreciate this opportunity to share my story with you, for as you see, today I have recovered from the disease of alcoholism and drug dependency, and returned to a useful life in my family, community, church, and medical practice. I am especially grateful when you realize that I abused drugs and alcohol for over 25 years, yet recovered with amazingly good physical, mental and emotional health. To me, this is nothing short of miraculous.

Although my story may be somewhat different, in that the period of addiction was longer than most, I doubt it is atypical and I hope it serves to motivate those of our colleagues who are still suffering to enter a recovery program. For, you see, today I live a life that is completely filled with joy and happiness and the shame and guilt I carried for a lifetime have disappeared. I no longer fear telling you that I have a disease of addiction and that I recovered from a lifetime of dependence on drugs and alcohol.

I was born in a northern Alabama county in the late 1930's to parents who were both educators. My formative years occurred in a rural setting and I was somewhat isolated. Both of my parents were practicing fundamentalist Protestant people. They were also strict disciplinarians. I came to believe that strict discipline, meaning physical punishment, was an expected way of life, though I began to resent it at an early age.

Much of what I experienced in my early years, I now know to be child abuse. In viewing this now from a distance, I realize my father only passed on to me what he had received. He was the oldest child in a large family with an alcoholic father at the head of the household. I recall the single overriding remembrance was that I was unhappy, lonely and desperately wanted to escape.

I was the oldest of two children, having a sister who was three years my junior, and who incidentally died at age 42 of the disease of alcoholism and drug dependency. We always attended church services on a regular basis, and religious activity always seemed to be a contentious thing in my family. Alcohol was condemned and there was never any alcohol abuse in my immediate family. Although I am certain I was loved, I cannot say I ever had a feeling that I was loved. I do not recall ever being held, nor my father or mother ever just putting their arms around me and saying, “I love you.” I did learn, however, to acquaint achievement with success and fairly early on I learned that if I did well I would receive praise, and that in turn seemed to alleviate the fear of punishment. I am certain that my sister had like feelings, although I never recall discussing it with her while we were growing up.

I did not fit in with many of the students in my junior high and high school groups, and this was especially true in the area of sports, where I could never compete and feel to be a part of the group. Nevertheless, I continued to do well academically and generally got along well. I was the so called “good child” and never really caused my parents any extreme emotional distress up until the time I was an adult. I entered high school at the age of 15 and over the next 10 years I rather easily completed three years of high school education and pre-medical education and medical school education, graduating with an M.D. degree several months prior to my 25th birthday. Although, I did not feel I was gifted academically, I had learned a better behavior which involved studying on a regular basis and applying that to the goal of obtaining a passing grade on the subject at hand.
In the freshman year of high school, I met my future wife and approximately four years later we were married. This marriage, which has now existed for over 35 years, with varying degrees of intensity, no doubt prolonged the length of my drug and alcohol dependency, but also probably saved me from dying from the ravages of the disease. A marriage born of this background and tempered by the trials of years of adversity has become in recovery incredibly more wonderful as time passes.

As you would expect, I never drank alcohol or experimented with drugs either in high school or college. Thus, the family history of alcoholism and dysfunctional family upbringing became operative in my formative years. However, in the third year of my medical education, after several years of constant weight gain, it became apparent that I was obese and needed to lose weight. This was made all the easier since at that time, in a university hospital setting, Dexamyl was freely available from pharmaceutical representatives. From the time I took the first capsule in my junior year of medical school up until the time I discontinued the drug some 10 years later, it remained an effective anorectic agent, and I never again had an obesity problem.

However, from the ingestion of the first capsule, I realized this drug was not only effective as an anorectic, but it also made me feel at ease with myself with other people. Initially this was not a major problem, but by the time I had graduated from medical school, the dosage had escalated until both physical and emotional problems were being encountered. At about this time I realized that the insomnia and irritability one experiences from multiple daily doses of amphetamines could be offset effectively by evening doses of Seconal. In retrospect I realized I had become fully dependent on stimulant and sedative drugs to function. During this period of time I realized the practice of general medicine was very demanding and not something I felt particularly emotionally comfortable with as a lifetime career.

I recall walking into the center of Denny Stadium at the time of graduation from medical school, receiving my diploma from the President of the University, and having an overwhelming feeling of being utterly lost. After all the years of work and struggle to graduate from medical school, it all seem so empty, and the overwhelming thought in my mind at that instant was "what do I do now?" Four days following this event the father whom I had both loved and resented, and wanted to be proud of me and whose influence I had wanted to escape, suddenly became ill and died in my presence of a massive cardiovascular event. This event was devastating to both my mother and my sister, who had also graduated from nursing school.

Although I had not yet entered my internship I began to realize I was "in over my head" since I had attended medical school on a state tuition scholarship, and had obligated myself to five years medical practice in a small Alabama community. By this time my wife and I had two children under two years of age, which seemed to further complicate my circumstances. Nevertheless, within two weeks of these events I plunged headlong into a rotating internship at a large teaching hospital in another state — using stimulant drugs almost on a daily basis to cope, interspersed with occasional hypnotics at night. This pattern tended to wax and wane depending on which service I was rotating through at the time. I began to be aware that my emotions and behavior were many times out of balance. This was manifested in patterns of anger and agitation, with occasional verbal assaults on attending physicians.

In spite of this behavior I was never confronted, nor disciplined in any way, nor did anyone even question the cause of such behavior. There were many other personal and marital problems that developed that directly impacted on my performance as an intern. However, I managed to complete the year satisfactorily. Toward the end of the internship I received notice that I had been inducted into the military service. This was certainly not a disturbing event in my life because I realized that I was grossly, emotionally unprepared to face a private practice setting. I subsequently volunteered to enter the Air Force. As a practicing flight surgeon I had much leisure time and access to jet aircraft to fly cross country on weekends. It also afforded access to the medication cabinet in the flight surgeon's office which was liberally stocked with Dexamyl and which I took at liberty during this entire two-year period of time.

In retrospect, I never recall taking off in a jet trainer when I wasn't high prior to the takeoff. During those years there was no such thing as drug testing although I had several confrontations with my commanding officer. During the last year of my military service it became apparent that I would finally have to enter private practice and begin to repay the five years I owed to the state for my medical education. It is interesting now in looking back, that I had spent the first 25 years of my life trying to escape from my family, their influence, and the locality in which I grew up, and now that it is time to enter private practice, I make a decision to return to my home town and
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enter a solo practice. Needless to say, this decision was ill-advised and was fraught with disaster from the start.

Although I faced many and various difficulties, as most physicians do when starting up a practice, the main problem was that of continued drug abuse. I had a ready supply of drugs on hand when I left the Air Force and by this time I was able to order stimulant and sedative drugs from mail order catalogs. The practice in my home town was complicated by numerous marital and personal problems, was a complete failure and lasted less that one year, leaving me deeply in debt. Because of the mounting financial problem, it became apparent that I would have to find another practice locality very quickly. Fortunately or unfortunately, as the case may be, a town in another area of Alabama was looking for a physician since both of their resident physicians had died within the prior 18 months. They had a clinic building that was initially rent-free and was fully equipped. It became apparent that I could not pass up this opportunity and it also met the criteria for repaying my state scholarship.

Following this move there was a six-month honeymoon period during which time I worked very hard and was able to pay off most of my immediate debt. This, however, required ever increasing usage of amphetamines during the day and sedatives and hypnotics at night. I recall that during that period of time my grandmother died and I was expected to attend the funeral, but was literally too fatigued to get out of bed. Some 15 months after beginning the practice I was hospitalized for the first time directly relating to drug dependency. By this time my weight had dropped to 135 to 140 pounds from the normal 165 pounds. I was unable to function and called an old class-mate of mine who hospitalized me for a "work-up" at one of the larger Birmingham hospitals. Although we never discussed it, I believe he was aware of the problem since we had attended medical school together and also interned together.

During this week of hospitalization I recuperated somewhat, and was able to return to my practice with the official diagnosis of fatigue. Of course the same pattern of behavior and drug-taking resumed. By this time I was beginning to have difficulties with both the medical staff and hospital personnel at both of the hospitals which I attended. Nevertheless, the drug-taking continued. I recall some two years after entering practice experiencing my first difficulties with alcohol which was aggravated by barbiturates, while visiting New Orleans with a group of friends. I had lost considerable sleep, was taking both amphetamines and barbiturates on the trip to New Orleans. After drinking a Hurricane at Pat O'Briens, in a matter of minutes I realized I was in trouble and had to be escorted back to my hotel room, where I immediately passed out. When I awoke the following day, my wife and the three couples who had gone with us, which included my office nurse, a state trooper and a dentist, had left me in New Orleans to fend for myself. After some manipulation of the French Quarter hotel, I was able to arrange a flight home. Following that event I never had a major difficulty with alcohol for the next 12 years. Again the same pattern of behavior resumed. Within a short time I was again fatigued and debilitated, at times being unable to work for periods lasting several days.

At one point I recall my wife and I making a trip to a psychiatric institute in Atlanta, Georgia. I refused to be admitted knowing I could quit the drugs on my own if I really set my mind to it. Following that, I did set my mind to it. However, as you would expect, this failed utterly and my wife became increasingly more unhappy with my behavior. Shortly thereafter she left, taking the children with her to live in the home of her parents for a period of approximately nine months. During this period of time I was able to "straighten up" somewhat, and I persuaded her to return. Of course, it was not long before the old pattern of drug abuse returned to a debilitating level and this time I really became aware that something had to be done. At this point my wife and I sought psychiatric consultation with one of my medical school professors who advised me that I could not stop using drugs on my own. However, I became angry and indignant and informed him that I certainly could and promptly got up and left his office, never to return.

The interesting thing about this story is that I did quit using amphetamines, and from that day on I have never taken another dose. I did not understand, however, that one could not substitute some other mind- or mood-altering substance to replace the amphetamine and I promptly began to search for some effective chemical to replace the high that the amphetamines always produced. After some degree of trial and error, which included the abuse of benzo-diazepines, barbiturates, Quaalude, meprobamate, and other drugs as well as various antidepressants, I settled on Darvon as the most effective drug. However, within the year after my wife's return home she again became increasingly unhappy with my behavior and my work habits, and this time left for good, divorcing me in the process, taking the children, moving back to
our hometown and taking a job as a nurse. The events surrounding her leaving were very traumatic to me and I intended to put a stop to it. Whereupon I showed up chronically intoxicated on drugs at her father's home during the middle of the night and promptly broke a window trying to enter the house. This produced a chain of events which were both traumatic and frightening as I was subjected to a rifle bullet being fired over my head and a pistol being placed in my back. The Deputy Sheriffs arrived on the scene, at which point I was handcuffed and taken to the county jail, booked and admitted. As with the earlier alcohol story in New Orleans, I was a fast learner, and I immediately realized that I did not like jail and have never been in a jail since that day. When I was released the following day I returned home, where I slept on the floor for an entire week, since my wife had taken all the furniture when she moved out. This series of events made a big impression on me and I recall thinking at the time that I had to turn my life around. I set about doing this, first of all by returning to the things I had been taught in my childhood, namely, strict discipline and zealous religious activity. I promptly returned to the church, became active in the church, and rededicated my life to our religious goals. This seemed to work very well. If I took any drugs for the next nine months or so they were very sporadic and minimal and I began to function quite well and did very well in my practice. By this time I had once again convinced my wife that I had reformed my life, that I was rededicated to the principles of the church and that we could again become a functional family.

Of course she bought into this idea and we were remarried on our original marriage date 17 years after our initial marriage. It was not long, however, before the old restless, irritable and discontented feeling returned, which I largely satisfied over a period of months by eating excessively. During this period my weight ballooned from the low of 140 pounds to 275 pounds within the span of a year. Once again I had to take charge of my life and since the newer generation of diet pills was available I reasoned that these were not true amphetamines and these would not be dangerous, so I promptly started taking these. This was not noticeable at first and over the next year I was able to lose some 90 or 100 pounds. However, as you would expect, when reaching my desired weight goal I did not stop using these chemicals, but continued to abuse them. In addition to returning to the old pattern of Darvon abuse.

This worked fairly satisfactorily for a period of three or four years during which time the family was able to take a trip to Hawaii, the Canadian Olympics in Montreal and several other extended trips. One of these included a fishing trip to the Florida Keys with my sons during which time I was taking extremely large doses of Darvocet. After a day of strenuous fishing and being awake many a hour, I recall suddenly seeing a bright light shining in my face, which was very disturbing. I shortly became aware that I was in the emergency room and that I was talking to a doctor. I soon realized I had sustained a grand mal seizure while in the parking lot of the hotel and had been taken to the hospital by a rescue squad. It is interesting that this event occurred 15 years after the time I took the first dose of amphetamines in medical school and it was just the first of some five or six grand mal seizures that I was to sustain over the next 10 years, one of which actually occurred while standing at the foot of a patient's bed during rounds. Of course this event necessitated some type neurological workup, which consisted of a CT scan of the head and seemed to satisfy all the parties involved including myself. As you might imagine, after experiencing the initial seizure and coming to realize the etiology of the seizure I had an awakening as to how to prevent this from ever happening again. That was to limit the dose of Darvocet to five or six tablets administered four or five times daily.

Although this worked fairly well for a while, my wife was aware that I was once again using drugs and she became increasingly unhappy. This became a somewhat moot issue about one year later. Shortly after having returned from my medical missionary trip to Africa sponsored by my church, I became seriously ill with a nephrotic syndrome. After three hospitalizations, with work-up including arteriogram and three renal biopsies, I was diagnosed as having glomerulonephritis. Fearing the long-standing drug abuse had caused the nephritis, I was able to discontinue all drugs. Although, I never admitted drug abuse to my nephrologist, he discounted this as the etiology of the nephritis. Nevertheless, the illness was not responsive to steroids and after being seriously ill for a period of approximately six months, I was placed on a course of Cytoxan which promptly relieved the nephritis.

After stopping the Darvocet entirely at the onset of the nephritis the old restless, irritable and discontent feeling once again returned, and the typical reasoning of an addict/alcoholic once again took over. I reasoned that if I was unable to take drugs which had to be excreted through the kidneys, I could probably
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take some small doses of alcohol in the evenings to allay my anxiety. Initially this worked very well and within a short period of time, although not taking drugs, I was having a larger and larger glass of wine each evening and generally beginning to feel comfortable with myself. I also reasoned that, after all, I had been through in my lifetime, I actually deserved to be able to drink some in the evenings, although my wife and my church both frowned on it. And as you would expect, this evening sedation gradually progressed up until the point I no longer found wine effective and had to switch to hard liquor. It also became readily apparent that vodka was more effective and that vodka miniatures could be effectively concealed in one’s clothing to be administered as needed during the day.

In less than three years from the time I first started drinking wine, I was hospitalized for the first of two psychiatric admissions for chronic intoxication. I recall staying in the hospital for a week, talking to the head of the psychiatry department, who was my attending physician, about the stresses of a medical practice. Never did he bring up the subject of alcoholism, nor did I broach the subject to him myself because I did not consider myself an alcoholic. I realized that during this period of time I continued to take steroids for the management of the nephritis and my day-to-day life was really very emotionally painful.

Shortly after this admission a pharmaceutical salesman showed up one day at my office, leaving a newly marketed analgesic drug, known as hydrocodone. Shortly thereafter, I recall having a headache and unthinkingly I took two tablets. Within a matter of minutes, not only was the headache relieved, but that restless and irritable feeling was once again gone. I felt better about myself and other people and in fact, I felt just like I had felt the day I first took an amphetamine. I reasoned that since my nephritis was two or three years old by now, and was in remission, and having been reassured by the nephrologist that it was not related to drugs in the first place, that I could probably take hydrocodone on an ongoing basis to feel better about the world.

This reasoning seemed logical since I had had one hospitalization for acute alcohol intoxication and could not afford to be readmitted. Following this I decided I had better cut down considerably on my drinking or quit altogether. However, this would pose a problem in really leaving me unable to deal with life situations. After a brief period of experimentation, I found that if I drank a reasonable amount in the evenings and took hydrocodone in the day-time to function, this worked very well. I could carry on a relatively normal lifestyle, functioning fairly well at the office and the hospital as well as at home. The only problem with this decision was that instead of taking hydrocodone in liquid form, I chose the type of hydrocodone and aspirin in tablet form. This was no problem at first. However, over a period of time I began to experience more and more gastritis symptoms which I treated haphazardly with antacids and H2 blockers with poor result in view of taking 20-25 hydrocodone and aspirin tablets daily. Also during this period of time I recall that, instead of just drinking at night, I once again allowed the alcohol dose to creep up to the point that I was becoming intoxicated at night — occasionally drinking in the day time and once again having episodes when I would miss several days from work at a time. It was also during this two or three year interval that several other seizures occurred. I managed to avoid any further hospitalization, either related to the nephritis and/or alcoholism for several years.

From the outside I am sure it appeared things were going well in my life. Of course this could not have happened without having a family and office staff who enabled me to drink and take drugs and continue to function at a fairly credible level. After a period of about four years, during which time I switched from wine to vodka to beer, to wine to vodka, plus the continued use of hydrocodone and aspirin tablets, usually in a dose of 20-30 tablets per day, it would seem reasonable that something had to give. And the thing that gave was my stomach.

After experiencing pain for numerous nights, the pain seemed especially severe one night and the following morning I decided I needed to get a GI series. The radiologist who did the study was just new in town and I yet recall the pallor on his face when he reviewed the films with me later and said, “I can tell you for sure this barium is in the peritoneal cavity.”

The other problem was that I had eaten breakfast immediately following the study and now had a peritoneal cavity full of, not only barium, but also bacon and eggs. Needless to say, I was shortly admitted to the hospital after walking to the emergency room and was placed under close observation. This proved to be a fortunate decision for later in the afternoon I began to vomit blood. Initially not much, but at about 6 p.m. that evening literally buckets of blood. Of course I was very anemic when admitted with a hematocrit of about 30 which later dropped to 18 or 19 in the evening. During one protracted period of retching I felt myself becoming unconscious and try as I did I
could not hold on. When I awoke I saw the same pal-
lor on the ICU nurse’s face where she explained I had
just sustained a grand mal seizure.

During this period of time I received six or seven
units of whole blood rapidly. During that night and
the following day I received a total of 13 units of
blood, had a 70% subtotal to control the bleeding, and
a subpancreatic abscess drained.

During this period of time and I truly believe all
the doctors involved felt the 2cm gastric ulcer perfor-
ation was related to chronic steroid administration. I
never brought up the subject of drugs, aspirin, much
less alcohol. An interesting recollection about this
chain of events is that the same mother-in-law who
some 17 years earlier had been holding the pistol in
my back, prior to my going to jail, was now standing
in the ICU waiting room with an apprehensive look
on her face fearing that I was going to die. It never
occurred to me, however, that I was going to die; in
fact, I did quite well as noted during and after the
operation. Certainly anybody of the same mind, after
having gone through this type experience, would
change his ways of living and straighten up his life.
Unfortunately, alcoholics and drug addicts do not
think this way, I reasoned that I could not take
aspirin-containing products. And since I really had
not had any major problems with alcohol for a con-
siderable period of time I could probably begin to
drink some small amounts again.

Within six weeks from time of discharge from the
hospital, my wife returned from a trip to California to
find me again, chronically intoxicated. I was still at
home, did not have any responsibilities, was basically
alone and felt that I needed a little alcohol to relax. So
once again I was determined not to drink alcohol,
which again proved to be effective for a short period
of time. Since insanity is the prevailing mental state
of an addict, once again I reasoned that my problem
was aspirin, and that I could probably take hydrocodone tablets with Tylenol satisfactorily. From
that day on for the next four years I found hydrocodone with Tylenol to be remarkably effective. I
could take six or seven hydrocodones and repeat
that four or five times a day and function extremely
well. This did leave one a little bit hyper at night and
it became necessary once again to seek some seda-
tion, which was most easily accomplished again with
vodka. So now I was taking large doses of hydrocodone in the day and drinking large doses of
vodka at night.

Within 15 months from the time I had the gastrec-
tomy I was subsequently hospitalized again by the

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**Yohimbine HCI**

**Description:** Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxyclic acid methyl ester. The alkaloid is found in Rubiaceae and related trees. Also in Rauwolfia Serpenfa (L) Senn. Yohimbine is an indolalkaline alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr) 5.4 mg of Yohimbine Hydrochloride.

**Action:** Yohimbine blocks pre-synaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone. Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other activities mediated by B-adrenergic receptors; its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the CNS and produces a complex pattern of responses in lower doses than required to produce peripheral adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug. Also, dizziness, headache, skin flushing reported when used orally.1,3

**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.1,3-4 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.3

**How Supplied:** Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100’s NOC 53159-001-01 and 1000’s NOC 53159-001-10.

**References:**
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 5th ed., p. 175-188

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Chairman of the Psychiatric Department of the large teaching hospital. This time he placed me on the psychiatric ward. Once again my psychiatrist and I talked about stress management and private practice and he introduced me to the exercise unit at this particular hospital. But I did not respond well to this type of treatment either. Also, he suggested that I come to a six-week outpatient program and talk to one of his 15 colleagues after my discharge. Again, neither during this hospitalization, or on the six-week outpatient follow-up was the word alcoholism, chronic alcoholism, or drug addiction ever mentioned.

Several weeks later I received a letter from the State Board of Medical Examiners asking me to appear before them and explain my failure to follow-through with treatment for alcoholism. I was outraged at the very idea that the State Board would suggest that I suffered from alcoholism, and furthermore I was outraged that the psychiatrist reported this to the State Board, since he did not advise me he was going to do so. Well, as you might imagine, I showed up for the State Board hearing very indignant, outraged, incensed, that I could be considered alcoholic. I vigorously pleaded and minimized my case, explained to them that I had attended the six-week follow-up as instructed, and that they should not worry about me for they would never see me again about a problem regarding alcohol. During this visit with the State Board, no one ever mentioned a drug screen, no one ever talked about drug abuse. In a follow-up letter a week later, I was advised that they would file this information and that someone would follow-up on me at a later date. Well, no follow-up ever took place, and at that point I fell through the cracks in the system regarding the diagnosis of my addictive disease.

As you might imagine, fear kept me from drinking for about nine months. Absolutely none of any of my prior treating physicians had asked me about drug abuse. In retrospect, I do not believe I would have lied had I been asked, but I was not asked and I did not have a urine screen. So, following this meeting with the State Board, I resumed taking hydrocodone and acetaminophen in ever-increasing doses over the next three years until the end finally came. As I indicated, I was sobered up with fear for about nine months, but after continuous stimulation with hydrocodone for a matter of months one has to detox periodically and during this detox phase the highs were most easily replaced with ethyl alcohol, namely vodka.

And within a year after meeting with the State Board I was once again off to the races using copious doses of both alcohol and hydrocodone. The same pattern as before, the hydrocodone during the day, the alcohol during the night. Over the two years prior to the end, the escalation in the dose of both drugs was rather incredible. During this period of time I found it necessary to detox from hydrocodone especially on the weekend, at which time I had begin to binge-drink as well as drinking nightly during the week. When trying to come off a binge, it became necessary to take 25-40 hydrocodones within a 12-hour period to sober up and return to work. This pattern likewise escalated and the binge-drinking became longer and longer, lasting up to a week or longer on each occasion. I recall that during the last 18 months of my drinking and drugging, as if on schedule every three months, I went on a binge drunk that lasted 7 to 10 days. On each and every occasion I vowed to quit drinking alcohol because I considered this my problem. It never occurred to me that drugs were an integral part of this problem. On each occasion I would vow to stay alcohol-free. But the disease always lies to the mind, the mind believes the lie and the lie is that it will be okay to take just one drink at night.

During all this period it never occurred to me that it was the first drink that made the drunk and the first pill that always kept me using drugs. During the last three years of the active disease phase of my illness, day-to-day life became progressively more desperate. I began to come to work later and later each day not really feeling like working, nor really wanting to work, but finding it a necessity. Yet, we really see no way out. It really becomes impossible to tell the truth from the false, and this type life actually seems to become normal. I find it interesting that after returning to my church, I always continued to attend faithfully and for a number of years actually functioned in the leadership role. The last two or three years of my active addiction I was enabled by numerous other high people in institutions. On at least one occasion I was stopped by the city police while driving under the influence, but was allowed to proceed on home. On another occasion during one of my self-imposed detoxification retreats, I became stranded at a state park, being unable to drive home. After making appropriate calls, a police car was dispatched to the state park and I along with my vehicle were delivered home safely.

On another occasion, while driving under the influence, I actually ran into a retaining wall in front of the police department and passed out with my vehicle still running. As on other occasions, I was delivered safely home in a police car. No charges were ever
filed. I am also certain the hospital administration, and numerous physicians on the hospital staff, looked the other way as long as it was possible to do so.

During that period of binge-drinking my wife and family all deserted me, leaving me at home alone and a friend actually carried me to his home and detoxed me from alcohol over a period of about a week. Of course he was unaware that I was continuing to take hydrocodone during the day-time while detoxing from the alcohol.

After that I was alcohol-free for a brief period of time, but never drug free, until I gradually got into the final binge. During a weekend when intoxicated I had fallen and broken my left shoulder, which was associated with a large hematoma and much pain, as you might expect. At that point it required that I take considerable doses of Tylox in addition to the hydrocodone to control the pain in addition to the continued daily drinking. I realized I was too chronically intoxicated to seek legitimate medical attention for the fracture because someone might find out that I had a problem. After that I remained intoxicated for the better part of a month, being driven to the hospital during odd hours, attending as few patients as possible.

At the end of this period I went on a real binge and could not return to the hospital for a week. Since my family and most of my friends had deserted me, I was once again taken to this friend’s house where I remained for about a week — all the while continuing to take drugs to control the pain of the broken shoulder and draining hematoma, which was in reality a compound fracture. At about that point I was read a letter since I was both physically unable to hold the letter or focus on the words. It was from the Hospital Executive Committee and the Chief of Staff, stating that I had been terminated from the hospital staff. I had been a member for almost 25 years. At this point I remember thinking that is has now become public knowledge that I have an alcohol problem, that the “jig is up,” and that this has to be stopped. I was immediately willing to enter a treatment facility and within three hours from that decision I was admitted to one of the large treatment centers dealing with professionals in Atlanta, Georgia.

The day of admission I was perfectly willing to admit I was an alcoholic, but in spite of all evidence
to the contrary, amazingly it took four more weeks to grasp the concept that I was also addicted to drugs. I still find that astounding. Since I was admitted to the treatment center at night I did not get a once-over physical until the next morning, whereupon they promptly transferred me to a medical hospital for the treatment of the hematoma and compound fracture of my left shoulder. I remained in the hospital, receiving large doses of IV antibiotics over the next week and was detoxified from both drugs and alcohol. Following discharge, I was transferred back to the treatment center where I remained in all phases for a total of almost five months. This was very fortunate, for only two weeks later, one morning while attending the daily big book study (Alcoholics Anonymous) I suddenly realized the basis of my problems which had haunted me for over 50 years.

We read a sentence which applied directly and specifically to me and in fact emphatically spelled out the root to all my problems. Something that I had never known before in my entire life. The sentence said, “selfishness and self-centeredness! That, we think, is the root of our troubles.” Earlier in this study I had learned that I had an illness and the hallmark of that illness was that I was powerless over drugs and alcohol and I accepted that. I had also learned that my dilemma was the lack of power and that to conquer this illness I would need to experience a spiritual change or transformation and I also accepted that. I also realized that my other choice was to choose to live life on a spiritual basis or be doomed to an alcoholic and drug death. I also became aware, at that point, that if any moral code, better philosophy or any amount of self-will could have saved me, I would have never been there. I have no doubt that on that morning I began what has been a profound spiritual journey that still continues and grows.

For you see, the hope of any alcoholic is the maintenance and growth of his spiritual experience. I also learned on that morning that my troubles were basically of my own making, that I had lived a lifetime driven by fear, self-delusion, self-seeking and self-pity. I accepted the fact, totally and fully, that my problems were basically of my own making and if I was to ever live sober, happy and free, I was going to have to be rid of such things as selfishness, dishonesty, anger, resentment and fear.

And above all, that day I learned that I would have to quit playing God. It was immediately obvious that the God of my life had been me, along with the Gods of alcohol, drugs, and scientific knowledge, and it was readily apparent that these things did not work. I realized that if I was going to recover I had to turn my life over to a power greater than myself — in other words, a new director of my life, and on that very day I was able to turn my will and my life over to the care of God, of my understanding and from that moment on I have not had one second of regret. At that point I truly began to lose the fear of the past, the present, and the future. Although this was only the beginning of recovery, to me it was very dramatic and I would not wish to trade it for anything.

I completed the full three-phase treatment program. The greatest thing I received was the introduction into the program of Alcoholics Anonymous and the 12-step way of life, which I aggressively practice today on a daily basis. That is the basis of trusting and relying on an infinite God rather than my finite self. I am in the world today to play the role He assigns to me, and I humbly rely on Him on a daily basis to match calamity with serenity and I make no apologies to anyone, for I have not been disappointed.

Following that experience I never have again had a desire to drink alcohol or to place mood- or mind-altering drugs in my body. I did not even have to swear off alcohol or drugs or make a mental decision to quit using them. It just happened automatically. It literally came without any effort on my part and that is the miracle of it. It is not that I any longer have to fight or even avoid temptation. For me the problem was removed. That is not to say that I am cured of alcoholism. What I really have is what all people who are truly in recovery have, and that is a daily reprieve based on the daily maintenance of a fit spiritual condition. Each day is a day in which I must carry my vision of God’s will for me in all areas of my life, that is into everything I think, do, and say.

That requires me to exercise love and tolerance of others as my code and to absolutely try to help others who likewise suffer. But aside from the joy, peace, and happiness I feel in my life today, I would like to briefly describe some of the things that have happened to me. I truly believe sanity has returned to my life, for today I have ceased fighting everything and everybody, and that truly is amazing. I have also begun to experience a new freedom and a new happiness; in other words, the freedom to live life on life’s terms, something that I never knew in my entire lifetime. And that astounds me. As I said earlier, I do not regret the past or even try to shut the door on it, because it truly is my schoolmaster. Without the past I could not be here today and I could not appreciate the peace and serenity I feel which is with me constantly. Today I am not bothered by how far down the social
or economic scale I went prior to recovery for I see how this experience can and does benefit others. The feeling of uselessness and self-pity that haunted me for a lifetime has disappeared. It is truly gone, and today I feel I am useful and have great potential in helping others recover.

I am truly amazed when I think of how I lost interest in selfish things and gained interest in my fellow man. The self-seeking ideal that always possessed me has gone away. I find myself astounded by this. Not only that I realize my whole attitude on life has changed. Truly, the fear of people, any people, and the fear of economic insecurity have left me. Today I am amazed at how I am able to handle situations which in my former manner of life I could not even comprehend, much less manage. You realize that although these blessings do on the surface appear extravagant, they are not in the final analysis because they always materialize if we work for them and continue to grow in understanding and effectiveness.

Although this is the real message of recovery it has to continue for a lifetime, but it is freely available to all who are willing to live life on a spiritual basis and to trudge for this the road of happy destiny. I would invite all who need to be in recovery and read this to join us. May God bless you.

About the Author

The author is an active member of Alcoholics Anonymous and respects Tradition 11, which states that we need to maintain personal anonymity at the level of press, radio and film. He is a full-time solo practitioner, engaged in the specialty of family practice and addictionology and has been located in the same Alabama community for more than 25 years.

This article is a first-hand account of the devastating disease of alcoholism and drug addiction (chemical dependency) and the personal and professional freedom that one can enjoy after entering a program of recovery. It is also dedicated to the support and promotion of the Physicians Recovery Network (The Impaired Physicians Program of the Medical Association of the State of Alabama) of which he is a member. He is also a member of the American Society of Addiction Medicine, American Medical Association, American Academy of Family Physicians and Southern Medical Association.

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Chemical addiction in the medical family is a family affliction similar to the disease in the non-professional. There are differences, however, in the family’s attitude toward the sick physician. The prominent reaction in the family is always denial — it is more comfortable to subconsciously ignore the problem than face it when there are no quick solutions.

Because of the fear of loss of income and social status in the community, there develops increasing isolation in the family’s reaction to their loved one, who may be becoming progressively involved with alcohol or other chemicals. This is compounded by the nature of the pedestal upon which society places the doctor’s wife. This increases their isolation by implying they are somehow different.

When the disease of chemical dependency becomes manifest in the physician’s family, the net result is progressive family dysfunction and despair. The family’s difficulties include the feelings of helplessness and unhappiness. They do not know where to turn for help.

The Physicians Recovery Network (PRN) addresses this dilemma through the family program. The PRN serves to advocate for impaired physicians and assist the family in the recovery process. Without volunteers who want to become involved in the recovery process for families involved with chemical addiction, PRN’s advocacy would be difficult to achieve.

The letter which followed was received from a volunteer physician’s wife whose family is in recovery from the ravages of the disease of chemical dependency. The success of their recovering family is demonstrated by the desire to become involved and reach out to help others. The letter exemplifies one successfully recovering family’s desire to be available to help other families in need.

October 6, 1992

Dear Jerry:

As seems typical with a lot of physician’s wives, I am working in my husband’s office and involved in his practice, even more than I would like (at times). In my case, it is a financial necessity due to the increased cost of operating a private solo practice these days. While I do enjoy this work, and my being in the office does not cause a personal problem with our relationship, it does create a unique distinction between myself and wives who are not involved with their husband’s practice.

As you also know, our situation has another “distinction” from other physician families, in that we are both in recovery from the disease of chemical dependency. Actually, by working together in the office, our journey toward recovery is much easier to follow and definitely enjoyable. We see a lot of patients who are afflicted with this disease, either as the addict or the family member. Our personal experiences can help them break their denial and start to improve their situations.

I have been active in our local support groups and am currently involved with the spouses of those in one of the Alabama Caduceus Recovery Groups. After I read your nice article in The Alabama M.D. recently, it dawned on me that there is little publicity about the availability of a support system for families of physicians with addictions. While I am thrilled to see all the hard work you are doing with PRN in Alabama, and I commend you and those on the Committee, I would love to be able to believe that the wives and children of those still suffering know that there is help for them. In reality, I do not think they know any more than I did 3-4 years ago when I was desperate and in pain and did not know where to go or what to do.

Physicians, while certainly not Gods, remain special professional people in our society. They have to live in glass houses in a world where there is little understanding of the disease concept of addiction. Their families are also isolated and elevated to higher positions in society, and our communities expect more from them than the average family. The family’s reactions to the impaired physician make them as emotionally unhappy as the sick physician when he enters treatment. Often, while the physician is in his treatment program, the families are left out of the pic-
ture. More often that not, wives feel alone and ignored, and they misunderstand what is happening to their family. More anger and resentments build up and recovery becomes harder to achieve. Other physicians, friends and their families are not knowledgeable about the disease. While they want to help, they often feel helpless, and just stay away. Since the family members have kept the illness a secret for so long, they frequently do not know how to ask for help.

I am gratefully enjoying this new way of life in recovery, and my life is worth living, with peace and serenity. I have found through the Alanon Program that I have to give away what I have learned in order to keep it.

I want suffering family members to know that by calling PRN, they can be put in touch with someone who understands their pain. I have to continue to share in order to grow personally. When I am reminded of my past pain by hearing of others who are living as I lived, I feel very responsible to reach out to them. I know that my efforts will be rejected by some, but I believe that those of us who have survived the horrors of active alcoholism and chemical addiction in our families have so much to offer those still suffering. I cannot tell you how much I would have appreciated someone sharing with me a few years ago — just to know that I was not alone with a world of burdens on my shoulders.

I am sure there are other wives of physicians in recovery who feel as I do and want to help. Because of the anonymity of these people, we hesitate many times to reach out to those we hear about. Many times, we simply do not know who they are or how to approach them.

The purpose of this letter is to ask that you and any of your staff that work with these physicians be aware that those of us who are in recovery are willing to visit or talk with any family members who may be concerned that their loved one may have a problem with drugs or alcohol. There are four or five wives in our area that would be available, and I believe this is the case throughout the state. We would not mind traveling to talk with them face-to-face if this would be best. Whatever we can do to share our experience, strength and hope with other families — we are available.

Again, thanks for all the hard work you are doing for professionals in our state. We will appreciate being a part of your work in any instance we can.

God bless you,
Sincerely,
June S.
(wife of a recovered physician)

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Alabama Quartet

John T. Morris, M.D.*

If I should die think only this of me:
That there's some corner of a foreign field
That is forever England.

— "The Soldier" by Rupert Brooke

In New York City's Greenwood cemetery Lot 24546, Section 182, rest in peace the earthly remains of four of Alabama’s most illustrious sons and daughters. Eliza Theresa Jones Sims is interred here. She was the stylish, headstrong daughter of a successful South Carolina physician. She went against her parents wishes and married a poor, sickly young man who had recently been granted a medical degree after a short period of study at Jefferson Medical College in Philadelphia, Pennsylvania.

After having lost his first two patients, children of prominent townspeople, the young doctor, James Marion Sims, left town. He went to Mount Meigs, Alabama, where he became quite successful and returned home to Lancaster, South Carolina, to claim his bride.

Rather than defy her mother, (her father, a prominent physician of the area, had died several years previously) the young newly-weds gathered all their earthly possessions and moved to Sims’s humble dwelling in Mount Meigs. Doctor Sims was a caring, conscientious practitioner, but he needed money and a wealthy plantation owner persuaded him to move to Montgomery, Alabama.

They purchased a large home and office and he continued to be successful. Their first three children were born there. Sims believed that the Negro servants in the community could hurt as much as their white owners — Calico could conceal as much misery as could crinoline. He treated both classes with compassion and developed a large Negro clientele as well as a white society practice. This was fortunate. The black women in that area had their babies delivered by black untrained “granny women,” who frequently left them with large genital tears. Some of these tears caused the urinary bladder to leak through the genital organ, a most distressing condition called vesico-vaginal fistula.

In 1845, when anaesthesia had not been discovered, antibiotics and chemotherapeutic agents were not known and blood transfusions were undreamed of, what could a caring physician offer these sufferers? Sympathy? Prayers? Sims was sympathetic, and he offered the prayers of a God-fearing man, but he wanted to do more.

In their misery, the women with vesico-vaginal fistulas were willing to accept the pain of operative procedures without anaesthesia, but one operation after another resulted in failure. Sims accepted the challenge. Failure followed failure. The challenge became an obsession. Sims never despaired, he studied each case, he polished his techniques, he invented instruments, some of which are still mainstays in the armamentarium of present day surgeons. He decided that infection and poor placement of sutures caused the failures.

Inadequate visualization prevented adequate suturing. How to circumvent these obstacles? In 1849, Sims found that silver wires, used as suture material to close the incisions, prevented infection. Using them with his superior technique and the instruments, especially the “duck billed” speculum he had invented, Sims was triumphant over this age-old affliction of child-bearing women. On this date, the summer of 1849, J. Marion Sims operated on Betsy, Lucy and Anarcha, on whom he had previously operated, unsuccessfully, forty times. This time all three operations were successful, a feat never before accomplished. Modern gynecology, the science of diseases peculiar to women, was begun by J. Marion Sims in a small infirmary that he had built in Montgomery, Alabama. This was the forerunner of the New York Women’s Hospital that Dr. Sims founded in 1855, the first hospital in history devoted exclusively to the treatment of women’s diseases.

II

At the time Sims launched his study of vesico-vaginal fistulas on May 26, 1845, a child, John Allen Wyeth, was born in a sturdy, two-story log house at Cherokee Missionary Station in Marshall County, Alabama. The parents, Louis and Euphemia (Allen) Wyeth, were well educated and taught their only son

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at home and he attended the local schools in Marshall County. John enrolled in La Grange Military Academy in 1861, and after one year, the college closed due to the outbreak of the War Between the States. After making a crop and protecting his family and possessions from bushwhackers and Yankee raiders through 1861 and the spring of 1862, John joined Company I, Fourth Alabama Cavalry, in the fall of 1862. He served under General John Morgan, General Joseph Wheeler, and General Nathan Bedford Forrest in some of the most desperate battles of the war. He was captured after fighting in the Battle of Chickamauga and returned home after sixteen months in a Federal prison, sick, weak and disillusioned.

John Wyeth recovered over a two-year period and entered Medical College at the University of Louisville, Kentucky, in the fall of 1867, and graduated with the M.D. degree in the spring of 1869. Doctor Wyeth returned to Guntersville, Alabama, and began the practice of medicine. Despondent over the death of his fourth patient, a severe diabetic, and disgusted because of his lack of clinical training, he closed his office and left town. After working at many different jobs for three years, John saved enough money to go to New York, hoping to obtain more clinical training. He was shocked to find out that America’s largest and most boastful city offered no such training.

He matriculated at Bellevue Hospital Medical College, in New York City on October 16, 1872. He graduated with his second M.D. degree on March 1, 1873. He remained at Bellevue on the faculty of anatomy and later he studied pathology there. He practiced surgery at New York’s St. Elizabeth Hospital and Mount Sinai Hospital. Never satisfied with his store of knowledge, Wyeth went to Europe in 1878 to tour the medical centers of Berlin, London and Paris.

III

In Paris Wyeth met the greatest surgeon of the day, Doctor J. Marion Sims, who congratulated him on his writing and on his surgical innovations. Sims had known John Wyeth’s father, Louis, when the latter was a member of the Alabama State Legislature in Montgomery. Plato had met Socrates. Both men had been through the agony of realizing their inadequacy in the face of disease. Both wanted to do something about the deplorable state of medical education in America. Wyeth told Sims of his plans for establishing a teaching hospital. Sims approved. A warm friendship developed between the two giants that would last until Doctor Sims came to rest in Greenwood Cemetery Nov. 18, 1883.

All was not professional talk at the Sims home in Paris in 1878. Miss Florence Nightingale, the doctor’s youngest daughter, appeared on the scene. Her beauty seems to have bewitched her father’s illustrious guest at their earliest meeting.

Wyeth returned home and founded the New York Polyclinic Hospital and Medical School in 1881. Some of the donations did not materialize and the undergraduate school had to be written off. The emphasis had to be placed on post-graduate studies. It, therefore, became the first postgraduate medical school in America, the first medical school to have interns and residents. Dr. Wyeth became Professor of Surgery and Surgeon-in-chief and was later the president of the institution.

He was a prodigious worker. He published more than 75 surgical articles. He had become friends with Henry Harper of Harper and Brothers publishers and Henry was eager to publish anything John wrote. He wrote “Belles Lettres.” John wrote a Textbook of Surgery, an eight hundred page tome that went through many editions. (This, however, was published by D. Appleton & Co.). Surgeons and students used it well into the twentieth century. He wrote of his experiences in the Civil War and about the Tennessee Valley. He carried on a correspondence with Florence Nightingale and they were married in 1886, three years after the death of Dr. Sims. Their union was blessed by the birth of three children.

Dr. Sims’s early work had been hampered by lack of anaesthesia and knowledge of antiseptics. He had quickly grasped the value of Crawford Long’s ether studies and had pioneered in designing apparatus for its administration. Sims’s silver sutures were early chemotherapeutic agents. Wyeth made full use of Sims’s innovations and added many more. Honors began to be bestowed upon him. He was the president of the American Medical Association in 1902. The University of Alabama and the University of Maryland conferred upon him the Doctor of Laws degrees. His masterpieces of lay writing are: With Saber and Scalpel, his Autobiography in which he included twelve poems, and Life of Lieutenant-General Nathan Bedford Forrest, reissued in 1959 as That Devil Forrest.

After nearly thirty years of marital bliss, Florence Nightingale Sims Wyeth parted from her earthly kin in 1915 and joined her parents. On May 8, 1922 John Allen Wyeth joined the wife he loved and the father-in-law he worshiped in Lot 24546 — Sec. 182, Greenwood Cemetery — A corner of a foreign field that will be forever Alabama.
The Laying On Of Hands

Richard B. Weinberg, M.D.*

I had been dreading the call all day. I was in the library when my pager sounded and, as I walked to the wall phone, I had an ominous premonition. It was my brother. “They found abnormal lymph tissue on the chest x-ray,” he said. “What does it mean?” Struck with an upwelling of nausea, I sagged against the wall. Healthy, active, he had gone for the x-ray at my urging, after complaining of fevers and strange chest pains for over a month. “Well, it could be lots of different things . . . ,” I began, reassuring him; but I knew. Like my grandparents and sister before him, my brother had lymphoma.

There was much to do. I made phone calls, contacted friends, arranged for a referral to a specialist in his city. I flew down to be with him before his diagnostic thoracotomy. It was lymphoma. A particularly aggressive variety. Together we called home to deliver the bleak news, and the next day I picked up my bewildered and frightened parents at the airport and drove them to the hospital. Together we sat as the oncologists explained the treatment options. When I was not at my brother’s bedside, I spent my time in the medical library reviewing the literature and on the phone seeking opinions from prominent experts. In the end my brother chose a new, but promising, chemotherapy protocol at a nearby university hospital and, after the first uneventful cycle, I returned home to work. But every week we would talk on the telephone about his progress, the side effects, his law school classes, life. He achieved a remission that lasted for the summer, and happiness returned to his voice. We made plans for a trip. But then the fevers returned, and he began an inexorable decline, sickened even more by repeated cycles of “salvage therapy.” His phone calls came more often and more urgent, and it became progressively harder for me to encourage him and give him hope.

That was when the pain began. I first noticed it as an empty, hollow sensation in my chest at the end of the day. I dealt with it by ignoring it. But as the days passed, the pain became more insistent. It was gnawing and pressing, like a balloon expanding inside my chest. Heartburn, I told myself, and stopped off at the GI clinic to grab some H2 blockers; but they provided no relief. Stress, I told myself; but neither exercise, nor alcohol, nor attempts to relax made any difference. The pain became constant and kept me awake at night. There had to be an explanation.

Was it angina? A cardiology fellow sneaked me into the heart station one evening and after hours of EKGS, treadmills, and echos pronounced my heart remarkably normal. The pain grew more intense. Maybe atypical pleurisy? I got a chest x-ray in the emergency room and brought it to Radiology. “Lung fields are normal . . . no effusions . . . mediastinum’s a bit generous, but its probably a normal variant,” The radiologist on call rattled off before he turned back to his board. The mediastinum is generous?! No! It couldn’t be lymphoma! That night I palpated the lymph nodes in my neck, axilla, and groin. They did feel a bit prominent. Soon they became tender, and as the days passed I was certain that they were growing larger. Meanwhile the pain became unbearable. I became obsessed with finding a diagnosis. I prepared a blood smear on myself, and peering down the microscope I saw my death: smudge cells! Leukemia! I grew faint. What will I do? I can’t die now! How will I tell my parents? As I panicked, my eye latched onto the tube of blood. A grey top. Fluoride. Metabolic poison. Kills white cells. Pseudo-smudge cells!

In the cold sweat of temporary redemption, I finally accepted the limits of self-diagnosis. I needed a doctor. But who? I knew as well as any informed layperson the names of the experts at our university hospital. But credentials could be deceptive. I had seen them at the bedside, listened to them at conferences, read their clinic notes, and weighed their advice on the wards. So who was the best doctor for my problem? The society cardiologist who couldn’t read a cardiogram? The hotshot oncologist whose housestaff nickname was “mad dog”? The famous pulmonologist who was never in town? If I made the wrong choice, I knew that my symptoms would be zealously pursued with painful tests which, if they didn’t disclose a diagnosis, would leave me more miserable than ever. Who? Then suddenly it was clear. Of course! Dr. Davidson!

Dr. Davidson was not a rising star in the Department of Medicine. “I admit he’s a very good teacher,” the Chief of Medicine was often heard to say, “but he just isn’t publishing.” “Of course he isn’t,” one wanted to scream back, “He’s out there on the wards every day, like you should be!” And Dr. Davidson cer-

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tainly tried to be "academic." He was always talking excitedly about his review on gonococcal infections in the inner city. "It's just about finished," he'd cheerfully tell us on rounds, "and it's certainly going to raise some eyebrows." But it never seemed to appear in print. The housestaff didn't care; we loved him.

He was an internist, and at the bedside he shined. It was Dr. Davidson who discovered that an elderly lady admitted three times in one month with near fatal status asthmaticus, had recently purchased a new parakeet — and was deathly allergic to it. It was Dr. Davidson who saved a man with tearing chest pain from emergency angiography by pointing out that he had ruptured his pectoralis from an over-enthusiastic weight-lifting session. When the Dean came down with a serious viral pneumonia, it was Dr. Davidson who sat outside his door and fended off the well-meaning Department Chiefs who descended in multitudes to give conflicting orders to the housestaff. "The Dean just needs to be left alone, and he will get better," he insisted. And he did. And mysteriously, whenever it all became overwhelming and you started to think about quitting medicine, it was Dr. Davidson's arm that came down over your shoulder. "Hey. Let's go down to the doctor's dining room for a cup of coffee," he'd say. You went, and he'd listen, and then it didn't seem so bad.

Surely, I thought, if something's wrong, Dr. Davidson will know. I found him on the wards, told him that I hadn't been feeling well, and asked if he would look me over. He suggested that we go to his office. It was disorienting to be sitting on the other side of the examining table, but Dr. Davidson quickly put me at ease, and soon I was pouring out the whole sorry tale of my chest pain and my brother's illness. It took quite a while. During his physical examination he poured over every inch of my body, felt for lymph nodes, and listened intently to my heart. When he finished, he looked at my chest x-ray and then scribbled a note in my chart. I dressed and, with my heart pounding, turned to face him.

"Do we need any tests?"

"No, I'd say you've done a pretty good job of that," he said with a smile.

"Then you know what's wrong?"

"Yes, I think I do."

"Is it lymphoma?" I choked out, fearing the worst.

"No, your lymph nodes feel normal to me and given the way you've been poking at them, it's no wonder they're a bit tender."

"My heart..."

"Your heart is fine."

"Ulcer...?"

"No."

"Are you telling me that I'm imagining all of this?"

"No. The pain is real."

"Then what's wrong with me? What's causing the pain?" I demanded.

"You have Heartache."

"Heartache?" The word struck me like a slap to the face.

"Yes. Your brother is seriously ill. You are his best friend, and you've served as his personal physician as well. You've helped guide him to the best treatment, comforted him during the tough times, and given him the strength to go on. You've had to be strong for him and for your family. Now things don't look so good, you know the prognosis of his condition, and you fear what is to come. But no one really understands how much it all hurts you. You love your brother very much, and so you feel his pain in your heart."

Tears streamed down my cheeks. I could not speak.

"It's okay to have Heartache," Dr. Davidson continued. "It's the price you pay for loving someone. And not many of us do as good a job of it as you're doing now, you know." The famous arm came gently down across my shoulder. "Now you keep right on being a good brother and a good doctor," he said, offering me a handkerchief. He sat with me, and after some time I composed myself.

"Thank you," was all I could say.

"You're certainly welcome. We'll talk about things again soon, right? Now, how about a cup of coffee in the doctor's dining room?"

My chest pain eased throughout the afternoon and by evening was gone. Like in the tale of Rumpelstiltskin, once Dr. Davidson had called the name of the demon, its power was vanquished. And although afterwards the heartache returned now and then, I no longer feared it. My brother died three months later after a valiant struggle, and I gave the eulogy at his funeral. I finished my fellowship and found a faculty position in another city. I later heard that Dr. Davidson — his magnus opus never completed — was denied tenure and had left the university for another job. I also heard that he was still teaching housestaff and was happy.

In The Oath we swear "...to consider dear to me as my parents, him who taught me this art..."— and to assist our fellow physicians with every kindness should misfortune befall them. And so it should be. For we carry a special burden: We have learned of the pain that disease brings to mankind and know that often we are powerless to stop it. And when the thin veneer we erect to protect ourselves from this knowledge is shattered, demons that lurk in our minds are unleashed to terrify our souls. In such times we cannot heal ourselves. Rather, in such times, as the Good Doctor Davidson knew, we must heal one another.
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The Seeds of Success

[I would like to clarify that Judy Marston, of Judy Marston Associates of Mobile, wrote the two articles that appeared in the two previous issues entitled: “The First Five Minutes” and “Building Patient Rapport.”]

“Every noble work is at first impossible.”
— Thomas Carlyle

In his book Mission Success the successful author and financial advisor Og Mandino tells of a World War II friendship at the age of 21 with an English widow, Winnie, who had lost her only son in the Battle of Britain. Refusing to give in to bitterness and despair, Winnie opened her home to young American fliers who were lonely, homesick and in need of nurturance and support. This is some of the advice Winnie gave Og Mandino for his future life in learning the difference between success and happiness.

I will forget yesterday, with all its trials and tribulations, aggravations and setbacks, anger and frustrations. The past is already a dream from which I can neither retrieve a single work nor erase any foolish deeds.

I will resolve, however, that if I have injured anyone yesterday through my thoughtlessness, I will not let this day’s sun set before I make amends.

I will not fret the future. My success and happiness do not depend on straining to see what lurks dimly on the horizon but to do, this day, what is clearly at hand.

I will treasure this day for it is all I have. I know that its rushing hours cannot be accumulated or stored, like precious grain, for future use.

I will embrace today’s difficult tasks, take off my coat and make dust in the world. I will remember that the busier I am, the less harm I am apt to suffer, the tastier will be my food, the sweeter my sleep, and the better satisfied I will be with my place in the world.

I will run from no danger I might encounter today, because I am certain that nothing will happen to me that I am not equipped to handle. Just as any gem is polished by friction, I am certain to become more valuable through this day’s adversities.

I will not waste even a precious second today in anger or hate or jealousy or selfishness. I know that the seeds I sow I will harvest, because every action, good or bad, is always followed by an equal reaction. I will plant only good seeds this day.

I will condition myself to look on every problem I encounter today as no more than a pebble in my shoe.

I will work convinced that nothing great was ever achieved without enthusiasm.

I will face the world with goals set for this day, but they will be attainable ones, not the vague, impossible variety declared by those who make a career of failure.

I will work this day with all my strength, content in the knowledge that life does not consist of wallowing in the past nor peering anxiously at the future.

I will pause whenever I am feeling sorry for myself and remember that this is the only day I have and I must play it to the fullest.

I will remember that those who have fewest regrets are those who take each moment as it comes for all that it is worth.

This is the day! These are the seeds.
Be thankful for the precious garden of time.

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Under structured fee schedules, etched in stone, we have to plod along and ply our trade. It is when the cost of doing business bumps its head on lowered reimbursement payments that we began to have serious problems. The greatest satisfaction I have received in medicine has been my practice and its rewards of satisfied and grateful patients. I suppose that is what sustains us all. Our biggest headaches will come from trying to fit good medical care into the molds structured by third parties.

Payment for services rendered could come in a variety of forms. How many of us would take out a gallbladder or remove a kidney stone for a goat and two chickens? Would Mutual Assurance accept goats and chickens? Would the power company? When I started in practice it was easier to barter for a fee than it is now and you did not have to fill out forms and claims.

One of my good friends in Bayou la Batre used to accept oysters for an office visit. He was checked by the IRS and they made him pay taxes on the oysters. The next year he filled up a brown manilla envelope with oysters and mailed them to the IRS in Chamblee, Ga. That was 15 years ago and he has not heard from them since. Bartering for fees has been around for a long time, but like most things, its time has come and gone.

So, what is the bottom line? If we are happy and satisfied in our practice, and want to continue, we need to be more flexible in our approach to reimbursement and stand our ground on what we have. Third parties are standing in line out there waiting to jump on the Chinaman from Harvard’s RBRVS bandwagon. We can’t use cost shifting because it is grossly unfair to the payors. Cost shifting is partially responsible for the problem with workmans compensation. We made our mistake 20 years ago by not stepping in and exerting our influence on those who would control us by tightening the purse strings and restructuring our practice.

There are three things important in life: health, family and career. Most of us love out career and wish to continue, whether on a salaried or fee basis. We have put in a lot of time and sacrifice to attain a high level of proficiency and we deserve to be reimbursed appropriately.

I personally don’t like the term “provider.” The term is demeaning and is an attempt to bundle us in the big package and to reduce our status in the public eye. A prostitute is a provider. A drug dealer is a provider. We are physicians and proud of it.

My father was a good and compassionate man, struggling to raise and educate his children back in the 30s when times were hard. He told me he would do his best to get me through medical school if I promised never to turn anyone away who needed my services and could not afford to pay. If he were alive today as I reach the end of my career, I would love to say to him, “Dad, I never did”.

“What I Owe You, Doc?”

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‘Clear it with Sidney’

For presidential candidate Bill Clinton, all things seemed possible: stimulate the economy, create millions of jobs, offer college educations to everyone, institute blue collar apprenticeships, provide universal health care, cut the deficit in half and reduce the national debt, etc. — all by the simple expedient of squeezing foreign corporations, soaking the rich, and other painless gimmicks.

For President-elect Clinton, the job ahead must appear somewhat less rosy. As this is written, he and his transition team are agonizing over what to do first next January; and his staff has set about attempting to lower public expectations, which they now regard as unreasonably high.

Never mind that this was exactly the pitch they wanted to achieve Nov. 3 and did. By all accounts, Mr. Clinton won because of his economic promises. Now he must deliver.

And that will not be easy. Every avenue of remedial action has its downside: overstimulate the economy to promote quicker recovery and you invite the return of the cruelest tax of all, inflation, the demon that haunted the Carter years. It is, in fact, virtually impossible to quick-fix anything without wrecking something else, given the state of the economy.

Mr. Clinton has long been characterized as a “policy wonk” (giving rise to the waggish October headline in a New York tabloid, which listed the three presidential candidates as, “a wimp, a wonk and wacko”). He dotes on the mechanics and involute dynamics of process, the obstacles and trade-offs, the delicate interaction of liabilities and assets, and so on.

While he cannot be described, perhaps, as the cold-fish technocrat that Mike Dukakis was, he is fascinated with the arcane turnings of economic theory as tempered by political theory. Perhaps he got that way at Oxford.

Because I want my country restored to its former economic might, I sincerely hope Mr. Clinton succeeds in that portion of his platform. But surely in the immediate post-election period in which this is written, he is learning some chilling postgraduate facts from his economic advisers, including his Oxonian schoolmate, Robert Reich. If not, he had only to read the lead story in The Wall Street Journal three days after the election.

“They aren’t elected,” the article began, “and you may not know any of them. Many are citizens of other countries. But big bond investors may now hold unprecedented economic power — perhaps even a veto — over U.S. economic policy.”

In fact, the financial newspaper continued, these invisible economic vigilantes, as some call them, fired warning shots across the bow of the Clinton campaign a few weeks before the election. Anticipating a Democratic victory, the unseen vigilantes pushed down prices of U.S. Treasury bonds and thus pushed up long-term interest rates, to 7.76% in early November from 7.23% in early September. The peril point is now considered to be 8%. The newspaper noted:

“It was the bond market’s way of warning Mr. Clinton that as the new president he will long be on probation, with his every move instantaneously scrutinized....

“Mr. Clinton won the election on promises to rein-
vigorating the economy and put the unemployed back to work. If can fulfill those promises with minimal increases in the nation’s budget deficit and inflation rate, bondholders will probably bestow their blessings by allowing long-term interest rates to ease. Such a move would, in itself, energize the economy.

"But if he proposes big spending programs or policies that accelerate inflation — bondholders’ deepest fear — the reaction could be swift and painful. With computerized trading linking global trading in U.S. government bonds, which now averages $150 billion a day, a worried investor can unload millions of dollars of bonds in seconds — and virtually 24 hours a day. If thousands of investors worldwide dump U.S. Treasury bonds, they could drive up long-term interest rates, which move inversely to bond prices, hobble America’s economic growth and even plunge the nation back into recession.

"The global bond market can be a very tough disciplinarian," warns Robert Hormats, vice chairman of Goldman Sachs International and former State Department official. 'Bond buyers have a very conservative bias,' and, he says, 'they’ll be looking very hard at whatever Clinton does."

Hence the name coined as long ago as 1983, when America’s mountainous debt was already alarming our creditors — "bond vigilantes."

In the past, Presidents might have looked at Wall Street stock prices for guidance: a rising market meant investor satisfaction with the national economy, a falling market indicated anxiety.

"And if it’s any consolation to Mr. Clinton," the Journal noted cheerfully, "the stock market seems to view his victory as a harbinger of a healthier economy and fatter corporate profits. Since early October, the Dow Jones Industrial Average has gained more than 100 points."

"But the U.S. doesn’t sell stock to finance its operations. Instead it borrows money — a lot of it — by selling debt securities, which are essentially promises to repay with interest a loan over a period of months (Treasury bills), two to 10 years (notes) and up to 30 years (bonds)."

In the past decade the government’s appetite for borrowing has soared along with the budget deficit, which grew to a record of almost $300 billion in the fiscal year ending Sept. 30. The red ink has quadrupled since 1980, the last full year of the Carter Administration, when the deficit was considered horrible at about $74 billion.

The U.S. government — meaning all of us — now owes investors in this country and around the world $2.7 trillion. That’s $2,700,000,000,000. In addition, we owe $1 trillion ($1,000,000,000,000) in debt now held by U.S. government agencies.

Without retiring any of the principal, we are already paying $200 billion ($200,000,000,000) a year in interest. The annual interest payments alone are now running at about two-thirds of the intractable deficit.

Welcome to Washington, Mr. Clinton. You have inherited liabilities far exceeding the cumulative debt of the country, including that incurred in all its wars, since the Republic was born. And would you mind repeating for us how you proposed, back in the campaign, to pay for job training, college tuition for everyone, universal health coverage, billions more for AIDS, untold billions to rebuild the nation’s infrastructure, and all the rest?

While you are framing your answer, you might want to consider the words of the man who invented the term “bond vigilantes” a decade ago, who almost no one seemed to be listening. He is Edward Yardeni, now chief economist at C.J. Lawrence, Inc., who says:

"... We created a situation that puts a lot of power in the hands of money managers all around the world. We created the monster, and now it’s coming back to

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Lest we forget, it was the American public, all of us, who acquiesced in the creation of the monster, by wanting it all and by our unwillingness to pay for it. But the bond investors themselves are not without their share of the guilt, the Journal notes:

“[They] tended to ignore the rapid growth of the budget deficits during the Reagan and Bush Administrations. They felt secure with Republicans in the White House, and Japanese and other foreigners became big buyers of U.S. Treasury debt and thus helped to absorb the growing supply.

“The bond market took a while to understand just how troubling the U.S. debt was, and were able to get away with financing an excessive amount of debt. Now, the scales have been lifted from their eyes.”

Fifty years ago, Franklin Roosevelt was chided for a comment he was said to have made: “Clear everything with Sidney.” Sidney was Sidney Hillman, head of the Political Action Committee of the CIO. For years after FDR, “clear it with Sidney” became a kind of running gag in American politics: before proposing anything, check with the power brokers.

It may be revived in 1993 to mean something entirely different in the Clinton Administration — as in “Clear it with Sydney, and Bonn, and Zurich, and London, and Tokyo.”

Most assuredly, something like that will be indicated in whatever health care reform plan Mr. Clinton finally proposes. It is not the conservative opposition in Congress he must now fear most: it is the veto power we have exported to the financial capitals of the world.

But, taking the long view, perhaps the bond vigilantes are a force for good. As a people, we seem to have lost the capacity to discipline ourselves, to balance our wants against our resources.

And we seem to have lost the horror we once had over passing on the bill for our extravagances to our grandchildren — who already owe around $4,000,000,000,000, give or take a few paltry billion.

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The Board of Censors

The public may see organized medicine as a monolithic aggregation of physicians who look alike, talk alike and think alike. And medicine itself may have been at least partly responsible for this perception, if for no other reason than the low profile it has studiously created over the years.

All that is beginning to change, with the AMA and specialty organizations compelled to elevate their presence and go public with many issues.

That trend is likely to be accelerated in the coming months as health care reform, long predicted, takes center stage under the Clinton Administration. A fortuitous byproduct of the impending controversies may well be that the public will begin to see that the house of medicine has within its walls a rich diversity of personalities and opinions to match the diversity of specialties.

The MASA Board of Censors is a microcosm of that larger universe of the American Doctor. On pages 9-14 you will find brief sketches of you representatives on the Board. This presentation is designed to enlighten MASA members, who may themselves look on the Association in much the same way the public sees all doctors — clones, walking in lockstep. Notice particularly the variety of backgrounds, specialties and outside interests of your Censors. One size does not fit all.

Anyone who has observed a meeting of the Board surely knows how amiss is the notion that it is made up of "good old boys agreeing with each other." Discussion ranges broadly over a full spectrum of opinion on issues before the Board. It often happens that a major issue will go through several such monthly debates before final resolution; not because of procrastination or dilatory tactics but simply because of the wide variety of viewpoints that must be accommodated in the final synthesis.

By tradition, all members support the final decision, however vigorously they might have opposed it during the discussion period. (It has been observed that in the course of an hour's debate, the 15 Board members sometimes offer 30 different opinions. Although somewhat exaggerated, that observation does make the point that when all sides are heard, initial viewpoints are frequently altered by the persuasiveness of contrary evidence and argument. That, after all, is what the deliberative process is all about.)

Under the Constitution and Bylaws of the Association, the College of Counsellors and House of Delegates give broad directives to the Board on specific issues and on matters of policy. But, obviously, the Board must fend for itself on many issues that come up on a month-to-month basis.

An annual meeting could never anticipate all the eventualities of the ensuing 12 months. That might have been a time when a burning question of the hour could wait a year for resolution, but that day most assuredly passed long ago.

The annual business meeting does establish the philosophical foundation for the Board's actions between annual meetings. It sets the tone and describes, better than many members may understand, the character and polity of the Association. It is for that reason that I urge all Counsellors and Delegates to plan now to attend the 1993 annual meeting in April.
Before each Board meeting, Censors receive a packet of background material covering items on the agenda. They receive similar packets on actions before the Board of Medical Examiners and the State Committee of Public Health. Some of them also receive another bulging notebook of material on cases before the Third Party Grievance Task Force. It is a formidable mass that requires hours of study in advance of the monthly meeting.

We are printing the roster of Censors [see page 9] in the hopes that you will contact your representative on any matter that concerns you. Such communication is the only way we can know what the membership is thinking.

Finally let me assure you that your Board Members and Officers are hard-working, dedicated, conscientious and true to the fiduciary relationship to which you have elected them. They are always mindful that their personal opinions are secondary to the good of the whole and that theirs is a position of trust, without which medicine would not have survived, and could not survive in the years ahead.

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Your Board of Censors: A Study In Diversity

Wm. H. McDonald

(See Cover) The MASA Board of Censors consists of the "three Presidents;" (the current President, the Immediate Past President, and the President-elect), one Censor from each of the state's congressional districts, and five Censors at-large. Seated, L-R, are Drs. Lazenby, Lightfoot, Esham, Morris and West. Standing, L-R, are Drs. Benjamin, Walburn, Sanford, Curry, and McCrory; Executive Director Conner, and Drs. Hall, Pittard, Story, Folmar and Jones. For clarity, this order is followed in the sequence of the abbreviated CVs of the Board members following.

As you will see from reading the brief biographical material for each member of the Board of Censors, there is no "typical Censor." They come to the Board from all points of the compass, not only geographical but by specialty, background, and interests inside and outside medicine.

When survey forms were sent out to Board members, each was asked to comment briefly on his/her views of the major problems: 1. facing the country in general; 2. U.S. medicine in particular; 3. Alabama in general; Alabama medicine in particular.

As you might have guessed, comments were similar in some respects — the sluggish U.S. economy, for example; the heavy burden of the national debt and annual deficit financing of government; the political tendency to create unrealistically high expectations for health care reform, far exceeding the willingness of Americans to pay for it;

Intervention of third-party payers in medical decision-making and the consequential weakening of the doctor-patient relationship; the continuing cost and burden of malpractice litigation; the weakness of American education vis-a-vis that of other industrialized nations; the perceived vacuum of real political leadership, nationally and in the state; rural health care;
The conflict generated by the world’s finest health care system on the one hand and, on the other, the denial of access for this system for many Americans; the declining emphasis on primary care and, as a corollary, preventive medicine; of the apparent apathy of physicians in their indifference to organized medicine; and so on.

Some Censors went beyond the headline issues to one that is plainly troubling to them — the putative deterioration of the vaunted American character and its bedrock virtues: individual ambition and self-reliance, seen as ultimately more insoluble than the deficit and the debt. One Censor ascribed this character decline to “humanism, the erosion of personal integrity, [the vanishing] regard for the common good.”

No less than the nation as a whole, Alabama was heavily faulted for failure “to meet the demands of post-industrial markets, with education and training that match skills to jobs.” The same Censor who made that specific comment also charged that health care must be restructured to make primary care the “balance point” for rectifying the conflicts between “technology, compassion and cost.”

Drugs and crime were seen as connected to the problems of education, employment opportunity, and poverty — connected, but not excused for that reason.

Several Board members cautioned of the dislocations of the fundamental changes coming to medicine no less than to society as a whole. They were concerned that rapid change could be not only disruptive but destructive, in medicine as in other aspects of national life; yet none denied the inevitability of transformations in the public and private sectors, as well as in the ways Americans think of themselves and their country.

By and large, Censors see these changes as challenges to the profession to meet with dignity, intelligence and resolve — rather than as threats from which to flee and hide. The overall view seemed to be that the responsibility of Alabama physicians is first to improving Alabama health care, whatever eventuates nationally.

Most condemned its limitations and the failure of state politicians to respond to the necessary but difficult spadework of tax reform and fiscal responsibility. And these were seen as necessary prerequisites to what virtually all Censors regard as central to all progress — vastly improved public education.

The Board of Censors cannot adequately perform the heavy responsibility it has to the membership unless that membership communicates its concerns to its elected representatives. Here they are. Call them, write them, bend their ears in the doctor’s lounges, whatever and however. Sometimes, the silence out there is deafening.

William D. Lazenby, M.D.  
(Immediate Past President)

Born: Lee County, Alabama 1931  
Medical School: Emory University 1957  
Residency: Grady Hospital, Atlanta  
Specialty: General and Breast Surgery  
Affiliations: Fellow, American College of Surgeons; AMA, MASA; member of original MASA Council on Continuing Medical Education; elected to Board of Censors 1981; MASA President, 1991-92; Opelika Chamber of Commerce, Board of Directors, President; Opelika Outstanding Citizen of the Year 1985; 25-year-member of Rotary and recipient of Rotary’s highest honor, Paul Harris Fellowship; Board of Directors, Farmers National Bank, 1972 to present; East Alabama Medical Center Board of Directors, every major hospital committee and virtually all staff offices; a founding father of Medical Arts Center of East Alabama and Surgical Clinic of East Alabama, president since inception; as Auburn undergraduate, president of Pre-Medical Honor Society; President, at Emory, of Student American Medical Association.

Avocational: Cattleman for 25 years, registered Angus breeder since late 60s; one of largest two or three registered Angus herds in Alabama; principal hobby: heading, with wife Peggy, family of physicians: daughter Audrey is a pathologist at Johns Hopkins; son Douglas is a surgical fellow at Barnes Hospital St. Louis; son Allen is a surgical resident at Emory and married to a general surgeon.

William M. Lightfoot, M.D.  
(Vice Chairman), 1st District, Mobile

Born: Montgomery 1948  
Medical school: University of Alabama School of Medicine 1974  
Residency: University of South Alabama 74-79  
Specialty: General Surgery  
Affiliations: Fellow, American College of Surgeons; AMA, Southern Medical Association; Alabama Chapter, American College of Surgeons;
Richard E. Esham, M.D.
Chairman, at-large, Mobile

A full profile of Dr. Esham will be found on page 17, et seq.

Regina Marcia Benjamin, M.D.
at-large, Bayou La Batre

Born: Mobile 1956
Medical School: Morehouse School of Medicine 79-82; UAB School of Medicine 82-84.
Residency: Medical Center of Central Georgia, Macon, Family Practice 84-87; (MBA, Business School, Tulane 91)
Specialty: Family Practice
Affiliations: Diplomate, American Board of Family Practice Advanced Cardiac Life Support, Advanced Pediatric Life Support; Chairman, Mobile Chapter, American Medical Women Association; President, Bay Area Medical Association; Past Chair and principal organizer, MASA Young Physicians Section; AMA Women in Medicine Project, appointed by AMA Board of Trustees 86-87; YPS Delegate to AMA; Delegate, AMA-YPS Assembly; Chair, Medical Center of Central Georgia Residents Association; Secretary and principal organizer, MAG-RPS; National Medical Association; FP Committee, Knollwood Hospital; Associate Clinical Professor, University of South Alabama; Basic Science Tutor, Medical Students, National Board Review;
Office: 25 Shell Belt Rd., Bayou La Batre, AL 36509 phone 824-4985
Avocational: Board Member, Mobile Community

Peter W. Morris, M.D., (President)

Born: Birmingham, Alabama 1930
Medical school: Alabama (Birmingham) 1956
Residency: University Hospital, Birmingham 1959-61; Duke Hospital, Durham, N.C. 1961-63
Specialty: Internal Medicine, hematology-oncology
Affiliations: Alabama Society of Internal Medicine executive committee; Birmingham Society of Internists, President; member, American College of Physicians; member, Southern Medical Association; AMA Alternate Delegate
Office: 2660 10th Ave. So, #630 Birmingham, AL 35205, phone 933-7451
Avocational: reading history, current events

James E. West, M.D. (President-elect)

Born: Knoxville, Tennessee 1939
Medical school: University of Tennessee, 1963
Residency: General Surgery, VA Hospital,
Memphis, Tennessee, July 1965 to August 1969.
Specialty: Surgery
Affiliations: Fellow, American College of Surgeons, Board member of FSMB; Consultant to USMLE Step 3 Committee; Vice-chief of Staff, North East Alabama Regional Medical Center; past Chairman, Board of Examiners; past Chairman, Alabama Board of Medical Examiners and State Committee of Public Health; past member of FSMB's Exam Board; past Board member of Stringfellow Memorial Hospital; presently on Board of North East Alabama Regional Medical Center.
Avocational: Enjoys working with organized medicine: "I guess that's my hobby of sorts. I also enjoy 'driving nails.' I never build anything of fine quality, but it relieves much pressure. I dabble with the piano, but only play for myself. That, too, is a great tension reliever."
Chest & Council (United Way); Deep South Girl Scout Council; Planning Committee, Bayou Area United; Church Council, Member, Lady Knight of St. Peter Claver; Student Member, Board of Trustees, Xavier University; member, Networking for Women in Business; Chaplaincy Board, Mobile Sheriff’s Dept.; Teenage Suicide Prevention Program, Bibb County School System; Teenage Sex Education Classes, Bibb County Girl Scouts; Special Olympics; Central Intelligence Agency, Student/Intern Trainee, 78-79; Hobbies — billiards, skydiving, aerobics, dancing, jogging (“slowly”)

James Hodo Walburn, M.D.
7th District, Tuscaloosa

Born: Birmingham 1940
Medical school: Medical College of Alabama 1966
Residency: Otolaryngology/Head Neck Surgery UAM
Specialty: Board Certified, American Academy of Otolaryngology
Affiliations: American Academy Otolaryngic Allergy; Medical Director, Tuscaloosa Ambulatory Surgery Center; MASA member and Counsellor for 14 years.
Office: 921 3rd Avenue E, Professional Plaza, Tuscaloosa, AL 35401, phone 758-9041
Avocational: Jogger since April 15, 1985; completed New York City and Marine Corps Marathons; hunting.

Jon E. Sanford, M.D.
at-large, Fayette

Born: Jasper, Alabama 1940
Medical school: University of Alabama 1966
Specialty: Family Practice
Affiliations: AAFP President, Alabama Chapter, AAFP 1977; AMA, Alternate Delegate and Delegate since 1983; Fayette County Hospital Board.
Office: 1732 Temple Ave. N., Fayette, AL 35555, phone 932-3900
Avocational: Flying, small plane owner; tennis, farming and gardening. Public activities: elder and Bible class teacher, Fayette Church of Christ.

William A. Curry, M.D.
at-large, Carrollton

Born: Columbus, Mississippi 1950
Medical school: Vanderbilt 1976
Residency: Vanderbilt, internal medicine 76-79; Chief Resident internal medicine, Vanderbilt 1981
Specialty: Internal Medicine
Affiliations: FACP, AMA, Alabama Society Internal Medicine; past president, current membership chairman & newsletter editor, American Society Internal Medicine; Associate Clinical Professor, University of Alabama College of Community Health Sciences (Internal Medicine & Community Medicine); Chairman, Rural Alabama Health Alliance
Office: 106 Hospital Dr., Carrollton AL 35447, phone 367-8197
Avocational: Deacon, First Presbyterian Church of Aliceville; Board Member, West Alabama Bank & Trust; vice Chairman of board, Pickens County Medical Center; Board member, Pickens Academy; member, Friends of Carrollton Public Library; Board member, Black Warrior Council, Boy Scouts of America and member of Eagle Board. “I jog, garden, read, and play the piano.”

Ellann McCrory, M.D.
4th District, Fort Payne

Born: Greenville, Alabama 1936
Medical school: Medical College of Alabama 1960
Residency: Baptist Hospital, Memphis Tenn. 61-64
Specialty: Radiology
Affiliations: American College of Radiology, Alternate Counselor 1991, Commission on Practice; Alabama Chapter, ACR, President 1992-94; American Association of Women in Radiology, Executive Board, Treasurer 1987; Chairman Nominating Committee, Radiology Society of North America; American Institute of Ultrasound in Medicine; Society of Nuclear Medicine; American Roentgen Ray Society; Dekalb County Medical Society, President 1977; MASA Vice President 1986-87; Censor 1988 to present; ABME Board; Alabama State Committee of Public Health; AMA, Southern Medical Association, Southern Radiology
Conference, AMWA.
Office: 309 Medical Center Drive, Ft. Payne, AL 35967, phone 845-4146

Avocational: Reading, gardening, sports, family; civic responsibilities, Ft. Payne Chamber of Commerce; Board President, Landmarks (historical), president 1977-78; national University of Alabama Alumni organization, district II vice president; speaks to schools, churches, civic organizations, as well as professional speaking; civic, spiritual and motivational addresses.

Garland C. Hall, Jr., M.D.
5th District, Moulton

Born: Goshen, Alabama 1931
Medical school: Medical College of Alabama 1959.
Residency: FP residency, Eastern Maine General Hospital, Bangor, Maine; Surgical residency, Carraway Methodist, 1962-63.
Specialty: Family Practice
Affiliations: Board of Directors and Chief of Staff, Lawrence County Hospital, Moulton; President, Lawrence County Medical Society; Alabama Board of Medical Examiners, State Committee of Public Health, Board of Censors 1983 to present; Board of Directors, Alabama Quality Assurance Foundation, 1983 to present; Advisory Board, University of Alabama School of Medicine; Alabama Delegation to AMA, 1988 to present; Charter Fellow, American Academy of Family Physicians; Diplomat, American Board of Family Practice
Office: 867 Irwin Drive, Moulton, AL 35650, phone 974-0646.
Avocational: Part-time standup comedian; gardener and horticulturist

Joel C. Pittard, M.D.
3rd District, Opelika

Born: Athens, Georgia 1946
Medical school: Medical College of Georgia, Augusta 1972
Residency: Naval Regional Medical Center, Oakland, California 1974-77
Specialty: ObGyn, Board Certified 1979
Affiliations: Fellow American College ObGyn; member, American Fertility Society; President, Lee County Medical Society; Chief of Medical Staff, East Alabama Medical Center, 1989-90
Office: 121 N. 20th St., #2, Opelika, AL 36801 phone 745-6447.
Avocational: Golfing, tennis, scuba diving, classical music; works with United Way in various capacities, and with Auburn United Methodist Church.

Robert H. Story, M.D.
at-large, Tuskegee

Born: Tuskegee, Alabama 1940
Medical school: Alabama 1967
Residency: Rotating internship, Duval Medical Center, Jacksonville, Florida, 1967-68
Specialty: Family practice
Affiliations: Alabama Chapter American Academy of Family Physicians, presently Treasurer, previously Southeastern Vice President; Macon County Medical Society, President for past five years, previously Vice President and Treasurer; Chief of Staff, Community Hospital, Tallassee, for past three years
Office: Lakeshore Clinic, 102 Lakeview Dr., Tuskegee, AL 36083, phone 727-5900
Avocational: Elder and chairman of the board, Union Christian Church (Disciples of Christ); grows roses, reads fiction, mainly mysteries; follows Auburn football

Pink L. Folmar, Jr., M.D.
6th District, Birmingham

Born: Alexandria, Louisiana 1945
Medical school: University of Alabama School of Medicine 1972
Residency: University of Alabama Hospital and Clinics 1972-75; Chief Resident in Medicine and Instructor, Department of Medicine 1975-76
Specialty: Internal Medicine.
Jefferson County Medical Society Board of Censors 1990-94; Jefferson County Board of Health, Secretary 1990-91; Baptist Princeton Hospital Executive Committee 1986-91; Quality Assurance Committee, Chairman 1986-91; Simon-Williamson Clinic PA, Chairman Finance Committee 1982-86, President 1986-89; "Internist of the Year" State of Alabama 1990, Alabama Society of Internal Medicine.


Avocational: Raises and propagates bromeliads (tropical plants similar to orchids). Ran Huntsville Marathon (26.2 miles) in 1981, 8 minute/mile pace.

Patrick B. Jones, M.D.
2nd District, Dothan

Born: Dothan, Alabama 1934
Medical school: University of Alabama 1959
Residency: UAB, Pathology 63-66
Specialty: Pathology
Affiliations: Houston County Medical Society; Southeast Alabama Medical Center, president of staff 1978; Alabama Association of Pathologists; MASA, AMA, CAP.

Office: Southeast Alabama Medical Center, Dothan, AL 36302, phone 793-8058
Avocational: "Golf, and golf."

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ARMY MEDICINE. BE ALL YOU CAN BE.
An American Odyssey

Wm. H. McDonald

Wherein Richard H. Esham, M.D., Chairman of the Board of Censors, is seen as he struggles to realize his dreams of glory in the little Ohio River Valley town of Vanceburg; how he is frustrated in this pursuit by the ghosts of German royalty and a mother’s strict code; how he ultimately follows in the footsteps of his father, a beloved physician in a family that came to Northern Kentucky’s Lewis County in 1805; how he finds his way to a UAB residency in part because of a lecture on the great toe; how he overcomes the despair of a malpractice suit to become a Professor of Medicine, thus beginning a personal effort to rescue primary care from its descent and to boost geriatrics in its ascent.

When Dick Esham was growing up in the hills and hollows along the Ohio River in Northern Kentucky, he was not as free as the other boys in and around the little town of Vanceburg.

One of his constrictions was very old; the other more recent. In Lewis County, the Tolivers and Martins had been feuding as long as the more notorious Hatfields and McCoys in Harlan County. Just why they had once hated each other is lost in the mists and myths of time, as ancient enmities usually are. Tribalism dies hard everywhere.

But it was the cultural history of HIS tribe and, as a boy distantly related to the Martin side, young Dick had to be indoctrinated with the details of the antique feud. After all, the Eshams had been there since 1805. That responsibility was assumed by his grandfather and uncles. The feuding had long since subsided but his family mentors dutifully regaled the boy with stories of the old days, just in case; stories of how a member of one clan who slighted or insulted the member of another might just disappear up a hollow and never be seen again.

The other constraint was not nearly so fearsome but neither was it as remote in time. It was real and omnipresent: as the son of one of the two doctors in the county, his God-fearing mother told him countless times, he was not at liberty to visit pool halls or otherwise indulge in the unseemly habits of the riffraff element among his buddies.

He must conduct himself at all times and in all places as the son of a beloved physician, Elwood Esham, M.D. It was young Dick’s paramount duty to preserve the image and status of the family, no light load for a young boy.

If it was fun, Dick soon learned, it was probably verboten in his mother’s reckoning; or at least subject to her judicial review. Verboten is used advisedly. She came by her strict convictions naturally. One side of her family was descended from the royal German family of Von Thurn. She was a Seventh Day Adventist, by way of Miami, who had been educated in parochial schools of that order, including the Adventist school of nursing at Murray, Ky.

It was there that she met and married Dick’s father, 12 years her senior and newly graduated from the Louisville School of Medicine. Had her nursing school superiors discovered the marriage, before her graduation, she would have been summarily expelled. Her crime was exacerbated by her marrying outside the faith. Adventists in those days had strict rules and enforced them without fear or favor.
Her Teutonic heritage and her religion were interlaced with the Kentucky work ethic with which both she and her husband were imbued. These cultural attitudes were strengthened and compounded by the hard life of Vanceburg's farmers in their immemorial efforts to eke a living from the hilly, marginal land of Northern Kentucky.

All of which made for a fairly rigid early life for Dick, his sister and his two brothers. But something worked: the sister is now a celebrated opera singer and the three boys are all established physicians.

It might have been otherwise for Dick. The rules imposed by his mother and father came down to this: he and his siblings would be excused from farm chores after school and during the summer only for some approved creative pursuit — music, approved athletics, etc. No pool halls or lollygagging of any kind. And indolence was a felony bordering on treason.

His options thus locked in iron, Dick turned to baseball in the cowlots of Lewis County. There wasn't much else going on. The Cincinnati Reds were at Crosley Field, just 95 miles away. Listening to their exploits on the radio was virtually his sole routine contact with the world beyond Vanceburg. When his father occasionally took him to see the Reds play, to Dick it was as if he had entered heaven's gates.

The behavior restrictions imposed by his parents, coupled with the tantalizing taste of major-league baseball, concentrated his mind on the game. As first observed by Ice Age parents perhaps, the energy and drive of a healthy, growing boy is awesome; it will find an outlet, for good or ill.

"I became passionately in love with baseball," Dr. Esham recalls today, the glow in his eyes reflecting the remembered wonder. "I did not miss a Reds game on the radio. How the Reds were doing was the principal talk in town, in the barbershops, everywhere. It became my life.

"There was a man in the community who had made the triple A level as a pitcher. When I started playing Little League, for some reason he took a liking to me and he influenced me to want to be a pitcher."

Not surprisingly, he soon aspired to be a professional baseball player and the greatest pitcher in the history of the game. Dr. Esham:

"After about a year, with his coaching, I became so good it wasn't any fun for anybody but me because I struck out everybody. We'd win every game. Nobody would get a hit; nobody got on base."

Powerful stuff for a 10-year-old. But unknown to him at the time was his mother's quiet observation of the boy's obsession. Up to a point, wholesome athletics passed her minimum standards. But the very enthusiasm he concentrated on the game was ultimately his undoing, as we shall see. There was another factor, in her eyes: in those days even star players were paid poorly by current standards, which made their calling somewhat declassé to a highborn German lady — simple entertainers, like actors and other lowlife.

The economy of Lewis County was based on corn and tobacco, principally the latter. Although there was abundant acreage, Dr. Esham recalls, there not a lot of good farm land:

"It was valley land, cleared, along the Ohio River Valley and back along the tributaries. It was hilly but not mountainous, similar to the topography of Birmingham, except the valleys were much narrower.

"There was no good roadway in or out of Vanceburg. You really had to want to go there. My father's father was a farmer and horse trader. He traveled around trading horses and cattle. My father and his brothers — he was the second oldest; there were seven children in his family — helped drive the cattle around for sale.

"It has always been a mystery to me how or when they all got interested in higher education. All but one of the seven children in my father's family went on to get college educations. The oldest boy became an insurance salesman; my father, the second oldest, became a physician; the next brother was an educator and became statewide director for Kentucky of what we would call continuing education. The three sisters all went to college at Morehead, now Morehead University. My dad, at one point, sat on the Board of Regents of Morehead.

"I think it was probably this personality trait of persistence that carried into my generation, as well as the traits of loyalty and self-reliance, which were drummed into us.

"My father had been accepted in medical school but he couldn't find the financing. He taught school for eight years and made a success of it. In admiration, several local merchants bankrolled his medical education. The Ford dealer gave him money and a car. And he was then able to go to medical school.

"He made a commitment that he would probably return to Vanceburg to practice, but in his heart he wanted to settle in Paris, Kentucky, the middle of the Bluegrass. He had developed a fascination for horses. If you drive through Lexington and then through Paris along U.S. 68 to the Northeast, you are driving through the heart of that beautiful horse country. On
that road you will still see the old hand-laid stone fences.

"And even though he felt a deep obligation to the people who had supported him in Vanceburg, he probably would have settled in Paris had not his mother, my grandmother, taken seriously ill just as he was completing his internship at the University of Louisville. But farming always remained the other great interest in his life, second to medicine."

As Dr. Elwood Esham's practice grew, whatever he could put aside he invested in real estate. Since the region and the nation were just emerging from the Great Depression, Dr. Esham was terrified of banks. Over the years he put his money in everything but banks — houses, farms, tree farms, gas stations — investments he could see on his rounds.

"When my dad took an afternoon off," his son remembers, "everybody knew where to find him — at the farm. If he wasn't doing farm chores he was bird hunting, but that's where he would be. There weren't any beepers then, and there wouldn't have been any in Vanceburg anyway. If you wanted him, you had to go to the farm."

And, of course, patients did. They not only sought him out on his afternoon on the farm, but would enter the Esham home without knocking at any hour any night of the week. Dr. Esham remembers being awakened three times in the same night for three deliveries. His father had a kind of scrub room in the home, an unsuccessful attempt to insulate his family from the walk-in traffic. Still an uninterrupted night was rare.

In the summer the Esham boys and their sister were required to work on the farm, with only "creative" work regarded as a valid excuse. Faith, the only girl, took piano lessons, which was good, ultimately leading to grand opera, and, according to Dr. Esham, her being named the only child their mother regarded as having really succeeded. (The medical careers the three boys chose were acceptable, but apparently not quite high enough on her list of "creative" aspirations. Her roots were in the land of Wagner and she brooked no compromise in her ideals as worthy objectives for her children.)

But the story of how her family got to America hardly resonates in this grand tradition, as Dr. Esham irreverently tells it:

"My maternal grandmother was a direct descendent of the Von Thurns of German royalty. My maternal grandfather's family, on the other hand — their name was Opfer — were just ordinary peasants. I have heard stories of one side of the family putting down the other for not being of the royal lines.

"How the Von Thurns got into the United States was apparently this — my grandmother's great grandfather was caught in the bed with the wrong woman by her husband. He bailed out of a second-story window, and escaped with his life, ultimately making it to this country."

[It would be interesting to see how a discreet genealogist might handle this notation. Possibly: "Von Thurn was advised, for reasons of health, to emigrate to North America." The Von Thurn's ancestral home was, naturally, a castle — Regensburg Castle. On the edge of the Bavarian forest in Southeast West Germany, Regensburg is today a thriving inland port at the confluence of the Danube and Regen rivers, a commercial, industrial and transportation center. One of the oldest German cities, it was important even back in Roman times. A major abbey was founded there in the 7th century. When Charlemagne set about subjugating Bavaria in the 8th Century, Regensburg had to be conquered; it fell in 788. During the Kennedy era, descendants of the old order were prominent in the international jet-set. The libidinous ancestral Von Thurn could have exited Germany much quicker today.]

The paternal ancestry of "Esham," variously spelled on old headstones in Lewis County, is English; the earliest settlers of that name arrived in the area with the dawn of the 19th century.

The short, happy life of Dick Esham the superstar pitcher was the victim of his own success. He simply got too good at it for his mother’s tolerance. What had begun, in her appraisal, as minimally acceptable exercise had progressed to heathen hedonism. It was one thing for him to occupy his youthful summers in such a fashion. It was quite another for his apparent decision to devote his life to throwing cowhide balls.

In his early teens, his talents grew; by 15 he was playing semi-pro baseball; by his late teens he played on the team that won the Tennessee-Kentucky semi-pro championship.
When the team wanted to try for the national championship in Wichita, his father finally agreed to take him, with the proviso that he play under an assumed name, thus to preserve his amateur status.

His team was eliminated after only one game, one reason being the name of the opposing pitcher — Satchel Paige. But Dick had tasted the big-time and was rapidly moving toward a pro career —

"At one point I had seven offers for scholarships to play college baseball."

He was on Cloud 9. Then came the Teutonic lightening.

"My father would probably have allowed the course of events to occur as they were going to occur, but my mother interceded and said, 'I don't want my son playing professional baseball.' In her eyes, it was not an honorable way to spend your life. That may have come from her religious background, but it was probably some of the Von Thurn thing to — the royalty side of the family telling her this was an unbecoming profession.

"So she put her foot down. I had finished my sophomore year at Lewis County High School and everything seemed fine. Then she made the decision, unilaterally and for the family, that I was going to be sent off to an Adventist boarding school, in Mount Vernon, Ohio, and that this would end my flirtation with becoming a professional athlete.

"At first I didn't want to go; but, on the other hand, there was something fascinating about moving up to a different level. Going away from home had its appeal. I thought I would be able to play baseball on the sly but, as it turned out, the only sport at Mount Vernon was intramural basketball. My mother knew that, of course. Still, it didn't enter my mind at first that I was permanently sidetracked. But, even though I played baseball in the summers, that's the way it turned out.

"I was given three choices for college, all Adventist institutions; one outside Chattanooga, one in Washington, D.C., and another in Southern Michigan. I chose Michigan because all my friends were going there. And because that was the Adventists' senior school in their chain of schools, which includes the Loma Linda medical school in California."

"At some point during this time, I began to think about what I was going to do with my life. I suppose it was beginning to dawn on me that I was not going into baseball as a career. I had not known anything but medicine all my life. We lived in it. My dad was on duty 24 hours a day, seven days a week. In that little scrub office in our home, I saw appendicitis, sutured heads, just about everything.

"Back in those days, my dad did home deliveries because the alternative was a midwife. There were only two doctors in the area but a lot of OJT midwives. Obviously two physicians were not going to deliver all the babies, but Dad delivered about 5,000 over his career.

"When I became old enough to drive, I had driven him up hills and down hollows.

"Away from home at school, I got to thinking about his life. That was not the kind of life I wanted. Later, in medical school, I became critical of some of his care — treating a diabetic coma in a home, for example. Why would they have done that? Of course, the reason was that these people had no money at all. If Dad told them they had to go to a hospital, they simply wouldn't go. They couldn't pay the bill and they had no insurance. They would just sit home and die.

"Once I got to Andrews University, in Michigan, 25 miles from the Southwest Corner of Lake Michigan, I began to think even more about medicine. The lake-effect snows were heavy and regular; we went to class through a tunnel. I guess that environment helped erase professional baseball from my mind. But what really turned me on to medicine was that I met a girl there who was pre-med, two years ahead of me, a straight-A student:

"Not only was I deeply attracted to her; I was fascinated by her scholastic skills. My grades jumped up dramatically. Within the first semester we became competitors. In my sophomore year, I learned she was going to be leaving the next year, going to Loma Linda medical school. I started taking 20 to 22 hours of classwork, instead of the usual 16 or 18, to finish in three years rather than four.

"Once she left for California — well, time has a way of eating away at romance. But at this point I was on track and the momentum was there to carry me. The problem I ran into was that I learned that Loma Linda had never accepted a student who had done what I was doing — compressing four years into three. Anyway, I was going to end up short, by 6 or 8 hours, of the total required for a bachelor degree.

"So when the time came, I looked at my second choice, the University of Louisville, my father's medical school. They accepted me in a New York second. My father was pleased with that. And that turned out to be the way I got out of the Adventist system. Since I had a few hours left on my Bachelor's degree, I did eventually get back in the summer to complete my course work, and got my degree.
“That’s how I got to Louisville, which had not been my first choice.”

Q: All right that gets you a little further South, but how did you get to Alabama?

A: “While at Louisville, we had several visiting professors from UAB and they were all impressive. One of the most impressive, Ben Branscomb, made rounds with us when I was in my junior year. We stopped at the bedside of a patient in a ward. The patient’s foot was sticking out from under a sheet, as I remember. Dr. Branscomb then proceeded to give a brilliant lecture — really brilliant — on the significance of the absence of hair on the great toe. I was overwhelmed that a professor could devote such a fascinating explanation to somebody’s big toe.”

Q: And what IS the significance of the absence of hair from the big toe?

A: “I can’t remember. All I remember was that the lecture fascinated me and the others.”

[A call to Dr. Branscomb, UAB Distinguished Professor Emeritus, got an immediate response. He fairly chortled with delight:

“I am pleased that Dick remembers my little lecture, but disappointed he has forgotten what I said. I have always tried to impress on residents and medical students the importance of clinical findings in medicine. That was Tinsley Harrison’s way of teaching. The development of clinical bedside skills is very important in itself, but teaching should also excite residents and students — turn them on.

“The absence of hair from the proximal phalangeal joint correlates perfectly with arterial insufficiency. You may not know it, but everyone has some hair, maybe only two or three hairs, on the second joint of the big toe. You may have to look closely, but they should be there. If they are not, it is an important clinical finding.

“It doesn’t stop there: you can learn a lot about a patient from the toes. But I do thank you for calling me: this makes my day — to have someone remember something I said long ago. Just the other day, I ran into a physician who had been one of my residents years ago. He offered an astute observation and I complimented him on it. He responded, ‘But Dr. Branscomb, you taught me that 20 years ago!’ Such recollections are great rewards for a teacher.”]

Another visiting UAB professor who impressed medical student Esham was Joe Reeves, M.D., whose lecture he had heard:

“I was terribly impressed by his presentation, and by the fact that he was an absolute monster of a man — six feet four, 250 pounds, looking like Charles Atlas — and he was a cardiologist.

“So Dr. Branscomb and Dr. Reeves were among the reasons I put in an application for a residency at UAB.

“Of course when I got there I loved it. It was a wonderful environment. Virtually no one who did intern and medical residency training at Louisville had ever passed his boards. There was one guy in practice in Louisville, Dr. Charlie Smith, who was a sort of doctor’s doctor. He had passed his boards and I was aware he had done his residency at Alabama. That was another reason.

“When I got to UAB I discovered that everyone there passed their boards. It was something you simply had to do. One extreme to the other. The difference, I think, was the tradition. The peer pressure at UAB was incredible. There was a strong work ethic. There were nationally prominent people there. Dr. Walter Frommeyer was chairman of medicine when I went there. He became President of the American College of Physicians. So, in this atmosphere, it was simply unacceptable not to pass your boards. It just was not done, that’s all.”

Q: How do you account for this tradition? Where did it come from?

A: “A lot of people. Tinsley Harrison, of course. Joe Reeves, Jim Pittman, all those. Dr. Kirklin came the year before I came. His first Fellow, Billy Hightower, moved to Mobile and I’ve had good relations with him since he was a Fellow.

“When I came to Birmingham as an intern in 1967, there were 12 medicine interns. The identical size South Alabama is now. I think we have very much the same atmosphere at South Alabama in 1992 as there was in Birmingham in 1967. It was a family then in Birmingham; it’s a family now at South Alabama.”

“Back in those days, when doctors who wanted to do their residency put in for a draft deferment, you would typically get your internship deferred and the first year of your residency. Deferment was highly selective.

“Dr. Tom Sheehy, wonderful man, took me under his wing. He was chief of medicine at the VA. He treated me like a son. To this day I call him Uncle Tom. He was a retired Army man.

“He made me aware that there was an alternate track for getting a full deferment. Somebody had a list. If someone on that list, who had received a deferment, changed his mind and said, ‘I don’t want this medicine residency after all; I want to go into OB,’ then someone moved into that slot from an alternate list.
"I sent in my application for the list, never dreaming I would make it. In the spring of '69, which was near the end of my first year of residency, I knew I was going to Vietnam. Things were hot. I had pretty much resigned myself to being a general medical officer in Vietnam.

"Then I got a letter from the Department of the Army. I knew that letter was my notice, '... you are to report to ....' My hands were shaking as I opened it up. But the letter said '... congratulations, you received a full residency deferment.' This was for a full residency. It was probably the best letter I ever received.

"In the spring of '71, or late winter, Dr. Reeves, who had become Chairman of Medicine, cornered me in the stairwell between the 12th and 14th floors of the Hillman Tower. A mammoth man, he backed me into a corner and said, 'You are going to be my chief resident.' I said, 'yessir,' but the complication was that I was scheduled to go into the army in July. I had completed my four years residency.

"Once again, Dr. Sheehy came into play and I was able to get still another year of deferment. That gave me a total of five years deferment to complete my residency and serve as chief resident.

"At that time the chief resident was an instructor in the department of medicine. He was the chairman's right arm. He controlled the lives of house officers. Even full professors of medicine didn't mess with him. It was a very strong position. He was the target for the chairman.

"That was heady stuff. We had good telecommunication then with all the hospitals in Birmingham. I was in charge of medical grand rounds. I would lead the discussions. In those days each chief resident was required to select scripts of grand rounds during the year, edit them and get them published in Southern Medical Journal. So I got six publications right off the bat."

The high-tech environment at UAB contrasted sharply with the older world of the elder Dr. Esham, back in Vanceburg, who still had to fetched from the farm if was needed when not in his office or at home. At that time, UAB had an experimental CCU, the only one in the state then, and considered pretty futuristic. Lidocaine was introduced during his intern year.

The atmosphere at UAB crackled with the intensity of such junior faculty members as Drs. Jim Pietman, Bob Kreisburg, and Durwood Bradley. The junior faculty, particularly, was very friendly; he felt a sense of family, often going dove hunting with Dr. Pietman and others. The medical center was in a period of explosive and exciting growth. By the time of his leaving, the list of internal medicine interns had grown from 12 to 30.

His long deferred military service finally caught up with him after his chief residency in 1972. After basic training for doctors at San Antonio, he was posted to Fort Jackson, South Carolina. The next year the baseball itch returned; he signed on with the hospital fast-pitch softball team, which had never had a physician on the team, or even an officer for that matter.

Back in 1967, between his junior and senior years in medical school, he had torn his rotator cuff while pitching with a semi-pro team in Louisville. The fast-pitch softball at Fort Jackson was entirely new to him but his team went on to win the post championship, and he was elected most valuable player by his teammates.

At Fort Jackson he was initially assigned to an ambulatory care clinic that had no admitting privileges to the base hospital. In a year, however, there was a reorganization and Dr. (Major) Esham was elected chief of medicine by his peers. With him were a lot of top-flight physicians who had been waylaid by the war. They wanted to do the very best medicine and Dr. Esham saw to it that they were allowed to do that.

His two-year service tour completed in 1974, he opened his practice in Mobile, remaining in private practice for 16 years. In May 1990 he was appointed Chief of the Division of General Internal Medicine and Geriatrics and Medical Director, Clinical Operations for the Department of Medicine, University of South Alabama College of Medicine.

His work with MASA began with the Council on Public Affairs in 1979, followed by service on the Council on Medical Education, election to the Board of Censors in 1984, service as Vice Chairman of the Board in 1991-92 and his election as chairman this past April.

He also serves on the Association's Legislative Affairs Committee, Third Party Grievance Task Force, and has been Chairman of the Finance Committee. He is Chairman of the State Board of Medical Examiners and the State Committee of Public Health. He has past service on the Alabama Statewide Health Coordinating Council. He is a member of the Alabama Board of Medical Scholarship Awards, serves on the Medical Services Committee of the Mobile Area Chamber of Commerce and sat on the board of the South Alabama Chapter of the Arthritis Foundation.

Despite such multiple contributions in time and tal-
ent, Dr. Esham emphatically rejects the suggestion that he is politically minded other than repaying the debt he feels he owes medicine:

“I don’t think I would be attracted to any voter constituency (laughter)... One of the things I have done is to solidify my academic goals. It should be very apparent to everybody that this country has a graying population. We have done a great job in American medicine and people are living so much longer. That is the principal reason I decided to seek certification in geriatrics.”

How he accomplished that is vintage Esham Family can-do. After the Thursday Board of Censors meeting at annual session last April, he drove to New Orleans that night, got up early the next morning, spent from 8 a.m. to 4 p.m. taking the exam, then drove back to Orange Beach for the annual Friday night bash. (He passed.)

“Geriatrics is a rapidly — I should say wildly — growing field. As a professor of medicine and division director of general internal medicine and geriatrics, my future is in trying to develop a training program in ambulatory general internal medicine and geriatrics. I think this is going to be the key to the health access problem.

“You’ve got to have the primary care doctor there to provide the care. If we don’t develop family practitioners, general internists, pediatricians and so on, this whole access question will become moot. Either we produce such doctors, or we will be inviting non-physician providers.

“In fact, when Dr. Richard deShazo, Chairman of the Department of Medicine, recruited me for this job —I had been a clinical assistant professor of medicine from 1974 to 1990 before this appointment — I told him he might be asking me to ride a dying horse. But I said I would ride like hell as long as the horse lasted. I think I could devote another 10 years to this easily.”

Q: A lot depends on what happens nationally, doesn’t it? What do you think is coming out of the political debate on health care reform?

A: “Oh, you could put all the plans, bills and ideas in a circle and then play spin a bottle. Where the bottle stops is as good a guess as any. But I truly believe we are going to have some kind of nationalized system. The feds can’t keep it out of it. Whether it will be a single payer system or variants of other alternative plans, I can only guess. But something is coming. The public wants something done. Whether or not we can justify the costs of health care, costs have gone through the roof. I hope we don’t destroy what 85% of our people now enjoy, the best medical care in the world, in the process of fixing the system.”

Q: As a general internist, are you disillusioned with what has become of the RBRVS movement?

A: “The push to make primary care physicians’ lives a little bit better is being diluted. The effect, it now appears, will be negligible.”

Q: Do you believe health care is the most critical issue facing the nation, whoever is elected in November? [This interview was last summer.]

A: “There’s no question of it’s importance and I suppose most physicians would rate this issue No. 1. But there may be an even more important issue: If we don’t do something big to overhaul our educational system, that could be the cancer that devours all of us. In fact, the same thing that is happening to primary care doctors is happening to primary and secondary school educators. They don’t have respect, they get a lot of hassle and they don’t get paid very well.

“Why would a high school graduate even think of going to college to become a teacher? For one thing, male teachers have all but disappeared. And who can blame them? If this situation is not turned around, you can forget about such issues as high-quality health care for everyone. There won’t be enough people with good jobs to pay for a new system, or even the old one.

“Just as the schools need good, dedicated teachers, so does the health care system need good primary care doctors. I can tell you, medical students are not stupid. I live with this everyday: when medical students finish their training, they will have an average debt of $45,000. Some will even owe $100,000. A considerable debt in any case. If that person goes into primary care, he can expect to make maybe $75,000 to $80,000 for the first five years. How can he even think of paying off that debt?

“Faced with this economic decision, most students turn their backs on general internal medicine and branch off into a subspecialty — cardiology, gastroenterology, and so on. A gastroenterologist probably makes five times what I make as a primary care internist. He has had no longer training than I have had. He does not have to be more intellectual than I am. The procedures themselves are relatively easy to learn. And they’re gold mines.”

Q: Critics of the primary care/specialty mix, such as Dr. Lundberg in JAMA, charge that this country has the ratio of specialists to generalists all out of kilter — 65% in specialty care, only 35% in primary care. The ratio should be about 50-50, he said. But to correct the present imbalance, it will be necessary to per-

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suade, somehow, 100,000 presently practicing specialists to answer the call to the colors, renounce their specialty and enter retraining as primary care physicians at substantially reduced incomes.

In the May 13 JAMA special issue on health care reform, he conceded this will not be easy: “Only financial incentives and disincentives will likely be strong enough to motivate that profound shift. Obviously, trained specialists will not be clamoring to become primary care physicians, at least not soon.”

In your opinion, will this kind of moral suasion, calling for sacrifice and disruption, work — even with the financial carrots & sticks he mentioned?

A: “It can’t be done. The first reason it can’t be done is probably the economic one: asking physicians to cut their income massively in the public interest. That’s not a pragmatic proposal, in my opinion. But there is another reason: specialists are not capable of primary care because they haven’t done it. It’s like asking a pathologist to become a family doctor tomorrow. He just can’t do it. He’s not capable of doing it; couldn’t do anything close to a quality job. I’m speaking from 16 years of working with these guys.

“Someone who has been out in practice in cardiology or gastroenterology for five years has forgotten general medicine. It’s passed him by.

“What Dr. Lundberg says is idealistic thinking. It makes some sense in theory, I suppose, but it is really naive; it ignores reality. Not even the subspecialists in internal medicine can do it. In effect, he and others propose that doctors go back into training so that they can make less money. It just won’t happen.

“The only approach is to make primary care more attractive in the future. There is a proposal being kicked around right now by the people who control certification — to redo how a person becomes a general internist or becomes a gastroenterologist. The first two years of residency would be considered core information that all internists ought to know. After the core years, you make a decision either to be a general internist or cardiologist or other subspecialty. You branch off at that point.

“The way it is now, all internists, general and subspecialty alike, take the certifying exam in general internal medicine. Under the new proposal, you could take either the general internal medicine exam and be certified or take the subspecialty exam and be certified."

Q: But wouldn’t that be counterproductive? If your intention is to increase the number of primary care physicians, why would you make it easier for them to opt for the subspecialties?

A: “You would have to exercise a specialty birth control. State legislators are beginning to say, ‘Produce X number of primary care doctors or we’ll cut your funds.’ But that won’t be as effective as it once might have been because the budgets of medical schools are not now primarily dependent on state funds. For most schools, state support probably averages about 25% of total funding. For the past 10 years the Feds have been pumping money into primary care schools. In the case of family practice, it has been a disaster. The only successful one in this state has been the Tuscaloosa program.

“But the bright side of it is that there is general awareness of the problem.

[In the past 25 years, the number of doctors in the U.S. has doubled to more than 600,000, while the percentage of primary care physicians has dipped from half in 1961 to about one-third in 1991. In a report due to have been published in October, the Council on Graduate Medical Education calls for creation of a national panel to set physician manpower goals and policies and monitor the supply and distribution of physicians. The panel calls on medical schools to boost to 50% the percentage of graduates in family medicine, general internal medicine, or pediatrics by the year 2030.

[Dr. Lundberg commented May 13 — “Our system of allowing individual physicians freely to choose the field they will enter has been terrific for individual physicians but a mass catastrophe for the country.”

[Dr. Esham is right on the money about the economics-driven attitudes of young doctors and doctors-to-be. A recent survey found that only 18% of medical school graduates were interested in becoming generalists. The COGME suggests loan and scholarship programs aimed at undergraduates to help influence their specialty choices — Dr. Esham’s birth control by incentive.

[Meanwhile, however, the House of Representatives recently slashed federal grants for family medicine programs by more than 25%. In sum, while many experts have faulted the imbalance, efforts to correct it have so far proven unavailing.]

Q: Moving from the general to the particular: what do you feel is the primary mission of the Board of Censors?

A: “My personal view is that our first duty is to represent the best interests of our patients. Board members and Officers are elected by their constituents, in my opinion, as patient advocates.”

Q: From time to time, it is lamented that there is very little routine grass roots participation in the busi-
ness of the Association. How would you respond to that?

A: “Of course, grass roots participation peaked during the tort reform movement. The mass of members was not heavily involved on a regular basis before that and participation slumped just after it. However, I believe that is higher now than in the immediate post-tort reform period. Members are concerned with the economic factor, the hassle factor, and they are worried about where the nation is going with health care.

“And there are a lot of people who, like me, are changing headings. In the 18 years since I got out of the army and entered private practice, my job description has changed. That’s true of many primary care people: we not doing what we thought we were going to do when we started practice. As an upshot, many primary care people are looking for other job opportunities — academic medicine, which was the option I took, management positions. One of my former partners, for example, a very good general internist, has been recruited by an HMO as a medical director. You could multiply my move and his move by many hundreds, maybe thousands, and you can see a big drain on primary care.”

Q: You are seeing disillusionment, disenchantment, in primary care. Is that due, in part or totally, to the belief that RBRVS was the light that failed?

A: “That’s part of it, but certainly not all of it. There are many factors — all contributing to a malaise in primary care. You see that in the doctors’ lounges. The people who are the most unhappy are not the surgeons, although their fees are being cut, but the primary care guys, particularly general internists. Family practitioners are somewhat unhappy, but they are actually doing better, at least economically.”

Q: Let’s zoom in on the general internists, then, since they seem to be the most dispirited, in your opinion. The anatomy of their melancholia might help explain the flow from general medicine to the specialties and subspecialties.

A: “You have to appreciate that during the medical education process, and this is a historical thing, the field of internal medicine was considered the field of the intelligentsia. That tradition, which goes back at least to the Middle Ages, carried forward. Young people in medical schools gravitated to that milieu. They got caught up by the whole exciting process of learning the mechanisms, the pathophysiology of diseases. Not just to cure somebody but to satisfy their intellectual curiosity — Why did that happen? How did it happen?

“It may sound strange, but in my own case, one of the things that saved me from the primary care malaise was the most traumatic event in my life — the 10-year period when I went through the pain of a malpractice suit. I could not get away from it; it dominated my life. I went to bed with it and woke up with it. It was everywhere. But it was one of those events in life that redirects your energy and completely reorders your thinking about almost everything.

“It was worse, in its total effect on me, than the loss of my father. Even when you get exonerated, finally, in the appeals process, it still doesn’t leave. I couldn’t enjoy anything recreational during those 10 years. I used to love to go duck hunting with a buddy of mine, a famous Auburn athlete, in South Louisiana. We would go out in the marshes and stay three days, living on the boat, talking about anything and everything. I lost that. This thing that was occupying my mind and body — I couldn’t get away from it, even in the Louisiana marshes with my close friend.

“I still have boxes and boxes of newspaper articles, depositions, interrogatories, letters. I would like to forget everything, but I can’t entirely, although it is better now. I can’t throw away all those reminders of the agony I went through. Probably the most difficult day I have had as a member of the Board was the time I had to explain the suit to my fellow Board members. That was a highly emotional time for me.”

Q: I remember it well. You looked like a soul in agony.

A: “I was, but the whole terrible experience helped me focus on what I wanted to do with the rest of my life. Eventually that led to what I am doing now in academic medicine. I am there because I want to do my part to change things if I can, to involve young people in primary care and to restore primary care to its rightful place.

“But let’s change the subject. I don’t like to dwell on my past unhappiness.”

Q: Tell me about your family, starting with your father.

A: “My father was born in 1905. He died in 1985, at the age of 80, of lung cancer. He had smoked three packs of Camels a day. But before he died, on his 80th Birthday, I had the good fortune of taking my young daughter, my oldest child, to visit him.

“His funeral was very moving. I listened to the doctors who had been his competitors all those years giving the eulogies. Virtually the whole town turned out to say goodbye to my Dad. It was incredibly moving to finally know how much this community, the
community I grew up in, thought about him. His former patients, many of whom he had delivered, came forward to say how much he had meant to them.

“My mother, who was born in 1917, still lives in Vanceburg, in the family home.

“My brother Bill [William Thorn Esham, M.D.], who had served as Coast Guard flight surgeon in Mobile, went back home and took my father’s practice for a few years. But he just could not tolerate people treating him the way they had treated Dad. He said enough is enough, went back for a urology residence, and is now a very successful urologist practicing in Portsmouth, Ohio [25 miles up the Ohio River from Vanceburg].

“My sister Faith was on track to follow her first two brothers into medical school. She went to the same parochial high school, but instead of Michigan she chose the Adventist college in Washington, D.C., but there she began to waver about medicine. She decided she wanted to do clinical psychology. Then midway through her master’s program at Eastern Kentucky, outside Lexington, she had the opportunity to audition for a vocal competition. She had long been involved in music, playing the piano and singing.

“Damn if she didn’t win, and with a lot of support from her mentors she won a full scholarship at the Juilliard School of Music. She earned a Master’s there and, ever since, has been a professional opera singer. Now she has an international reputation. She won a Grammy with Placido Domingo, with whom she had made the opera movie Carmen.

“My second brother, George (George Elwood Esham, M.D.) followed the same track that Bill and I did. All three of us graduated from the University of Louisville School of Medicine. At the end of his internship in Indianapolis, George decided he wanted to train in internal medicine. He got in the internal medicine program here at South Alabama. He tried practicing in Monroeville, Alabama, for a couple of years but that didn’t work out. He had an opportunity to buy a practice in Portsmouth, up the river from Vanceburg. It was a lock & key deal. George bought this guy’s practice, his furniture, even his receptionist. He continues to this day in solo general internal medicine practice there in Portsmouth. He has a coverage group. And he loves it; he is very successful.”

Q: “And your children...?”

A: My two boys live with me. In July I loaded them on the bus to go to Paris Island, S.C., to be young marines for 10 days. My namesake son, Henry, is a senior in high school this year. The youngest boy, Clay, is in the 8th grade. My daughter is a freshman this year at Auburn, in pre-veterinary medicine.”

Q: And you — you seem happier now, or at least less tormented.

A: “Oh, yeah. Certainly more than five years ago. The malpractice thing, the professional letdown — all those pains are still there but they are receding. What I have learned is this: If you find yourself unhappy, as I was, you’ve got to start looking for something that will change that state of mind. It may be a career change, some new avocation, becoming involved in a new project. You’ve got to do something new and different.

“I enjoy working with the Board of Censors. I have been very impressed by the altruism of the Board members. You see that when they are serving as members of the State Committee of Public Health and the on the Board of Censors — two very different roles that must be handled differently.

“My future in medicine is in trying to develop a training program in ambulatory general internal medicine and geriatrics. I think both of these fields, which are connected of course, are the key to the health access problem.”

The Von Thurns of Regensburg Castle would be proud of their son. Whether the shades of the feuding Tollivers and Martins will rest easier remains an open question.
Benign Familial Neonatal Seizures

Teri Raispis, M.D.*
Meyer E. Dworsky, M.D.

ABSTRACT

Benign Familial Neonatal Seizures (BFNS) occur in normal newborns without perinatal neurological damage or metabolic abnormalities in the setting of a positive family history for neonatal seizures. This autosomal dominant disorder has an excellent prognosis, in contrast to most other causes of neonatal convulsions. This paper points out the need to include BFNS in the differential diagnosis of neonatal seizures and to specifically seek a family history to avoid an unnecessarily extensive diagnostic evaluation and poor prognostication. We present a family with one atypical and three classic cases. Further study of BFNS may reveal more definitive basic science information leading to the inclusion of variant forms into the currently narrow clinical definition.

INTRODUCTION

Neonatal seizures are fairly common and generally carry a poor prognosis. Several large series including the National Collaborative Neonatal Project found mortality rates varying from 10-42%, while 30-40% of survivors suffered morbidity including seizure disorders, cerebral palsy and mental retardation.1,2 A poor outcome is quite common even when risk factors associated with prematurity are excluded. Perinatal hypoxia and/or intracranial birth injury are the most common etiological factors and seizures occur in 80% of these infants within the first 48 hours.3 Other common and serious causes of early neonatal seizures include central nervous system infections and dysplasias with an average onset of three days postnatally. Mortality and severe handicap are both several times greater for seizures in the first four days of life as compared to those beginning later. This early onset coincides with the usual timing of BFNS and it must be ruled out in order to avoid overly extensive workups and to relieve parents' anxiety.

The diagnostic evaluation for neonatal seizures may include measurement of blood chemistry, CBC, and analysis of blood, urine and cerebrospinal fluids as well as anatomical and electrophysiological studies. In a term infant with no risk factors for serious injury or metabolic derangement the search for specific etiology may reasonably be restricted to a few treatable causes, especially in the presence of a positive family history.4 This approach also results in significant reductions in hospitalization time. The family can be counseled appropriately to relieve fears of sequelae and long term anticonvulsant therapy can usually be avoided. BFNS, however, is often overlooked in the differential diagnosis of early onset neonatal seizures. Few clinicians realize that familial seizure disorders may begin in the neonatal period and a family history is rarely sought. Also, because of its short course and lack of sequelae, family members may forget to mention a family history unless specifically asked.6,7

Although BFNS has an autosomal dominant inheritance pattern, family history should extend to grandparents because of incomplete penetrance. At least four families are described in which there was an unaffected generation.8,9,10,11 Leppert et al.,12 whose research established BFNS as an autosomal dominant disorder secondary to a single gene located on chromosome 20, found further evidence of incomplete penetrance in three unaffected individuals with the gene marker.

Diagnostic criteria vary but most descriptions include: seizure onset on postnatal day 2 or 3 (82%)9

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in a healthy term infant; family history suggesting autosomal dominant inheritance; normal physical examination and diagnostic studies; uneventful pregnancy and delivery; normal birth weight; normal interictal period; no subsequent abnormalities of motor or intellectual development; frequent seizures (10-40/day) usually lasting approximately 30 seconds to 3 minutes; spontaneous resolution generally before six months of age. Seizures may be focal or generalized and frequently involve periods of apnea and cyanosis. About 50% of initial EEGs show non-specific abnormalities which carry no diagnostic or prognostic significance. Follow-up EEGs are usually normal.

CASE REPORTS

CASE I: This 3875 gram product of an uneventful term pregnancy was delivered by cesarean section to a 29 year old gravida 2, para 1. Apgar scores were 8 and 9. No abnormalities were noted on initial physical examination. The infant's mother reported brief seizure activity during feeding on day three. This was followed by 5 episodes lasting 5 seconds to 2 minutes each of eye rolling, head turning and generalized jerking of limbs over the next 24 hours. CBC with differential, blood cultures, CT scan, EEG, phosphorous, SMA-6, glucose, calcium, magnesium, ammonia, CSF studies, and urine amino acids were all normal. The mother reported a family history of infantile seizure in herself, her father and her son and a familial seizure disorder was suspected.

Further intermittent stereotypic seizures involving opisthotonic posturing and rhythmic disjointed movements lasted 40-75 seconds. No cyanosis or postictal state was noted. An EEG recorded during an active seizure revealed a relatively normal background with active epileptiform bursts of sharp wave and spike admixtures predominantly of the left frontotemporal region. Phenobarbital easily stopped the seizure activity which had been as often as one every 1-3 hours. Follow-up neurological and developmental exams, EEGs and MRIs have been normal.

CASE II: Our proband's older brother was born after a normal term pregnancy. The infant remained healthy but was seen by a pediatrician when 2 seizures occurred at approximately 6 and 8 months of age. According to the mother's account, he initially "went limp then became rigid and began shaking all over for about 3 minutes." Lumbar puncture was normal, as were serum protein, electrolytes, calcium, glucose, blood cultures, CBC with differential, urinalysis, CT scan and general physical exam.

A diagnosis of idiopathic familial seizure disorder was made and the infant was discharged without medication. Another seizure occurred eleven days later, at which time phenobarbital was initiated.

CT scans have been normal. Now four years old, he remains on anticonvulsant therapy having had two further seizures at 15 and 38 months.

CASE III: The mother of these children began having seizures the day she first went home from the hospital following spontaneous vaginal delivery without complications. She continued to have seizures until the age of 2 1/2 years. No medication was prescribed.

CASE IV: The mother's father also had seizures beginning on about day three and persisting until he was 2-3 years old. This history is given by his sister who is unaware of any of their ten siblings having a similar disorder.

DISCUSSION

Neonatal seizures often predict poor outcome. The National Collaborative Neonatal Project documented a mortality rate of almost 35%. Thirteen percent of survivors had cerebral palsy, 19% had IQs less than 70 and 20% had recurrent non-febrile seizures at 7 year follow-up. In a study of infants with seizures during the first four days, 73% of brain damaged convulsing infants and 97% of metabolically disturbed infants had abnormal values for at least one of the following: Ca, Mg, Phos, Na, Glu. Most of those infants also required tube feeding or resuscitation and had some type of focal neurological deficit.

Rare causes of neonatal seizures include autosomal recessive disorders of the urea cycle, amino acids or organic acid metabolism, which are associated with failure to thrive and developmental retardation. The diagnoses of B6 deficiency are also autosomal recessive, can be differentiated easily from BFNS by its prompt response to pyridoxine.

Fifth day fits (FDF), however, have many features in common with BFNS and carry a similar prognosis. They are usually frequent and multifocal, beginning on the 4th or 5th day of life in term infants following uncomplicated deliveries. FDF are idiopathic and self limited, and normal development follows. Some authors believe that FDF and BFNS are identical, however, FDF usually have no familial pattern, last an average of 24 hours and are refractory to drug ther-
apy. They may also be distinguished from BFNS because of a characteristic EEG pattern with "true electroclinical status epilepticus lasting 12-36 hours, with a special interictal tracing called sharp alternant theta" and interictal hypotonia which is often prolonged by anticonvulsant treatment. Although sometimes referred to as Benign Idiopathic Neonatal Seizures, a study by North et al. found abnormalities in 50% of 33 infants followed for up to 2 years. These included subsequent non-febrile seizures, developmental delays, microcephaly, minor neurological impairments, ventricular septal defect, hypothyroidism and one death from SIDS.

Most neonates with BFNS have responded to treatment with phenobarbital. Treatment, however, is rarely necessary as few neonates continue to have seizures for more than a few weeks. Lack of treatment in this age group does not cause injury. Because most were treated, the true duration of the disorder is unknown. Also, reports of recurrent seizures during treatment are not necessarily drug failure but may reflect inappropriate dosages as the infant grows.

In cases where family history points to an expected duration of several weeks or less, phenobarbital therapy is probably unnecessary. If treatment is indicated, most recommend doses of 5-6mg/kg/day and re-evaluation at 3-6 months intervals.1 If initial EEG showed abnormalities, normalization can be used as an endpoint for treatment.

Although most infants have spontaneous cessation of seizures before one month of age without subsequent developmental abnormalities or later epilepsy, several cases have been described with later onset, longer duration or adult epilepsy.2,3,5,16

Risk of subsequent epilepsy appears to vary with family history and may represent two separate disorders. A review of 113 cases showed eleven patients (6 of 15 families studied) with non-febrile seizures beyond infancy.17 Most reviews of BFNS have found risk of subsequent epilepsy to be 10-14%. This is approximately five times the incidence in the general population and indicates a genetic susceptibility to epilepsy which may be manifested after the neonatal period as well as during it.18 Kaplan and Lacey estimated the risk at about 20% in those with positive family histories.19 Follow-up into adulthood in more families may reveal a much higher incidence.

Although there are no relatives known to have epilepsy in our family, information about many of the grandmother's siblings is limited and Case II may prove to have subsequent convulsions in adulthood in light of his late onset and prolonged duration of symptomatology.

**CONCLUSION**

Treatment of most cases, despite a usual course lasting days to weeks, has definitely obscured the clinical course. Some have reported a lack of clear cut response to anticonvulsant therapy as a diagnostic feature.17 It is, however, difficult to discern whether recurrences despite treatment refer to true treatment failures or seizures while on subtherapeutic doses secondary to growth of the patient. Also, because several cases were treated with long term anticonvulsants, it is unclear what the true endpoint of the seizure disorder is for most cases. Endpoint data, confused by many reports of patients who are seizure free at follow-up, neglect to mention whether or not phenobarbital has been continued. Longer term follow-up of more well-defined cases may be necessary to differentiate the usually benign outcome of this disorder from the occasional case destined to have neurologic sequelae.

**REFERENCES**

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Public Speaking: Pain or Power

In everyone's lifetime there will come a time when he or she is called to the microphone to "say a few words." Even those of us who had college speech courses can barely remember them. To avoid "microphobia" sweaty palms and quaking knees, these are a few points learned from personal experience and the expertise of the speech coaches provided at the AMA training sessions.

A speaker has far more contact with his audience when he can look at them without staring at a manuscript. If reading glasses are used they should be full-sized, not the half glasses through which the speaker peers out at the audience in a characterization of Mr. McGoo. Know the central idea you wish your listeners to come away with. If you can put this idea into one sentence, illustrate with stories and examples; you will crystallize your thinking for the audience. Relate to the everyday lives of your audience and address their interests and concerns. Use easily understood words. Don't use a "quarter" word when a five-cent one will do. Good speakers rehearse a speech many, many times Most use a tape recorder for timing and voice inflections and video taping for body language and posture. Watching yourself can allow you to be your own best critic. Speak in a normal tone. The old adage "when in doubt shout" is archaic and not applicable. The best speakers make their points by pausing or lowering their voices. Pauses emphasize the message and allow the audience time to absorb.

Be proud of what you are, including a regional dialect. You cannot change what you are. Use first-hand experiences, and feel free to make yourself the butt of your own jokes. Candor can be very disarming. Dark colors are less distracting and give an impression of power.

Female speakers should stay away from prints, stripes and plaids that are distracting to the eye. Dangling jewelry that makes noise at the microphone is taboo. People who believe strongly in what they are saying can obtain great power by the force of the conviction delivered at the podium.
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Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overshoot. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, sinoatrial conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metabolite and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents.

Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neuropathy), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (beat-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a somaticogenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

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Enthusiasm
If It Ain’t Broke, Break It

Most Americans, I believe, are behind President Clinton’s efforts to reduce the national deficit and debt, both of which have quadrupled since the presidency of Jimmy Carter.

It is not arguable that we have acted imprudently in selling our future to foreign investors, the purchasers of our Niagara of red ink. That $4 trillion debt is the result of a credit-card mentality shared by recent Presidents and members of Congress alike, Democrats and Republicans. They willingly embraced the wish-fulfillment fantasy that the deficit would magically disappear if we ignored it for a few years.

Otherwise reasonably savvy politicians convinced themselves that they could put off—forever trying to reconcile the mutually exclusive demands of the public: more of everything and lower taxes. The chickens born of that curious notion are now at roost on both ends of Pennsylvania Avenue.

Enter Mr. Clinton at full gallop. While portions of what is known thus far of his program are healthy and overdue, he is exploiting the national sense of emergency by overreaching. In so doing he is reverting to an old Democratic compulsion: If it ain’t broke, break it.

In the very extravagance of his blueprint there is another disquieting element too often seen in individual Americans mired in debt. According to that new American occupation of “debt counsellors,” these citizens try to spend themselves out of debt. They consolidate obligations here and there, add more loans to the mass and, sustained by the relief from immediate insolvency, they go on another spending spree.

It is a pathological condition that can only be remedied by an austere budget that leaves the victim on a bare subsistence income. All discretionary spending on luxuries is taboo for the duration.

Now some of Mr. Clinton’s grand social programs, while dear to his heart and to Hillary’s, are also luxuries in the context of the times. If we could afford them, fine. But while we are strapped with old debt, any thought of buying some of those shiny new gadgets may have to wait until we see how well we manage paying off the mortgage on the old homestead.

Mr. Clinton’s call for sacrifice is credible only to the extent of redeeming our lost status in the family of nations, having sunk from the world’s greatest creditor nation to the greatest debtor nation in less than a generation. Americans plainly want that redemption and the polls say they will take a fair hit to pay for it. But the same polls say Mr. Clinton has nowhere near the support for his proposals to expand domestic spending, however worthy the objectives. Like most politicians, he is all too eager to festoon his place in the history books by his good works.

But the American people may ask that he sacrifice something too — a major portion of his grandiose aspirations.

What the President is attempting to do, taking one idea with another, is to combine the sacrificial gloom & doom message of Paul Tsongas in last year’s primaries (when, incidentally, Mr. Clinton ridiculed the very message he now embraces) with the expansive social experiments of Lyndon Johnson’s Great Society and Franklin Roosevelt’s New Deal.

Mr. Clinton is a well-educated and plainly dedicated man but he may be seeking more personal glory than the country can afford at this perilous juncture. In a booming economy with full employment and
chart-busting prosperity we might be more inclined to indulge his taste for luxury, but until such a time returns he may have to make do with such renown as attends national economic recovery.

That should be more than enough for one president to achieve. If he makes a solid beginning on that essential project, the country may extend his contract for four years and possibly then grant him permission to try some of his social worker ideas.

Some years ago, the General Accounting Office did a comprehensive survey on rural health clinics and the public's sense of entitlement regarding them. In a surprisingly trenchant report, GOA said Americans have trouble distinguishing between needs and wants. True, and the same observation might be made of Mr. Clinton.

As the year progresses, we hope to see Congress making that distinction for him in all matters, specifically including the as yet unveiled Bill & Hillary health reform plan. If they try to requisition a Rolls Royce, we trust the mechanics in Congress will decide that a Ford Escort will do just fine for starters.

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A Perilous Year

I don’t have the demographics before me, but if memory serves, about two-thirds of Alabama’s population lives in the northern one-third of the state’s land mass.

It follows from this that there should be a similarly disproportionate concentration of interest in medical affairs in that region. Unfortunately, this cannot be proven by the attendance of MASA counsellors and delegates from portions of that area at recent annual sessions of the Association.

To cite one glaring example: year after year the faithful Mobile County delegation has established an attendance record eclipsing that of my own Jefferson County delegation. I have heard various excuses, none of them very persuasive.

Most physicians, I know, resent being told something is their duty. They regard such injunctions as patronizing. Therefore, I’ll make my pitch to my colleagues on a different plane — your own self-interest. If there ever was a year when physicians from Maine to Southern California should close ranks in a mighty expeditionary force, 1993 is that year. A political juggernaut is bearing down on us at warp speed.

We all treasure our rare free time. The business of organized medicine subtracts from that. But the survival of our profession and the unequalled achievements of the vineyards in which we toil are on the block. Even as you read this, literally thousands of minds are at work on reducing American health care to lowest common denominators, intent on exchanging expediency for excellence.

Whatever happens this year, we will not survive unscathed. I think we all accept that. Thus the role of organized medicine at all levels all across the land is damage control.

It is only through such gatherings as that scheduled for Birmingham April 16-18 that all the elements of our profession can piece together their concepts of acceptable and unacceptable losses. The health care cost/benefit ratio is going to be altered; our job is to deflect, when we can, the more reckless tiltings of patient care.

We pride ourselves in being patient advocates. But most patients know less about the delicate balances in our health care system than they know about disease processes. It is our professional job to be their advocates in the turmoil and confusion of this massive attempt to reverse-engineer that system.

Reverse engineering, as you may know, is the term given to the practice of taking a fine product and constructing it cheaper. We all know there are economies to be made in medicine, but we also know that most of those who will try to reshape the system more to their heart’s desire have no real grasp of what is vital and what is expendable. We have already seen microcosmic examples of that danger in some of the mismanaged care enterprises wherein less is always more, cheaper is always better.

There is a dangerous and persuasive mindset abroad in the land that almost anybody with a little knowledge and some clever software can dictate medical care. For a decade, Fortune magazine commented recently, it was an article of faith in the American business community that a good manager could manage any kind of endeavor without knowing the first thing about the product or its production. The major
business schools propagated this costly nonsense.

This folly, Fortune said, has been demonstrated to have been one of the nation’s costliest mistakes in world market competition. In Germany, Japan, Britain and the rest of the industrialized nations, managers are, first and last, finished experts in what they produce. BMW doesn’t hire hotshot lingerie plant managers to take over one of their assemblies; they hire, and further train, experts in the building of fine cars.

And so it goes throughout the best industries in Europe and Asia: thus who manage must first be experts in what they produce. BMW doesn’t hire hotshot lingerie plant managers to take over one of their assemblies; they hire, and further train, experts in the building of fine cars.

And so it goes throughout the best industries in Europe and Asia: thus who manage must first be experts in what they produce. BMW doesn’t hire hotshot lingerie plant managers to take over one of their assemblies; they hire, and further train, experts in the building of fine cars.

Physicians are the experts in medicine. But all experts must get together frequently to share and exchange what they have learned. All advanced human knowledge — certainly this applies to medicine — is a mosaic of individual contributions over time. The entire history of our art and science is of such accretions — a piece of the puzzle here, another there.

We need each other’s wisdom here in 1993 more than ever before in the long march of American medicine. Our patients, oblivious perhaps to the frenzied efforts of those who would compromise their interests and their welfare, need our collective strength and knowledge more than ever before.

I am not suggesting you will get all the answers at annual session in Birmingham in April. But you may learn some of the questions. And these will guide your thinking and that of your colleagues through this perilous year of decision-making.

That’s not a stick but a carrot.
Addressing the Hospital Impaired Physicians Committee

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Pink L. Folmar, M.D.**

Twenty years ago the AMA published a landmark article, "The Sick Physician," which emphasized the idea that chemical dependency as well as emotional or psychiatric disease may affect a physician's ability to practice medicine. Furthermore, the article pointed out that treatment of these impaired physicians could result in their rehabilitation.

The Alabama Board of Medical Examiners works together with the Medical Association of the State of Alabama in helping to protect the public and assure that sick physicians get the treatment they need. The program they have developed is designed to do the following: 1) assure confidentiality, anonymity, and immunity for concerned referral sources; 2) promote early evaluation of impaired physicians; 3) reduce the potential for professional liability; and 4) protect the sick physician from the public arena.

During the past decade, hospitals have become increasingly aware of corporate liability. Hospitals are being held accountable more and more for what their practitioners are doing within their walls. When hospitals have failed to provide an adequate system for identifying and monitoring the sick physician, the potential for liability is dramatically increased. An Alabama supreme court decision has demonstrated that liability. The Joint Commission on Accreditation of Health Care Organizations suggests that hospitals provide reasonable policies to identify and monitor physicians who have had alcohol, drug, or psychiatric problems.

Fifteen percent (15%) of physicians will develop an illness leading to impairment of medical practice at some time in their professional career. Early recognition, intervention, evaluation, and treatment of impaired physicians is in the best interest of the patient and the sick physician, not to mention the risk management position of the hospital. Disciplinary or punitive policies within the hospital do not help the sick physician. A punitive attitude is not humane to our colleagues. Punitive attitudes reinforce the conspiracy of silence and keep the problem underground. Hospitals who allege that they “never have a problem” usually have a written or non-written policy reflecting a punitive attitude.

Hospital-based impaired physicians committees, perhaps more appropriately referred to as the Medical Staff Health Committee (MSHC), can be a vital link to protecting the public and assuring help for the sick physician. When gross impairment in performance is present in the hospital setting, there is usually advanced disease. Earlier detection of illness, which may progress to impairment, is paramount. Co-workers and colleagues are the first to notice a change in behavior needing attention. These co-workers are more likely to call on an in-house group for assistance than an outside group. They are also more likely to refer a sick colleague to a committee that is confidential and one that does not suggest a potential for disciplinary action.

A hospital needs clear guidelines and procedures for receiving information, investigating its accuracy, and initiating action concerning impairment among the medical staff. An impaired physician committee (MSHC) should be established by the medical staff bylaws which set forth purpose and goals of the committee. Because of changing dynamics in the hospital-physician relationship, it is vital that physicians play an active part in developing the policies and procedures for the committee. Explanations voiced by

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administrative officials or hospital counsel in the minutes of meetings may not be enough. Establishing an MSHC within the hospital and medical staff organization for confidential, supportive, and early intervention in the disability process may avoid the need for more drastic disciplinary action later. Furthermore, informal committees within a hospital do not have the capabilities for strong advocacy. A well organized, formal committee within the hospital enables hospitals to address the problem and become a part of the solution.

The goals of such a committee should be: a) protection of the patient, b) advocacy for impaired physicians, and c) education of the hospital medical staff. Establishing the committee within the hospital staff bylaws should include the following key concepts.

Confidentiality should be available to all physician participants except those who are not compliant. In this way, physicians will tend to take advantage of such a committee if it represents a non-disciplinary avenue for assistance. The administration does not need to know the names of the physician participants involved with the committee unless they are non-compliant, a danger to patients, have broken federal or state law, or represent a distinct liability to the hospital. On the other hand, if a program does not report a physician who is non-compliant, then it may allow the impairment process to get worse.

The involvement of the Medical Association of the State of Alabama’s Impaired Physicians Program, the Physicians Recovery Network (PRN), is important for several reasons. By involving PRN, confidentiality is assured and conflict of interest is avoided. PRN can advocate for physicians to the hospital credentialing committees, insurance companies, and the Alabama Board of Medical Examiners. In-hospital interventions by inexperienced individuals frequently fail. The last thing local hospital committees need to be dealing with is a difficult case without the support of the Medical Association’s program.

Non-coercive measures, when presented in a concerned, caring manner, usually are effective to encourage cooperation. Coercion through exposure to a regulatory board is entertained as a last resort measure. The experience of PRN can be utilized to avoid a claim of liability by the physician due to violation of due process for an unreasonable restriction of hospital staff privileges, defamation, or interference with business relationships. PRN’s confidential files are protected from discovery thus avoiding exposure to the public media.

Referring to PRN any information on any physician or osteopath practicing in a manner to endanger the health of patients satisfies Alabama law (§§ 34-24-36 and 34-24-34) requiring physicians to report such information. Referring to PRN also satisfies the requirement of Alabama law (§ 34-24-59) for the chief administration of the hospital to report physicians involved with impairment in medical performance.

Committee membership should include those physicians who are interested in the problem. There should be no fewer than three members of the active medical staff with terms as deemed appropriate by the medical staff executive committee. A physician-only membership enhances the feature of confidentiality. There should be a mix of ages and gender on the committee. It is advisable that a member not be serving concurrently on either quality assurance or peer review committees as this reflects a potential disciplinary action. Often, physicians who have a proven record of recovery from addiction or psychiatric illness are the most effective members of the committee. Presence of hospital administration on the committee suggests the presence of an authority figure which discourages referral.

Committee activities should include receiving referrals, discreet investigation respecting the anonymity of the physicians involved, and contact with the PRN. Involvement with the PRN early in the process ensures an unbiased investigation. It also offers a competent intervention, recommendations for evaluation and/or treatment, and aftercare monitoring. The committee activities also involve establishing treatment agreements, assisting PRN in conducting urine drug screens, serving as a support group for the recovering physician, and, in consultation with PRN, reporting non-compliant cases to appropriate authorities. The committee needs to educate the medical staff about its existence, the early signs of impairment, and available resources for treatment and support obtainable for both physicians and families.

The committee members need only to perform committee work. They do not diagnose or make treatment recommendations. The committee serves as a conduit for evaluations performed by an outside approved treatment provider. When the sick physician is resistant to suggestions for evaluation and/or treatment, it is essential to have documentation from a professional who is experienced in the area of impairment. The PRN will arrange for this professional expertise. It is important that the committee not attempt to wear “two hats.”

Record keeping is a sensitive issue for the MSHC. It is often suggested that the committee have regular
meetings at approximately quarterly intervals and to keep minutes at the meeting without recording names. Some committees use code numbers. All records are to be kept confidential. PRN files are confidential through state statute. Documentation kept in the records include evaluation and treatment reports, monitoring contracts, results of urine drug screens and any written material related to the case. These records are protected by the federal confidential guidelines that apply to alcohol/drug abuse programs. Retention of an ongoing case record detailing the individual process is important for documentation. Advocacy for recovery through letters of support from the committee and the PRN will need to be available for future use.

Flow of information should be a discreet, confidential and organized network with interaction among the MSHC, the PRN and the hospital. This assures success of the program. The initial referring source contacts a member of the MSHC or the PRN. The data is reviewed and additional information collected if necessary. Together the MSHC and PRN decide who will be involved in contacting the physician. PRN will take responsibility for assessment, intervention and recommendation for evaluation by an approved treatment provider.

After assessment and/or treatment has been completed and recommendations made, a PRN advocacy contract (agreement) is developed in addition to a MSHC agreement. The MSHC designates a physician monitor within the hospital. Both the MSHC and PRN monitor compliance. As long as the physician is compliant with the advocacy contracts, neither the hospital administration nor the regulatory board need to be involved. Monitoring records are available to provide advocacy to the credentials committee of the hospital, insurance companies, and if necessary, to the Alabama Board of Medical Examiners. Involvement of the PRN in the process relieves the MSHC of the potential for physician-peer conflict.

The MSHC jurisdiction may include physicians, dentists, oral surgeons, certified nurse anesthetists, or other allied health professionals who work within the hospital. The committee is not a panacea. Some problems persist. Someone has to care enough to take the initiative to refer the physician to the MSHC or PRN. Sick doctors rarely spontaneously reach out for help. There are some personal and emotional risks for the referring physician. The MSHC policies and procedures attempt to minimize these risks. Doing nothing for the impaired physician is associated with real consequences — patient injury, physical and mental health, hospital and medical liability, even death of the physician through suicide or overdose.

The Physicians Recovery Network has coordinated efforts with hospitals and reviewed the literature on hospital impaired physician committees to develop the following model policy statement concerning physician impairment. The statement may be modified for any individual health care organization. It is hoped that this generic model will be useful in developing an impairment policy in your organization.

**Mutual Obligations**

All employees and medical staff members are strongly encouraged to express concern about an impaired physician and to make a confidential referral by contacting the Medical Staff Health Committee in the hospital and/or by contacting the Physicians Recovery Network (PRN) of the Medical Association of the State of Alabama, 1-800-239-6272 or (205) 2612044.

**Policy**

The term "impaired professional" is used to describe the practitioner who may be prevented by reasons of illness or other health problems from performing professional duties at the expected level of skill and competency. In some contexts, impairment also implies a decreased ability and/or willingness on the part of the affected individual to acknowledge the problem or to seek help to recover. Clearly, such a situation places the professional at risk, and may pose an actual or potential risk to public health and safety.

The medical staff and administration of (insert health care organization's name) believe that the conditions of impairment are often treatable illnesses and that the focus of an impairment program is to help potentially impaired health practitioners identify any impairing condition that might exist, receive rehabilitative services, and return to or remain in active work status (Insert name) has formed a Medical Staff Health Committee (MSHC) to coordinate the assistance provided to impaired professionals. The Medical Staff Health Committee is composed of (insert number, usually 3-5) members of the active medical staff. These physicians are experienced and interested in dealing with issues of professional impairment.

**Procedure**

It is the policy of (insert name) that referrals of impaired physicians be made to the Medical Staff
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Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions. PRECAUTIONS: Special Risk Patients: VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison’s disease, prostatic hypertrophy or urethral stricture. Cough Reflex: Hydrocodone suppresses the cough reflex, as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease. Drug Interactions: Patients receiving other narcotic analgesics, antipsychotics, antidepressants, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressants or hydrocodone. The concurrent use of antihistamines with hydrocodone may produce paralytic ileus. Usage in Pregnancy: Teratogenic Effects: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well controlled studies in pregnant women. VICODIN/VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Nonteratogenic Effects: Rubes born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stool, sneezing, yawning, vomiting, and fever. Labor and Delivery: Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used. Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. Pediatric Use: Safety and effectiveness in children have not been established. ADVERSE REACTIONS: The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects may be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated by the patient lying down. Other adverse reactions include: Central Nervous System: Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, depression, psychic and mood changes. Gastrointestinal System: The anticholinergic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above). However, some phenothiazine derivatives may be antianorectic and to increase the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation. Genitourinary System: Urinary spasm, spasm of vesical sphincters and urinary retention have been reported. Respiratory Depression: Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythms, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated. DRUG ABUSE AND DEPENDENCE: VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule II). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics. Therefore, VICODIN/VICODIN ES Tablets should be prescribed and administered with caution. OVERDOSAGE: Acetaminophen Signs and Symptoms: In acute acetaminophen overdosage, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemia, coma, and thrombocytopenia may also occur. Early symptoms following a potentially lethal overdosage may include nausea, vomiting, diaphoresis, and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post ingestion. Hydrocodone Signs and Symptoms: Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and tidal volume), Cheyne-Stokes respiration, cyanosis, extreme somnolence progressing to stupor or coma, skeletal muscle fasciculations, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.
Recovery

The Medical Staff Health Committee, in conjunction with the Physicians Recovery Network, will arrange for assessment, treatment, support, and monitoring to facilitate recovery and appropriate return to work.

Cases referred to the Medical Staff Health Committee will be handled in the following manner.

1. The committee may ask the referral source to have others who may have relevant information confidentially contact a member of the committee. The committee does not conduct formal investigations, but rather serves as the recipient of information from concerned colleagues and other sources.

2. It is the policy of the Medical Staff Health Committee not to disclose the source of referrals to the physician in question.

3. The Medical Staff Health Committee will collect whatever information is readily available concerning the problem and will contact the Physicians Recovery Network of the Medical Association of the State of Alabama.

4. The Medical Staff Health Committee, where appropriate, may do the following:
   a. Encourage the physician to seek assessment and/or treatment services in conjunction with the Physicians Recovery Network.
   b. Contact the appropriate department chairperson and the president of the medical staff if the impaired practitioner has entered into a recovery agreement with the Physicians Recovery Network and the committee. Notification is also given if the committee has failed to successfully engage the medical staff member in an appropriate assessment/treatment/recovery program, and the committee believes that an impairment exists.
   c. Maintain and document the physician’s cooperation with treatment and recovery activities in conjunction with the Physicians Recovery Network.
   d. Make efforts to assist the physician to continue in his or her professional duties to the extent that the practitioner is considered able to do so by the committee and the Physicians Recovery Network.
   e. Write an agreement for monitored recovery which refers to the Physicians Recovery Network agreement. This agreement requires continued compliance with the Physicians Recovery Network agreement.

5. The Medical Staff Health Committee will be responsible for monitoring the effectiveness of the impaired physician’s treatment plan in conjunction with the monitoring services of the Physicians Recovery Network. When the Medical Staff Health Committee considers the physician to be able to re-enter practice and knows the physician is enrolled and actively participating in the Physicians Recovery Network’s monitored recovery plan, appropriate medical staff individuals may be informed.

If the physician is unable to demonstrate involvement in a recovery process, or violates the agreement with the Physicians Recovery Network or with the hospital, the committee will so notify the department chairperson who will refer the case to the Medical Executive Committee for formal action in accordance with the medical staff bylaws. Having done so, the committee will remain available to assist in a recovery plan if the physician agrees to participate. Any further action against the physician will be the responsibility of the Medical Executive Committee in accordance with the medical staff bylaws.

References

6. Reed, T.J. “Economic Credentialing, Contracting and Medical Staff Bylaws: Hospital-M.D. Conflicts in the 90’s.” Address to the AMA, Hospital Medical Staff Section, Chicago, Illinois, June 19, 1992.
Physical Activity and Fitness Assessment in Clinical Practice

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Abstract
The health benefits of regular participation in moderate to vigorous physical activity are well established yet 40-60% of the US population remain sedentary. The growing need to address this issue by physicians is becoming more important in light of the fact that lifestyle changes that promote reduced risk have a greater potential for reducing the national death rate from Coronary Heart Disease (CHD) than medical interventions and that most patients view physicians as respected sources for prevention as well as medicinal therapy. In order to assess practice behaviors and knowledge related to physical activity and fitness assessments, 1600 members of the Medical Association of the State of Alabama were surveyed. The results demonstrated that during a health visit only 25% of the physicians recorded a detailed history of physical activity and only 7% conducted a fitness test. The collection of a detailed history of physical activity and performance of an objective exercise test increased to 59% and 23% respectively during the performance of a CHD risk assessment. Whereas 50% of the physicians used the information to make recommendations to increase the duration or amount of physical activities routinely performed by the patient, only 30% of the respondents provided their patients with an exercise prescription that included intensity, duration and frequency on an activity. Thirty seven percent referred patients to another health professional for the development of exercise guidelines. The most frequently listed barriers cited in preventing them from obtaining physical fitness data in their office were lack of physician time (78), lack of staff time and lack of equipment (75%) followed by lack of physician training and trained staff at 68 and 71% respectively. This survey suggest that if an improvement in cardiovascular risk factors through increased exercise is going to be met as specified in Healthy People 2000 as well as Healthy Alabama 2000, there is a need for increasing the awareness level, training of physicians to incorporate such evaluations into their routine practices.

Introduction
Today cardiovascular disease remains one of the major causes of death in the United States. In 1990 more than 934,300 Americans died from cardiovascular disease which is more than died from all the wars during the last century.1 More than half (55%) of the deaths were due to coronary heart disease (CHD), with approximately 45% of the deaths occurring in persons younger than 65 years.2 In 1989, 7000 Alabamians died of ischemic heart disease.3

Whereas considerable interest has been focused on the established associations between elevated serum cholesterol levels cigarette smoking, elevated blood pressure and the increased risk of heart disease, less than admirable attention has been given to the role of physical activity in reducing risk of heart disease. This is in spite of mounting evidence supporting the health benefits of regular participation in moderate to vigorous physical activity.

In a recent report from the Centers for Disease Control (CDC),4 sedentary life style was reported to be the most prevalent modifiable risk factor for CHD (58%) followed by cigarette smoking (25%), and
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hypertension (17%). Investigators have reported that the relative risk of sedentary persons dying of CHD is approximately twice as likely as physically active persons.\textsuperscript{4,5,6} Based on these probabilities and using data recorded in 1987 that reported that almost 58% of Alabamians lead a sedentary lifestyle,\textsuperscript{7} it is estimated that approximately 34% persons dying from coronary heart disease in Alabama in that single year could have been attributed to a sedentary lifestyle. Arroll and Beaglehole\textsuperscript{8} has suggested that a potential decrease of approximately 40% in CHD mortality could be obtained if regular physical activity was adopted by the whole population.\textsuperscript{8} Not only is exercise attractive to reduce overall mortality, but the literature indicates that the external cost (costs borne by others) to the public due to lack of physical activity would be improved by an improvement in fitness. Using data from the National Health Interview Survey and the RAND Health Insurance Experiment, Keeler et al\textsuperscript{9} estimates that the lifetime subsidy from others to those who adopt a sedentary life style is $1900.

It is unfortunate that few Americans participate in regular physical activity despite the potential benefits. Less than 10% of the U.S. adult population exercise at the minimal level recommended (20 minutes or longer, 3 or more days a week at an intensity of 60% or greater of cardiorespiratory capacity) for enhancing physical fitness. More alarming is the fact that today less than 50% of the adult population exercises 3 or more days per week for 20 minutes or longer regardless of intensity.

### Risk Factor Assessment

<table>
<thead>
<tr>
<th></th>
<th>Blood pressure, height, weight</th>
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<tbody>
<tr>
<td></td>
<td>Family history of heart disease</td>
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<td></td>
<td>Family history of hypercholesterolemia</td>
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<td></td>
<td>Total cholesterol</td>
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<td></td>
<td>Detailed history of physical activity</td>
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<td>Fitness test</td>
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![Figure 1](image) Percentage Physicians Responding

Figure 1. Percentage of physicians performing risk factor assessments on 50% or more of patients during health evaluations.
Since a sedentary life-style is the most prevalent and modifiable cardiac risk factor, and given the impact that exercise can have on disease progression, from a optimal health perspective, increasing physical activity seems to be the most advantageous modification that Americans can make in risk reduction and enhancing their overall health.11,12

Although improvement in fitness may be only one component of cardiovascular disease prevention, increased physical activity has been shown to have beneficial effects on several other risk factors that have been targeted for action as well by the Public Health Service by the year 2000 including obesity, cigarette smoking, elevated blood cholesterol and hypertension. Because the reduction of the risk for cardiovascular disease can have such a potentially significant impact on the health of America and Alabama, an improvement in cardiovascular risk factors through increased exercise is specified as a major objective in the health promotion priority area of the Healthy People 2000, the U.S. Department of Health through health promotion and disease prevention12 as well as Healthy Alabama 2000, Alabama’s health promotion /disease prevention guidelines document.11

Presently recommendations for a comprehensive evaluation of fitness and physical activity patterns, with guidelines for exercises and protocols for counselling have not been established for Alabama. Before these can be developed there is a need to determine the present level of awareness, practices and need for training by Alabama physicians. The purpose of this survey was to assess practice behaviors related to

### CHD Risk Factor Assessment

<table>
<thead>
<tr>
<th>Blood Pressure</th>
<th>Weight</th>
<th>Total Cholesterol</th>
<th>Family History of CHD</th>
<th>Smoking History</th>
<th>Lipid Profile</th>
<th>EKG</th>
<th>Detailed Physical Activity History</th>
<th>Chest X-Ray</th>
<th>Diet History</th>
<th>Fitness Test</th>
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Figure 2. Percentage of physicians performing risk factor assessments on 50% or more of patients during a coronary heart/artery evaluation.
physical fitness assessments by Alabama physicians with these questions in mind.

**Methods**

During the winter of 1992 a three-page 16-question physical fitness and activity questionnaire was mailed to all (1600) Internist and family practitioners who were recorded as members of the Medical Association of the State of Alabama. The questions were designed to elicit information on the practice behaviors, attitudes and needs related to the assessment of physical activity patterns and physical fitness of their patients. All questions were formatted for either a “yes/no” or “multipl-choice” response. Multiple-choice responses based on the percentage of patients on which an action was performed were arranged into five categories: 0%, 1-25%, 26-50%, 51-75% and 76-100%. Questions were pretested with a group of physicians to establish clarity, sensitivity, and specificity. None of the physicians participating in the development of the survey tool or the evaluation were included in the data analysis.

**Results**

Three hundred thirty one of the questionnaires were returned completed within 30 days of the mailing for a response rate of 20%. Forty eight percent of the responses were received from internist and 53% from family practitioners. The final tabulation had the following characteristics: men, 85%; mean age 46.1 years; average time in practice 16.3 years. Forty one percent of the respondents participated in a group practice with two or more practitioners. Thirty six percent of the practitioners had solo practices while

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**Method of Determination of Fitness**

<table>
<thead>
<tr>
<th>General appearance and weight</th>
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<tbody>
<tr>
<td>General activity history</td>
</tr>
<tr>
<td>Running in place</td>
</tr>
<tr>
<td>Step test</td>
</tr>
<tr>
<td>Bicycle ergometer, step test</td>
</tr>
</tbody>
</table>

![Figure 3. Percentage of physicians utilizing various means of determining physical fitness.](image)
12% worked at a university medical center. Less than 1% worked for a public health clinic or a health maintenance organization. Seven percent did not specify their type of practice. Fifty one percent of the respondents reported a daily average daily patient census of 25 or less patients. Forty four percent reported attending 26-50 patients each day while less than 5% attended more than 50 patients each day.

Figure 1 conveys that during a health visit only 25% of the physicians recorded a detailed history of physical activity and only 7% conducted a fitness test on 50% or more of their patients. The more conventional type of data collected during a health visit in 50% or more of their patients was blood pressure (93%), height (93%), weight (93%) and some form of history of heart disease (78%) or family history of hypercholesterolemia (64%) and total measurement of cholesterol (65%).

These values remained the same or increased slightly when the physicians performed a coronary heart disease risk assessment as shown in Figure 2. In addition to factors routinely collected during a health visit, the collection of a detailed history of physical activity and performance of an objective exercise test increased to 59% and 23% respectively. Figure 3 indicates that the preferred means of conducting an objective fitness test during a CHD risk assessment visit was the treadmill (72%) followed by running in place (37%). The step test (14%) and bicycle and field test (12%) were the least preferred methods.

Figure 4 presents what physicians did with the information they obtained relative to physical fitness. Fifty three percent of respondents limited the use of the information to recording it in their medical

**Utilization of Fitness Data**

- Record, compare at future visits
- Recommend increase in activities
- Give detailed exercise Rx

**Figure 4. Utilization of fitness data by physicians that perform fitness assessments.**
records to use for future comparisons. Fifty percent of the physicians used the information to make recommendations to increase the duration or amount of physical activities routinely performed by the patient. Thirty seven percent referred patients to another health professional for the development of exercise guidelines. Only 30% of the respondents themselves provided their patients with an exercise prescription that included intensity, duration and frequency on an activity to enable them to improve their fitness level.

Figure 5 lists a number of barriers the physicians believed were “important” in preventing them from obtaining physical fitness data in their office. The three most frequently listed barriers cited were lack of physician time (78.2%), lack of staff time (75.5%) and lack of equipment (74.6%). Lack of physician training and lack of trained staff were listed almost as frequently at 68 and 71% respectively.

**Discussion**

Lack of sufficient physical activity not only results in a decrease in quality of life but an increased risk of developing CHD as well. Goldman has suggested that lifestyle changes that promote reduced risk have the greatest potential for reducing the national death rate from CHD, 15 to 20% better than medical interventions. Therefore it would seem that physical fitness assessment would be a valuable adjunct to the routine clinical examination by internist and family physicians. This becomes especially important in

**Barriers to Fitness Assessment**

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Percentage Physicians Responding</th>
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<tbody>
<tr>
<td>Physician Time</td>
<td></td>
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<tr>
<td>Equipment</td>
<td></td>
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<tr>
<td>Staff Time</td>
<td></td>
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<tr>
<td>Clinical Space</td>
<td></td>
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<tr>
<td>Physician Training</td>
<td></td>
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<tr>
<td>Trained Personnel</td>
<td></td>
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<tr>
<td>Medical Justification</td>
<td></td>
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<tr>
<td>Insufficient Reimbursement</td>
<td></td>
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<tr>
<td>Patient Compliance</td>
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Figure 5. Percentage of physicians identifying various barriers to determining physical fitness.

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light of the observation that more than 400 million visits to primary care physicians are made annually.\(^{18}\) Over 90\% of adults see a primary care physician every 5 years and over 75\% visit annually.\(^ {19}\) Most patients view physicians as respected sources for prevention as well as medicinal therapy\(^ {20}\) and 85\% of adults indicate that a physician’s recommendation would encourage them to increase their exercise level.\(^ {21}\)

The results of this survey indicate that only 7\% of the respondents completed any type of objective physical fitness testing as part of a health visit (Figure 1) and only 23\% during a CHD assessment (Figure 2). Additionally it was noted that most of the physicians depended on observations of their patients at rest instead of completing dynamic tests to assess physical fitness.

A important discovery made from this study was that even in those instances where fitness data was objectively collected, very little was done with this information. This is probably a reflection of lack of training. Most physicians reported they did not receive training relevant to exercise physiology during their medical education. Eighty five percent indicated that they have never taken an exercise course (either undergraduate or medical school) in which exercise principles were taught. Whereas lack of training was listed as a significant barrier at the present time to obtaining objective fitness data (Figure 4), 92\% were interested in receiving additional continuing education in exercise development in order to incorporate these concepts into their practice. This positive attitude is supported by the response that 53\% indicate that they have a personal exercise program in which they exercise at least 3 times per week for a minimal of 20 minutes.

These results make in clear that the current challenge is to effectively target sedentary life style in an attempt to reduce the risk of CHD and other chronic diseases associated with physical inactivity. Physicians have a key role to play in using their influence to promote exercise in their clinical practice. In order to do this, additional training and continuing education must be provided if this goal is to be reached.

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1) Mead W. Is exercise tolerance testing indicated for diagnoses and/or screening in family practice. J Fam Practice 28:473-480, 1989
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Paradise or Paradox —
A Study in Contrasts

Arthur A. Stamler, M.D.

There is little argument what loving parents everywhere want for their children — a proper education, a secure future, a loving environment. And good health, physically and mentally. Especially that.

But what happens when the system goes wrong? Especially in a developing nation. In a nation like Guatemala, for example. What happens to the Guatemalan children, who have just as much right to an education, and health and a good future as children anywhere? What do they want to be when they grow up? Alive, certainly. But more than that, an even break with all children, everywhere.

Guatemala is a Central American nation of some 8.5 million people, 80% of whom live in poverty. It is about as big as Alabama south of Birmingham. There is only one doctor for every 2600 inhabitants, only 15% of the population has a reasonable access to health care, and 40% of the children die before age 5. Most of the children have never seen a doctor; almost 2.3 million of them don’t go to school.

Since 1977, an organization called Casa Guatemala has provided a home base for malnourished, abandoned and abused infants and children in two facilities. One, in Guatemala City, provides administration, an outpatient clinic, a nursery for newborns, and associated services for those under age two. From here, some of the more desperately ill children are sent to the US for specialized medical and surgical care which may be unavailable in Guatemala. The US program has treated nearly 300 children; in addition, volunteer physicians from the US have cared for more than 3000 youngsters and have performed over 160 plastic reconstructive procedures including cleft lip and palate, blepharoplasties, burn cicatrix releases and such. After age two, the children are sent to the farm program orphanage in the beautiful Rio Dulce rain forest region of eastern Guatemala.

In an effort to reduce infant mortality and malnutrition, a maternal-child health program has recently been initiated in cooperation with “World Share,” an international group. By 1992, over 3000 mothers in the city and rural areas benefited by being provided pre- and postnatal care, education, and nutrition.

Located on a river in the country’s eastern rain forests, the Rio Dulce (Sweet River) orphanage is home for about 100 children. Because they have been declared wards of the state by the Guatemalan courts, most of the children living at Rio Dulce cannot be adopted. Here the program strives to create a true community to provide the children with the training, education, love and guidance they need to become responsible and productive members of society.

The Rio Dulce orphanage is also an important asset for the area’s inhabitants, Kekchi Indians, who live in relative poverty and isolation. The center is the first school ever to serve the surrounding communities, and about 75 Kekchi children now attend classes there. With eight teachers and innovative educational methods, the school offers the children a full curriculum which includes English, the 3 Rs, athletics and vocational education. Knowledge of English is particularly valuable, for it expands considerably the opportunities for employment and an advanced education.

The orphanage provides all the area’s inhabitants with free medical services at its clinic, and the children receive a daily hot lunch. Some 50 families grind their corn at the orphanage’s mill, and many of them are also employed there.

The Rio Dulce farm operation is expanding, not only to make the orphanage self-sufficient in food, but to help teach the children sustainable agricultural techniques. The farm now has hundreds of banana and orange trees, pineapples, yuca, hydroponically-grown vegetables, chicken and hog production, a fishpond filled with hybrid African tilapia, and lumber production. A bakery is in construction to teach new skills and to provide bread. Vocational training also
includes typing, sewing and carpentry.

Where do these children come from? They’re abandoned in bus stations, on the streets, in hospitals by family who give wrong names and addresses and don’t return. They are orphans without relatives to provide ongoing care. They are the abused and neglected, the starving (kwashiorkor exists here); they are the trash children no one else wants. They are rescued, or they die.

An ad hoc committee has been formed to permit those with an interest in such matters to express themselves. Guatemala and Alabama have long had an active and productive relationship within an organization known as Partners of the Americas, dating from the time of President Kennedy’s administration. For this reason, your committee plans to begin its activities with that country, and to add more programs over time. A list, for example, is being prepared for those who may wish to contact organizations which will link volunteer physicians with overseas opportunities.

Physicians are being sought to provide medical care for the Casa Guatemala orphanage and the surrounding villages. Pediatricians, family practitioners, emergency room physicians and general internists are especially needed. Family members, especially those with teaching ability, nurses, foresters, nutrition specialists and farmers are also invited to participate. Room, board and laundry are provided; no stipend is furnished. Interested physicians and others may obtain additional information by writing to: Arthur A. Stamler, M.D., P.O. Box 489, Carrollton, AL 35447.

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Josiah Clark Nott and the Heroic Age of Alabama Medicine

John T. Morris, B.S., M.D.*

"Mrs. Gorgas, you have a fine healthy son. You can expect great things of him." Dr. Nott cut the umbilical cord October 3, 1854, and William Crawford Gorgas became the first born son of Captain Josiah and Amelia Gayle Gorgas, who had moved to Toulminville, Alabama to avoid a raging yellow fever epidemic in New Orleans. William C. Gorgas and Josiah C. Nott were to be joined by the tenuous cord of circumstance as principal actors in one of the most thrilling detective stories ever to adorn the annals of history and of medicine — the saga of yellow fever.

Dr. Nott had already done much of the ground work on yellow fever when he delivered baby Gorgas. Nott proved by clear logic and his knowledge of the diseases, that the doctrine of "Bad air" or "malaria" cannot explain the origin and spread of yellow fever or "intermittent fever" (malaria). That was the first step in unravelling the riddle. Nott had also postulated that the disease was caused by an "animalcule a million times smaller than any the microscope has yet reached... It is known, on the authority of Murchison and others, that the malignant pustule is taken by gnats from the animal and communicated to man by its bite. So there are many ways that diseases might be carried and communicated by insects."

A wag once said that Alabama was created from the undesirable portions of Mississippi and Georgia. The soil wasn't particularly fertile. Insects were everywhere, the native indians were hostile, the climate was too hot in summer and too cold in winter. At first, there was little disease, but as the white population increased, disease ran rampant. Alabama became a pest-hole. All this at a time when the best practice of medicine, even in the civilized areas of America, was at its worst. Most of the physicians practicing in rural Alabama were poorly trained. Some had no formal education, not even the equivalent of a high school education. They had only "read medicine" with a practicing physician and had passed an examination of sorts. In 1837, none of the medical practitioners in Bibb county had ever heard a medical lecture, and it was 1849 before a medical school graduate came to practice medicine there.

Quacks, Thompsonian herb healers, black faith healers and even some Indian medicine men, practiced healing on the poor afflicted settlers of Alabama. These practitioners often had better healing records than the regular physicians who believed the popular doctrine of the day, that all fevers were caused by miasma that arose from rotted animal and vegetable matter. The accepted medical practices were: 1. Venesection to rid the blood of the poison. 2. Purging with large doses of calomel to rid the gut of it and 3. Blistering to draw off the poison water in the body. Little wonder that some people preferred the Indian dance or the voodoo charm to the ministering of the legitimate doctors.

A French ship, the Pelican introduced yellow fever to Alabama in 1704, while Fort Louis de la Mobile was the Capitol of French Louisiana. The Pelican brought a cargo of supplies, colonists, soldiers, two lay nursing sisters in charge of 23 girls, who were to be married to colonists, already established. The ship had stopped in Havana, Cuba, where some passengers and crewmen contracted yellow fever. Half the crew, some passengers and thirty soldiers died very quickly. Subsequently epidemics occurred in Alabama practically every year for almost two centuries.

From 1763-1781 Mobile was under British rule. The British soldiers regarded Mobile as "the most unhealthy place in the world." Typhoid fever became endemic in Alabama. Intermittent fever (now known as malaria) was probably the most widespread and lethal of the fevers in early Alabama. Tuberculosis was common and, although it was a febrile condition many people believed to be hereditary. Dysentery, cholera, various pyogenic conditions, wreaked a heavy toll on the early settlers. Yet, the population of

*1316 Legion Drive, N.W., Cullman, AL 35055.
Mississippi, including Alabama was 10,000 in 1800, and the population of Alabama alone had grown to 127,901 by 1820, one year after she achieved statehood.

In this setting one wonders why any intelligent, fairly wealthy, well trained (for the times) doctors could be enticed to come to Alabama. But by the 1840s there were several well trained and highly motivated doctors there. Doctor Josiah Clark Nott was one of them. He came to Alabama in 1836 and began the practice of surgery in Mobile. Nott was successful. He soon gained the reputation of being the best surgeon in the Southern Gulf States. He could perform all the standard surgical procedures with more precision and dexterity and faster than any other Alabama surgeon. Without anaesthesia these assets were essential.

Josiah Clark Nott was born in Columbia, South Carolina, a university city and capital of the state, March 31, 1804, of a scholarly family. His father, the Honorable Abraham Nott, was a Judge in the appellate court and was elected to the United States Congress in 1800. Josiah’s mother’s maiden name was Mitchell. Josiah had three sisters and four brothers. At least three of the brothers gained some distinction: One brother, Professor Junius Nott, was a brilliant writer at the University of South Carolina. A second brother, Dr. Gustavus Adolphus Nott, was Professor of Anatomy at the Medical College of Louisiana (became the medical college of Tulane University 1884). He served as dean of that institution from 1849-1852. A third brother, James E. Nott, M.D., practiced medicine in Mobile.

Josiah Clark Nott graduated from South Carolina College in 1824 with an A.B. degree. In 1825-26 he attended lectures at the College of Physicians and Surgeons in New York. In 1827 he graduated from the University of Pennsylvania with an M.D. degree.

Josiah liked Philadelphia. Influenced by America’s premier scientist Benjamin Franklin, Philadelphia had become the most intellectual city in America. There the first chemical society in the world had been organized and The Philadelphia Academy of Natural Sciences was organized while Josiah lived there. These great organizations, and the scientific atmosphere they exuded, undoubtedly influenced young Nott’s scientific thought processes. He interned at the Philadelphia Alms House (Old Blockley) from September 1827 to September 1928. The next year he spent as a demonstrator of Anatomy at the University of Pennsylvania. He began practice in his home city, Columbia, South Carolina, in 1830 and in 1832, he married Sarah Chesnut Deas, the daughter of Colonel James S. Deas. Josiah and Sarah named their first-born son James Deas Nott after his grandfather.

After 1834, Josiah studied medicine and natural history in Europe, mostly in Paris, the Mecca of southern doctors. Among his teachers were: Charles Alexander Louis, a physician and authority on tuberculosis, and Antoine Louis, a surgeon and anatomist; and with Gabriel Andral, Chomel, Armand Troussseau and Alfred Armand Louis Marie Velpue. The northern American doctors usually studied in Edinburgh, where the instruction was as good (with their ready supply of hanged criminals for dissection). There they did not have to learn the language.

Upon returning from Europe in 1836, Dr. Nott moved to Mobile, Alabama, where he lived until 1861. The Notts had hardly settled in Mobile when that city experienced one of its worst yellow fever epidemics. Doctor Nott was not only an excellent surgeon. He had a thorough knowledge of anatomy, having taught it at the University of Pennsylvania, and had mastered the careful operative techniques of the French surgeons. He was a great humanitarian as well. “His manner was gentle and tender, and his assiduous attention to his patients endeared him to all who put themselves under his care.” (Dr. Anderson). He plunged into the disaster and became a great epidemiologist, one whose understanding and theories were far ahead of his time.

Noting that the black population of Mobile, while showing some immunity to intermittent fever, suffered as much from yellow fever as did the whites. Dr. Nott, with Dr. George A. Ketchum and Dr. William H. Anderson established a private infirmary for black patients of Mobile in 1848. It was called Dr. J.C. Nott’s Infirmary and was operated by these Doctors until after the War Between the States. A good doctor has but one grade of medical practice. It is certain that these great pioneer doctors treated their black patients with as much care and diligence as they did their white patients. The establishment of this infirmary was a pure humanitarian act. The doctors treated the free as well as the servant blacks. The owners of the latter gladly paid for their treatment.

During the five epidemics he worked through in Mobile, from 1837 to 1845, Dr. Nott made minute observations on individual cases, including autopsies on fourteen subjects. In the Journal of the Medical Sciences 1845, he published an article: “On the Pathology of Yellow Fever.” In a long and somewhat tedious article published in the New Orleans Medical and Surgical Journal, dated 1847 (but did not come
Dr. Nott published what would certainly be a classic if it had been read and understood by his contemporaries. Apparently the medical profession before 1850 was so embalmed by the “bad air” theory that they could only ridicule Doctor Nott’s clear reasoning.

He had found that yellow fever, while mimicking intermittent fever, favored cities and towns. The latter fever wreaked its misery and death among the settlers along river banks and swamps and in rural areas. Both diseases were usually contracted at night. The first frost usually ended any epidemic of both febrile illnesses.

Nott became absolutely convinced that the theory of miasma of bad air was untenable and must be abandoned. He writes, “The morbid cause of Yellow Fever is not amenable to any of the laws of gases, vapors, emanations &c., but has an inherent power of propagation, not dependent on the motions of the atmosphere, and which accords in many respects with the peculiar habits and instincts of insects.” A French writer, M. Chervin, had written extensively promoting the “malaria” theory. Nott attacked each of his postulates and spent many pages proving them wrong.

He proved beyond any doubt that Yellow Fever and...intermittent fever (malaria) were separate diseases; each was *suis generis*. Nott: “The island of Barbados, which is thoroughly drained — almost every foot of it in a high state of cultivation, is according to the authorities exempt from Intermitent Fevers. Intermittents once prevailed here extensively, but have been exterminated by drainage and cultivation.”

Dr. Nott was a social creature. His former associate, Dr. Wright, tells us that he was the charm of every circle that he entered. He was six feet tall and never weighed more than 140 pounds, but he held himself erect. Even in a group of learned men he stood out as a man of unusual character. Though he belonged to no organized church (because he could not understand the concept of The Trinity), he was really a religious man. In the words of Dr. Anderson:

“The Doctor showed by his life and actions, by his humanity, by his charity in word, thought and deed, that he believed in the broad principles inculcated by religion. There was no Christian virtue that he was wanting in . . .

“His own elegant and hospitable home entertained most of the distinguished who visited Mobile. Being a general scholar, there were few topics on which he could not converse, and as his manner was sprightly and his diction fluent and graceful, he was a most delightful companion. His natural disposition was gay and lively, and he always had a large fund of appropriate anecdotes suited to the circumstances. On occasions requiring gravity he could, however, assume a becoming dignity. At a public dinner he was the life of the company, but seldom had time for such entertainments. His chief relaxation was at home in the midst of his charming family.”

Using everything he knew about the epidemic and endemic diseases about Mobile, Dr. Nott had chosen a home site in the healthful pine hills, seven miles outside the main city of Mobile. Here the disease had never been, and there were few swamps in the vicinity. The Notts had eight children, one of whom died in infancy, while the family was on a European trip. On one occasion the doctor noticed several mosquitoes biting his sleeping children. The next day there was no sign of irritation on any of them. This was in 1856. Within one week four of his beautiful children died of yellow fever. In spite of this crushing shock the great doctor would allow himself little time to mourn. As soon as the last little one was laid to rest, Dr. Nott was once again in the saddle giving aid and comfort to the many other victims of the epidemic.

While Dr. Nott was unable to prevent his own children from contracting this formidable disease, he was willing to stay in town and risk his life working with the victims. Many citizens of Mobile would leave town when the yellow fever season arrived late summer or early fall.

In August 1839, a group of gentlemen met and founded the Can’t Get Away Club. This club would be better named the Won’t Get Away Club. John Hurtel was its first president. It was later incorporated by an act of the General Assembly, and approved by Governor John A. Winston February 1, 1854. The club assigned itself the tasks of remaining in town and aiding the helpless victims in any way possible. They would cook or bring food and cheer to the victims. They did nursing chores, bathed and held the patients’ hands at considerable risk to themselves. And in the end, the club would give Christian burial to the victim.

Dr. Nott was a versatile person. He made many contributions to the medical and surgical journals. He was the first to describe the condition of “coccygodynia,” and he performed the first coccyrectomy for the condition. During his academic training in Philadelphia and Paris, (and following the admonition of Alexander Pope: “The proper study of mankind is man”) Dr. Nott had made a thorough study of anthropology. He wrote many treatises on “ethnology.”
Among these works, his best known are: 1. *The Connection Between the Biblical and the Physical History of Man*. 2. *Physical History of the Jewish Race*, 1850. 3. *Indigenous Races of the Earth*, 1857 and *Types of Mankind*. This latter book was so popular that ten editions appeared in 1871, the year Darwin’s *Descent of Man* appeared. Today, many of Nott’s premises are rejected, but they established him as an expert in Europe, where scholars regarded him as America’s preeminent anthropologist.

Dr. Nott always seemed frail, but he lived plainly, he was abstemious of alcoholic beverages and heavy foods; he did not use tobacco in any form. During the great fever epidemics he would go for weeks and sometimes two to three months with little or no rest or sleep. Worn thin from his demanding practice in 1857 he answered the call from The University of Louisiana Medical College and spent one year as their professor of anatomy.

II

Dr. Nott returned to Mobile in 1858 with his enthusiasm renewed, and he was refreshed by his year among the undergraduates and older professors at Louisiana. He, with several friends, including Dr. Wright and Dr. George A. Ketchum, decided to establish a medical school in Mobile, Alabama. They found support in the city where friends subscribed about $75,000 for the purchase of teaching supplies and equipment.

The group of citizens and doctors organized the medical school and appointed Dr. Josiah Nott as the first professor of surgery. They commissioned Dr. Nott to go to Europe in the summer of 1859 to purchase the anatomical and pathological preparations, wax models and the chemical and other apparatus for all the departments of the new medical school. Dr. Nott bought wisely and accumulated museum pieces that were to be the envy of all the existing medical schools in America and the pride of Dr. Nott’s life.

On Monday Nov. 14, 1859, Alabama’s first medical school opened its doors in a rented building. It soon became apparent that the building was not suited for medical instruction. It simply could not contain Dr. Nott’s museum. Some directors and Dr. Nott decided to go before the state legislature and ask for aid. Seeing the feasibility, after Dr. Nott’s presentation, the General Assembly of the State in 1860, granted another charter and this time also appropriated $50,000 to build a medical building. It became a department of the University of Alabama.

The first class graduated on March 7, 1860. Dr. J.C. Nott gave the Graduation Address. We excerpt it here because it so beautifully asserts the humanitarian qualities of Dr. Nott:

"[You are]...the first graduates of a Medical School in the State of Alabama...I have already alluded to one great want which many others have felt as well as myself - viz., a public library...I have had to import books...to the amount of several thousand dollars at my own expense to carry out even my limited studies... There are no books on zoology, botany, chemistry, geology, mineralogy, mining, or any other department of science which will enable one to make a complete study. With the immense amount of superfluous wealth which we see floating around us, it is to be hoped that the means will be found ere long for supplying some of these glaring deficiencies.

"I have not regarded it simply as a school where young men were taught how to drug their fellow creature; but I have regarded medical colleges, what experience has everywhere proved them to be, as the centers, the very fountains from which have flowed the whole chain of natural sciences... Botany, therefore, with its thousand applications to agriculture and the various wants of man, was the offspring solely of the Medical profession. ...I clearly perceive that already a great stimulus has been given to the Medical profession. The professors of the College are laboring hard to perfect themselves in their respective branches, and they are becoming able practical physicians every day. The ambitious and enterprising young men outside are already talking of starting a preparatory school, and this influence is extending throughout the State.

"Our hospitals are all undergoing a new organization and the medical wants of the poor will be supplied in a manner heretofore unknown.

"We have already a proposition from an able medical gentleman in New York, to transfer the publication of a Medical and Scientific journal to Mobile and place it under the patronage of our College.

"...The excited state of feeling which had suddenly sprung up between North and South, together with the stampede of southern students from Northern schools, came just in the nick of time to cast the sword of Brennus into the scale.

"...With one of the most commodious and admirably arranged buildings in the United States, now in course of rapid construction — with the larger part of the appliances necessary for a course of thorough instructions — with the patronage of the State to back us, and the assurances of good feeling from the
interior of Alabama, Mississippi, Florida and other states, full success is no longer doubtful. Unless some unexpected commercial crisis should convulse the country.

"Here is the channel in which my patriotism and my ambition run. I never wish for a large fortune with any other feeling than the desire to found institutions and libraries which would rouse up the dormant talent and virtue which is slumbering through the South...learn that those alone gain honorable reputation in our profession who pursue it as a science and not as a trade...no profession demands a higher moral tone than ours. The relations of the physician with the circle in which he moves are peculiar; he sees humanity, not only in its gay, its guarded, or its sober moments, but in its most unguarded moments, when the mind is wrung by suffering, despondency or despair. The private sanctuary is laid open to him, and he sees and hears much that should go down with him in silence to the grave.

"...Above all, gentlemen, remember that yours is a mission of charity—it is not only those who can reward you with gold and silver that will call upon you in the hour of suffering for sympathy and succor, but the poor and helpless, those oppressed by all the moral and physical ills of life...I can honestly say, gentlemen, and it is the proudest boast of my life, that for the first ten years of my professional career I never refused to go to see a human being, night or day, far or near, or in any weather, because he could not pay me...You will find the luxury of doing good the most enduring of all luxuries."

After so auspicious a beginning, the Medical College of Alabama did not open for the 1861 term. The "unexpected crisis" did "convulse the country." All the professors and prospective students went into the Army of the Confederate States of America.

III

And so we find Josiah Clark Nott and two of his three sons, James Deas Nott and Henry Junius Nott in General Braxton Bragg's corps. Henry was killed in 1862 at the Battle of Shiloh Church, the first great battle in the West. James Deas Nott was mentioned in several dispatches, and was cited for "soldierly bearing," "gallantry" and "distinguished conduct." He was killed leading a charge in the Battle of Chicamauga Creek. His regiment, the 22nd Alabama infantry, had lost two thirds of its strength in killed and wounded.

We can understand why Dr. Nott would be despondent, having sustained the loss of his children. Of the original brood of eight, one had died in infancy; his old nemesis yellow fever had taken four; and now, the Union Army had taken two of the remaining three.

He plunged into his work. The blockade had cut off medical supplies. His experiments with turpentine showed that it was no substitute for quinine in the treatment of malaria. He found that turpentine worked well as a counter-irritant for pleurisy and some inflammatory conditions and the south had plenty of turpentine. Dr. Nott served the Army of Tennessee as its medical inspector for the duration of the War. Battle casualties were greater than anyone had ever imagined possible, but disease killed more soldiers in both the Northern and the Southern armies than did the warfare itself. The situation seemed impossible and Nott said so in his dispatches.

After The War, Dr. Nott returned to Mobile. In a letter to the editor of The Mobile Weekly Advertiser published Sept. 3, 1865, Dr. Nott requested him to announce that the Medical College would not open that winter. He explained that the institution had been taken over by the Freed Men's Bureau and appropriated to the purpose of a Negro school soon after Union Troops had taken possession on the city. The entire Chemistry Department was occupied by one black cobbler. The precious Museum, Dr. Nott's pride, had been vandalized. A great many of the most beautiful, expensive, irreplaceable models and anatomical preparations had been taken off by those in possession.

General Oliver O. Howard was the head of the agency that was responsible for the desecration of Alabama's only Medical College. He had been the commanding general in charge of the right wing of the Union Army of the Potomac when General Thomas A. ("Stonewall") Jackson made his famous flanking attack at Chancellorsville. General Howard probably remembered that the attack that had annihilated his corps was led by five Alabama regiments.

Always the gentleman, Dr. Nott must have exercised the utmost restraint when confronted by General Howard. He only said, "I'd prefer to see The Medical College of Alabama burned."

Although he had returned home to resume his medical practice after the war, Mobile did not seem the same to the doctor. The summers, now, seemed long and hot. Many old friends did not return from the war. All the happy sounds of his many children were forever silent. Only the empty rooms and their abandoned projects remained. The infamous recon-
struction, a plague Nott could not treat, was intolerable.

In 1867 Dr. Nott moved to Baltimore, Maryland, and decided to specialize in the surgical portion of gynecology. This was the new specialty that his friend, J. Marion Sims, had launched in Montgomery, Alabama before The War (1846). After mastering it, he decided to move to New York City in 1868.

After the brutality and suffering of The War, doctors from both sides seemed to share a general mood of reconciliation, and Dr. Josiah Clark Nott's reputation had preceded him. He was received with open arms by New York's leaders of the profession, including his fellow Alabamians, the great pioneer gynecologist, Marion Sims and John Allen Wyeth, who was to found the New York Polyclinic, the first post graduate medical school in America. But it was due to his skill and personal magnetism that in a short time Dr. Nott built up a large and lucrative practice.

Dr. Nott had taken only a mild interest in the Mobile County Medical Society, and the Medical Society of Alabama. He became very active in The New York Obstetrical Society as founding fathers. He served as vice president and later, as president of that organization.

In 1868, the year Dr. Nott moved to New York, the Medical College of Alabama in Mobile reopened with 22 students reporting for study. Although Dr. Nott never taught there again, his influence continued to be a factor. The catalogue for the Medical College for 1871-72 has the following statement: "As usual in past years, valuable prizes will be awarded to meritorious students. The Nott Medal, valued at one hundred dollars will be given to the first graduate." The Medical College of Alabama has pursued a tenuous course from its founding by Dr. Nott to its modern position (in 1993) as one of the world's leading medical institutions.

The harsh winters in New York took their toll of Dr. Nott's vitality. He developed a respiratory condition and was advised to seek a milder climate or he would die of tuberculosis. He moved to Aiken, South Carolina. His condition worsened. He returned to Mobile, the city where he had reared and lost his family, and where he had enjoyed such great success in his chosen profession. His was a triumphal entry. He was greeted by admiring men of his profession and by friends who showed him every consideration. It was said of him that "No man ever had such affectionate friends." In these warm surroundings and administered to by his loving wife, Sarah Chesnut Nott, Josiah expired peacefully on his 69th birthday, March 31, 1873.

IV

In 1900, Surgeon General of the Army George Sternberg, himself a bacteriologist, appointed the Yellow Fever Commission with Major Walter Reed, as its head and consisting of James Carroll (1854-1907), Jesse Lazear (1866-1900) and Dr. Louis Agramonte, a Cuban working under American contract. It is noteworthy that all the American members of "the commission" had studied at Johns Hopkins School of Medicine under Dr. William Henry Welch.

The commission applied the "scientific method" of experimental research, ruthlessly using human volunteers, and not sparing themselves. Carroll was among the first eight volunteers. He and one other volunteer contracted the disease and became very ill, but recovered. The other six volunteers remained perfectly well. Lazear did not consider the proof to be conclusive. He allowed a mosquito to bite him. He became ill in four days and died in agony after a brief illness. Lazear's death convinced the commission that the Stegomyia fasciata was the carrier of the Yellow Fever germ. Further experiments showed that the mosquito must bite the person with yellow fever during the first four days of his illness to get the germ. The mosquito cannot transmit the disease for 12 days after it has bitten the patient. As Nott had pointed out, patients cannot transmit it directly to another human.

V

While Willie Gorgas was a young child, Captain and Mrs. Josiah Gorgas moved to Richmond, Virginia, and Captain Gorgas accepted the post as chief of ordnance with a general's commission in the Army of the Confederate States of America. He became a chief advisor to President Jefferson Davis. It was said that by his management of ordnance, General Josiah Gorgas kept the Southern Confederacy and the War going for at least one year after the armies should have been depleted of arms and forced to surrender. Young Gorgas saw many of the great soldiers who came to Richmond: General Lee, Jackson, Longstreet, J.E.B. Stuart, Nathan Bedford Forrest. He admired their soldierly bearing, and the way their uniforms looked.

From a very early age William Crawford Gorgas was determined to be a soldier. After the war, Josiah Gorgas moved to Tuscaloosa as president of the University of Alabama. William attended the
University of the South at Sewanee, Tennessee, and graduated in 1875. He applied for a scholarship to the National Military Academy at West Point. He had the distinction of being the best qualified candidate ever to be turned down by that distinguished institution. He was told point blank that it was because of his father’s role in the “War of the Rebellion.” He was bitterly disappointed, but he was determined to become a soldier. Having decided to become a doctor and go into the Army as a surgeon he entered Bellevue Medical School and received his M.D. degree in 1879. He entered the army as a surgeon in 1880 and after 18 years of uninspired routine army service, Surgeon General George Sternberg sent him to Havana, Cuba, as the chief sanitation officer of the American occupation army.

Yellow Fever had been endemic to Cuba for two hundred years. Gorgas found that the Aedes aegypti (formerly called Stegomyia fasciata) was frail and likes to inhabit houses. They almost never travel more than two hundred yards from their breeding sites. Major Gorgas had his men make a concerted effort to kill all the mosquitoes in the city’s houses, eliminate cisterns and other household standing water. Every case of yellow fever was strictly isolated from mosquitoes. Everyone was required to use mosquito netting. The results of his energetic efforts were astounding. He completely eradicated yellow fever in Cuba.

During the 1880s, the French engineer Ferdinand De Lesseps, with his son, Charles De Lesseps attempted to construct a canal through the Isthmus of Panama. Although they had been successful in constructing the Suez Canal, connecting the Red sea with the Mediterranean sea, the French venture failed and the De Lesseps, father and son, were disgraced. (They were fined and given jail sentences, but were exonerated on appeal.) The main reason for the failure was the inability to cope with the rampant diseases, mainly yellow fever and malaria. They were unaware of the transmission of these plagues by certain species of mosquitoes. Though Josiah C. Nott had suggested the mosquito vector theory, no one had believed him. Dr. Carlos Finlay had suggested that the Stegomyia fasciata mosquito was the vector in 1881. It was not until 1900 that Major Walter Reed’s Yellow Fever Commission proved beyond all doubt that the spread of yellow fever was by the bite of Aedes aegyptii mosquito.

When the Americans took over the Panama Canal project, Colonel William Crawford Gorgas was put in charge of sanitation. The problem here was different from those Gorgas had encountered in Havana four years previously. Panama is almost one thousand miles farther south than is Havana. There is no cold weather to impede the breeding of mosquitoes. Most of the Panamanians were immune to the disease and had little respect for the Gringo’s rules. Panama wasn’t an occupied country. Using tact and his personal magnetism, Gorgas charmed the Panamanians into complying with his sanitation measures. Governor Charles E. Magoon came to Panama as governor in 1905. He was a stern character and put the fear of God into all the Americans in Panama. He enforced compliance with Gorgas’ rules. On September 29, 1905 the last case of yellow fever was reported in Panama. Dr. Gorgas offered the reward of a $100 gold coin to anyone reporting a new case of yellow fever in the Canal Zone or in the city of Panama or Colon. The coin has not been claimed as of this date (1993).

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Enthusiasm

Sir Edward V. Appleton, the Scottich physicist whose scientific discoveries made possible worldwide broadcasting and won him a Noble prize, was asked for the secret of his amazing achievements. “It was enthusiasm,” he said. “I rate enthusiasm even above professional skills.” Without enthusiasm one would scarcely be willing to endure the self-discipline and endless toil necessary in developing professional skill. Enthusiasm is the dynamic motivator that keeps one persistently working toward a goal.

One of the greatest human needs of our time is a weapon to fight mediocrity, one that will teach us how to make use of zest and vitality and the creative forces buried deep within us. What we so desperately need is the capacity for exercising enthusiasm. Enthusiasm makes the difference between success and failure.

The fortunate individuals who achieve the most in life are invariably activated by enthusiasm. Those who do the most within their lives are those who approach human existence, its opportunities and its problems even its rough moments with a confident attitude and an enthusiastic point of view.

The enthusiastic, optimistic, cheerful, hopeful people believe in something. They are the dynamic individuals who set events in motion, always working for the betterment of society, building new enterprises, restructuring old society and creating, hopefully, new worlds.

You can deliberately make yourself enthusiastic. You can go further and develop a quality of enthusiasm so meaningful and in such depth that it will not decline or run dry no matter what strain it is put to. It has been established by repeated demonstration that a person can make of himself just about what he wants to, provided he wants to badly enough and correctly goes about doing it. A method for deliberately transforming yourself into whatever type of person you wish to be is first to decide specifically what particular characteristic you desire to possess and then to hold that image firmly in your consciousness.

Second, proceed to develop it by acting as if you actually possessed the desired characteristic.

Third, believe and repeatedly affirm that you are process of selfcreating the quality you have undertaken to develop.

Emerson wrote: “Nothing great was ever accomplished without enthusiasm.”

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with increases in hepatic enzymes. Elevations in transaminases (ALT and AST) of more than 2 times the upper limit of normal have been reported in approximately 5% of patients. However, the vast majority of these enzyme elevations are self-limited and do not appear to be related to treatment discontinuation. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued, the elevations returned to normal when pravastatin was reinstated (see ADVERSE REACTIONS). Occasionally, elevations of levels of gamma-glutamyl transferase have been noted; however, this enzyme is usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be reported. As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Therapy should be discontinued if any of the above abnormalities are noted. Patients receiving pravastatin for 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported rarely.

General: Myalgia, defined as muscle aching or muscle weakness, has been reported in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal. Myalgia has been noted in a small percentage of patients receiving pravastatin (approximately 2%). In some cases, muscle weakness, myalgic tenderness or weakness, or marked muscle tenderness or weakness has occurred. Myalgia, weakness, and/or muscle tenderness, particularly if accompanied by myoglobinuria or failure, should be closely monitored. Pravastatin therapy should be discontinued if myalgia is severe or if rhabdomyolysis occurs (see ADVERSE REACTIONS).

Stroke: Rhabdomyolysis occurs in patients with renal dysfunction (see WARNINGS).

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1993-94 MASA President, Dr. West --

Pianissimo to Fortissimo

--Pg. 11
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EXECUTIVE DIRECTOR

‘Include Me Out’

The old movie mogul Sam Goldwyn shared with baseball’s Casey Stengel a rare gift for grotesque malaprops and fractured English. I was reminded of Goldwyn’s classic remark, “include me out,” now enshrined in the national folklore, in reading about the resistance and denunciations that the Clintons, Hillary and Bill, are encountering as they attempt to re-invent the American health care system in a bureaucratic vacuum.

“Include me out” has becoming a welling chorus in the nation’s capital, from the ranks of consumer advocates and providers alike.

Relying only on their hand-picked, secret, light brigade of some 500 health care technocrats — chiefly from the rabbit warrens of government and academe — the Clintons brought down all manner of indignation on themselves. It was a short honeymoon.

The executive director of the of the Federation of American Health Care Systems, Michael Bromberg, disturbed by the secrecy surrounding the evolution of the Clinton reform plan, said caustically that if the Clintons unveil anything that “smacks of turning one-seventh of the economy over to the government, we’ll oppose it.”

By now the Clinton brain trust should have learned a couple of lessons about Washington — nobody, but nobody, has ever been able to keep a secret in that town; and, secondly, the very attempt to exclude not only the “vested interests” but any realistic representation of the public as well has generated advance resistance and suspicion that will not make a Herculean task any less so.

In barring not only AMA, and other organizations that have been wrestling with these problems for decades, the Clintons served autocratic notice that only certified and Simonized theoreticians need apply. All those others would only mess up their theories with untidy facts and practical experience in the trenches.

So much for returning government to the people. Policy wonks, as Hillary and Bill have been accurately labeled, trust only other policy wonks. That is the reason, in addition to a singular show of distrust of actual experience in the field, for the assembly of a task force unlike any that I ever heard of, headed by an unelected chairperson who presumes to speak not only for the Executive branch of government but the Legislative as well. She’s bound to get her comeuppance from a Congress fanatically sensitive to invasion of its turf.

Many years ago, an Air Force commanding general — Gen. Twining, as I recall — was presented with the accomplished fact that much of the strategic planning of his service was being done by Ph.Ds. General Twining dismissed their relevancy with a label that stuck — a “tree-full of owls.”

The owls are back (possibly the same owls) and the last thing they want is to be soiled by association with the masses and those who have been providing care for these peasants. The real world is too prosaic for them.

Inevitably, this paternalistic attitude has created towering resentment, which was not mollified by the public meetings of the task force after it had done its work. Throwing a bare bone to the public is tokenism,
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worse than no bone at all.

The Clinton Administration seemed in the early months of the year to be deliberately bearding the lions it must ultimately win over. Early on, an administration spokesman tried to preempt the expected tide of criticism by saying that it had deliberately sought to exact sacrifices from everyone so that no one would have the gall to complain of his own specific hardship. That might be taught in the PR classes at Oxford—that the way to win is to alienate everyone—but the thesis has not been tested on these shores.

For the first transparently phony public hearings after the secret sessions, Hillary et al directed, for example, that the U.S. Chamber of Commerce should concentrate its part of the meeting on this question: “What can large employers do to ensure their employees have access to high quality health care?” The Chamber was flabbergasted: its membership consists almost completely of small employers, many and perhaps most of whom can’t afford to buy coverage for their workers.

Similarly, the Group Health Association of America was asked to address the question of why insurance companies use pre-existing conditions to determine who is covered. Group Health was not amused by the obvious attempt to drag it into matters that are not among its major concerns.

John Motley, chief lobbyist for the National Federation of Independent Business, flat-out rejected his invitation to appear at the public hearing. The Federation has, he said, 1,000 to 2,000 small business members in every congressional district and “I might as well spend my time getting ready to fight.” Mr. Motley’s group believes that the Clinton proposal would force crippling costs on them at the very moment in history when the chief concern of small business is brute survival.

And it is this group that the Administration fears, The Wall Street Journal has reported, more than it does doctors, hospitals, insurance companies, or drug companies. White House adviser Ira Magaziner had, in fact, warned in his initial memo to the task force in January that small business would be the biggest obstacle to the President’s plan.

Consequently, the Administration talks of preparing a seductive “package” of small business aid that will divide the ranks. In an transparent move to split the opposition into fragments (a strategy it has also planned for physicians, hospitals, etc.) it has offered olive branches to such groups as National Small Business United, the Small Business Legislative Council, and the National Association of Women Business Owners.

As naive as high schoolers plotting a class election, the young Clinton operatives seemed convinced of their political acumen when these little stunts are embarrassingly obvious in a city where political chicanery has developed over the years into a high art form. Many old pros in Congress are chuckling in their beards over the amateurism they are seeing.

Clinton’s aides were persuaded by the November election of their own genius, but the public opinion experts know that it was not their brilliance that beat George Bush. He was beaten (1) by the economy and (2) by George Bush.

But nothing has so inflamed the people and groups the Administration must persuade to go along with its reform plan as much as the secret task force meetings headed by Hillary the Hun, as she may be dubbed any day now. Arrogation of authority was bad enough in itself, but to assert the right to secret meetings by anonymous people in an operation that could result in the greatest social revolution of this century was exorbitantly stupid—much to the delight of the “vested interests” she excluded.

If the bill to be offered Congress around the first of May is as gauche as the tactics surrounding its preparation, Mr. Clinton might be well advised to send that tree full of owls back to the minor leagues. As for Mrs. Clinton, a woman of considerable moxie who hit the ground running over everybody in sight, she should be advised that the proper role model for a First Lady is not Eva Peron.

And while the Clintons have succeeded beautifully in their plan to outrage those vested interests, individual Americans have not been heard from at all in any believable manner. The real test of popular sentiment will come later, when the shape and function of the Clinton reform plan is made clear to Main Street. If the delivery system is to be formed of a few giant HMO-like contraptions, the public will see the question framed in a new light. No one has put that question better than Newsweek did (April 5, p. 40): will Americans “entrust their health, and perhaps even their lives, to a big, profit-oriented corporation?”

Part of the public’s disaffection with the status quo is that modern medicine, for all its wonders, has become too depersonalized. Transfer that criticism to the brave new world Mr. Clinton is expected to serve up very shortly. How would I feel, I asked myself, about subjecting a member of my family to the tender mercies of a mammoth provider the size of, say, Sears, General Motors, or IBM—knowing as I do that each of these got in their present dire straits by
the very fact that their gargantuan appetites blinded them to individual needs? These were all excellent companies at one time but they became so big they forgot their customers, and they are paying for that now.

Would I really believe that such a corporate provider would place the interests and welfare of my family above that of its highly paid officers and hungry stockholders? As an American, I believe in the profit motive. I think it has been the engine of our greatness. But is the dollar the proper determinant of the care my family will receive? I suppose it comes down to this: what happens to the physician’s traditional patient advocacy when I must deal with a corporate provider whose loyalty to me is compromised by his loyalty to the company’s bottom line?

Another question: are we in the process of creating huge oligopolistic monsters that we cannot control?

It is of course easy to sit on the sidelines and taunt the participants. The Clintons have undertaken one of the most complex problems in the nation’s history. There is virtually unanimous agreement that something has to be done to contain the skyrocketing costs of medical care and provide access to those who have none. As JAMA said last year, the system faces meltdown.

These are givens. Defining the problems is relatively easy. Solutions are much more elusive. Mr. Clinton told the voters last year that they were relatively simple. I doubt if he really believed that but in any case he couldn’t believe it now. What I fear, what physicians fear, what the country will fear as it begins to see the shape of the future is that the proposed remedies may be far worse than the disease.

What distresses me most here in the early goings is the Clintons’ arrogant removal of the design process from the methods by which a democracy, this democracy, has always eventually found its way. It is not always a pretty sight, these sprawling, brawling debates. As Winston Churchill once said, the American system of government is the worst in the world — except for all the others ever attempted by mortal man. What he meant was that freedom is, after all, often messy and discordant. Even so, I hope Bill and Hillary develop a more tolerant attitude toward our way than they have yet displayed.

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ARMY RESERVE MEDICINE. BE ALL YOU CAN BE.
President’s Report

An appeaser is one who feeds a crocodile, hoping it will eat him last.

— Winston Churchill

The past 12 months have been a busy period for the Board of Censors, not the least reason being the gathering storm on the horizon. The storm actually had its genesis near the end of the previous year, when Harris Wofford, an obscure academic, unhorsed a popular former governor and U.S. attorney general, Dick Thornburgh, in the Pennsylvania Senate race.

Wofford had been trailing distantly, not given any hope of victory, until he discovered a dynamite issue — reform of the health care system. He snatched victory from the jaws of defeat on that issue alone, startling the Bush White House and handing the Democratic presidential candidates a potent issue for the 1992 elections.

Although President Bush attempted to turn the issue to his benefit in his bid for re-election, he was severely handicapped by his having virtually ignored, until too late for credibility, a public anxiety that had been smoldering all along when Wofford fanned the flames to life.

The ultimate survivor in the Democratic race, Bill Clinton, made much of the fact that Mr. Bush had done nothing to address health care reform until Thornburgh had been impaled on it. That, the economy, and a generally disenchanted electorate gave Mr. Clinton victory in November, pledged to make affordable health care available to all. He promised a bill in the first 100 days in office, thus assigning health care reform the highest priority in his nascent administration.

This was the backdrop against which many challenges to physicians were presented to the Board of Censors during the year. The politicalization of health care nationally emboldened our detractors in the Alabama Legislature. Suddenly, the mood was generated that physicians were not only fair game, as always, but uncommonly vulnerable because of our being made whipping boys in wild political invective.

Illustrative of this reckless opportunism was the incredible attempt by certain industries and their handmaidens to advance the fantasy that in re-writing the Workers Compensation Law the Legislature had not established a fee schedule of PMD + 7.5% but a flat PMD rate.

The Board found it difficult to believe that anyone would seriously argue that the Legislature had not done what it thought it had done and what all participants had agreed on. A bizarre suit was filed, naming me as one of the defendants, seeking an injunction against your officers telling you what the new law and fee schedule provided — the plaintiffs insisting that the law said something quite different if one read between the lines, or something like that.

We marshalled our forces to eradicate this nonsense; ultimately an attorney general’s opinion vindicated our position 100%, agreeing that the law said what it said and not what the challengers claimed they saw written there in invisible ink. If was frustrating to be forced to devote so much time to defend against an idiotic claim, which might never have been made but for a national perception that physicians were on the ropes, defenseless.

At the beginning of this I quoted Mr. Churchill on
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the risks assumed by crocodile feeders, and their motivation. That is a dangerous temptation within the ranks of organized medicine in these very dangerous times. Before Mr. Clinton was inaugurated, it was obvious that the new administration’s strategy in bringing to pass a major social revolution would be to fragment the opposition — not only physicians but elements of business and industry fearful of the fiscal consequences of what really is an effort to socialize one-seventh of the U.S. economy.

This strategic campaign started early, but even before it had begun the American College of Physicians, last Sept. 15, published an article, presented as policy, which contained many of the worst elements we fear will be found in the Administration’s proposal. In fact, the timing was itself suspicious of crocodile feeding — just before the election. The ACP article contained many of the features Mr. Clinton had favored in his campaign.

I will not impose on you a repetition of the ACP points except to say they would ratchet down a national cap on health spending, with limits on doctor and hospital fees for both public and private patients; establish a national commission with broad powers; empower state health care regulatory boards similar, it would appear, to public service commissions.

The Board of Censors, acting the day after the ACP story hit the national news, instructed its four ACP members to write a strong letter of dissent to the author and to the endorsing ACP officers. Our letter received favorable comment from as far away as California.

Nor would ACP relent in its crocodile feeding. When the AMA held its interim meeting in December in Nashville, ACP was on the scene to issue its own press release attacking the AMA’s more conservative stance in language clearly intended as a direct challenge to AMA’s presence in Washington as the principal spokesman for the U.S. physician. In a sharply worded critique of the AMA Board of Trustees, ACP said AMA was not serious about cost control and that its reliance on market forces was wrong-headed, while its own notions of global budgeting would work.

The Board of Trustees, enraged by the renewed challenge to its Health Access America plan, blasted the ACP news release as “inaccurate, unprofessional and insulting.”

It was obvious that ACP was attempting to supplant AMA, with membership four times that of ACP, as the power broker for medicine in the Clinton years. Thus even before Mr. Clinton took the oath of office, the crocodile feeders were shoveling out the fish.

The net result of the Battle of Nashville was to convince the Clinton people that U.S. physicians were already fighting among themselves, and thus ripe for picking off, specialty by specialty. We had hoped to have been able to present a united front when health care reform went before Congress, but ACP obviously had a different agenda — plainly hoping other elements of organized medicine, namely AMA, would be eaten first.

Having established, without even trying, that American Medicine does not speak as a single voice, the Clinton Administration will work at creating other conflicts in our ranks, throwing minor concessions to win the fealty of first this segment and then that one with a few crumbs from the table.

The unfortunate AMA-ACP collision adds to the perception of us as warring among ourselves and simply incapable of presenting a united front. And the damage from that is not limited to the national scene. It will be felt on the state level.

As I said earlier, the routine business of the Association throughout the year has been given a spooky added dimension by the ominous feeling that we may well be approaching the edge of a great divide; that the history of this period may one day mark 1992-93 as the beginning of the end of the good old days. Will some 21st Century MASA President write of us: “They were good doctors but in their complacency they let slip from their hands, and our hands, the most precious ingredient of medicine — physician control of patient care”?

I don’t want that to be my professional epitaph, and I hope you don’t. United as never before, we still have a chance. Divided and factionalized, we will jeopardize the finest health care system in the world and certainly one of the greatest social institutions of all time.

Join with the Association and its linkage with other state associations across the nation in the months ahead, responding to our pleas for letters or personal contacts with Senators and Congressmen, and we may be able to salvage the most important of our treasures — the doctor-patient relationship, physician decision-making, and our professional autonomy.

I urge you to give my successor in the presidency, Dr. Jim West, the same support and encouragement you have given me. He’s a fighter and wholly dedicated to the cause I have tried to describe.

If for some reason you cannot join with us in this, the Armageddon of American medicine, perhaps you could at least refrain from feeding the crocodiles and give us a fighting chance. Thank you for everything.

May we all make it safely to that distant shore.
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BASF Group
Dr. West: Pianissimo to Fortissimo

William H. McDonald

Tennessee-born James E. West, M.D., the 1993-94 President of MASA, is the first to admit that his choice of Anniston for his practice was influenced to some degree by the proximity of the Appalachian Mountain chain he had grown to love in Knoxville.

Although Anniston is technically in the piedmont plateau of the Appalachians, it is close enough to the hills of home to have given Dr. West an immediate sense of place when he located there after Vietnam war service. No such sanctuary would have been afforded by the coastal plains to the south; no flatlander he.

Mountains are reputed to offer all manner of revelation and Epiphany to people who avail themselves of the lofty serenity to contemplate their destiny. Did young Jim West receive his call to medicine from a mountaintop, giving the fact that his mother says that decision came at the age of 7?

"Not likely," Dr. West responds today. "The mountains weren't that high." He will quietly confess, but only under pointed cross-examination, that he believes he was called to medicine in the older meaning of the word. No one who knows him would gain-say him on the point: he demonstrates that calling in his dedication to his patients and to his profession.

For example, he abides strictly by a policy of not permitting his office personnel to inform him whether a patient can pay or not. "I don't want to know. A doctor's job is to help patients. I do not believe I would be influenced by knowing, but I think it is best not to know."

As a consequence of this policy of those in his surgical group, about 30% of their work is gratis. Normally, this charity is not extended to those seeking cosmetic surgery. True, there is an occasional cheat who instead of paying Dr. West's fee will spend it at the Talladega race track or wherever. That is galloping duplicity but it goes with the territory, Dr. West says.

What should not go with the territory, he believes, is the practice of some physicians who refuse to take any charity cases, thus dumping their share on physicians who remain faithful to their commitment to the healing profession. Dr. West considers such behavior morally and ethically reprehensible.

"No one would question this as a business practice. But medicine, while it necessarily has a commercial component, is not a business. As physicians we must carry a heavy burden of professional duty. When we fail to carry that burden, we make ordinary trade out of a noble profession."

Dr. West, who has been a member of the Board of Censors since 1982 and has served as chairman, is not sanguine about the health care reform bill now being cobbled together in Washington. In common with most informed observers, he believes that rationing is inevitable under any redistribution of the wealth that would provide basic care for everyone. For that care to be of the level now enjoyed by 80% of the population would require substantially more new revenues, he believes, than Americans are willing to pay.

Additionally, a new system would be forced to compete with national resources diverted to reducing the deficit and retiring the $4 trillion public debt — all at a time when the economy is less than booming.

In short, it is not the most propitious time for reinventing the American health care system, he believes. And he fears that the physician may end up being the fall guy. "The physician cannot ration his services; he must give his best to all." But as coverage is restricted by various mechanisms, physician decision-making may be circumscribed by the dictates of "managed competition."

Here is a brief background to the interview below with Dr. West:

One of the chief worries of medical leaders such as he in the current rush to judgment on health care reform is that medicine has so few allies this time. Business and industry have been trumpeting for change so loud and so long, they cannot be counted
on to resist a program even though they might agree that it will prove disastrous down the way. They say they are desperate for almost any "solution" proffered by Washington. Desperation often breeds disastrous mistakes.

Even the insured element of the public, those who do not now have an access problem, is anxious as well — made so by the waves of horror stories of those who have lost their coverage through protracted illness, unemployment, job changes, or their employers' decision to sharply dilute health insurance for active employees, even to withdraw it in the case of company retirees.

The general mood of the country is high anxiety, at times approaching panic — a poor climate in which to engineer a social revolution of a scope not seen since the New Deal of the 1930s, when the nation was also desperate for any kind of relief.

Only recently, for example, has there been any evidence of the public's understanding of the impact rationing has already made on the lives of millions. Since neither the politicians nor the insurance industry will admit to rationing, and it appears in protean forms not clearly discernable for what it is, popular attitudes are based on very limited understanding of the complexities of medical economics. Unburdened by clear insights into that maze, the average American is at the mercy of too many political con men who may have even fooled themselves into believing that health care reform is a relatively simple and painless procedure.

It was to Mr. Clinton last summer when he gleefully joined the chorus for the oxymoronic "managed competition." Politicians cannot find the courage to tell the people that they are a major portion of the problem, in their appetite for everything the system has to offer when they or their loved ones are sick. Over-utilization is as meaningful to the average citizen as subatomic physics. They do not see the connection between their insistence on the best and most of everything and the rising cost of health care. Their attitude toward the technological explosion in health care, which has wrought miracles but at high cost, is so simplistic as to make gibberish of any public discussion.

Over the years, insurance has had the effect of insulating insureds from the real cost of health care, which seemed essentially free. That insulation is now

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wearing thin as the reality of costs has touched just about everyone. That reality is the product of news about the costs of artificial hips, organ transplants, coronary bypasses, bone marrow transplants, and so on — procedures that did not exist three decades ago, the formative years for the notion that “don’t worry — insurance will pay for everything.”

Only now is it beginning to dawn on an informed minority that eventually we all pay the tab. Miraculous as have been the advances in medical technology, the gains have increased the number of diseases that can be attacked but also the costs of attacking them.

One medical ethicist (Willard Gaylin of the Hastings Center) has noted that “half of what we call health today would not have been considered health fifty years ago.” As the range of the treatable has expanded, as the numbers of the aged have increased to produce even more diseases, costs have expanded as well, in some instances, geometrically.

Even experts in the field, the people who crunch the numbers and study the print-outs, are often bewildered by the sheer magnitude of the problem. Small wonder that the average taxpayer is utterly at sea in trying to comprehend the approaching revolution. Thus it should hardly have been surprising that a recent poll found Americans heavily in favor of harsh regulation of the health care industry but opposed, by a like percentage, to materially altering the present system or the fundamental structure of the doctor-patient relationship.

This has been translated by the pollsters to mean Americans want the government to somehow provide them with low-cost, high-quality health care in a setting identical to what they have now. As for the sacrifices they are prepared to make in exchange for this benefit, a few bucks a year is about all they are willing to pledge. “We prefer to have our cake and eat it too,” they seem to be saying. That attitude is characteristic of us Americans: the best is barely good enough if “somebody else” is paying the bill.

And, compassionately, we want all the medically indigent taken care of in the bargain — but only if, again, somebody else pays for their care.

President Clinton has his work cut out in informing these millions that the Tooth Fairy is dead, and that the national debt represents all those other free lunches we ordered over the years.

After such a general discussion as the foregoing of the precarious environment for epochal legislation, Dr. West was asked to speculate on the outcome in Congress:

A. “I see a change in the reimbursement of medicine. I see a change in the insurance industry and a change in the practice of medicine. But I don’t believe President Clinton will be able to alter things in a dramatic way instantaneously. He has already backed off on some of his ideas. For instance, he surrendered to the AARP people after suggesting that social security might be pared. He had promised to lower taxes on the middle class; now he says taxes will be raised on the middle class... So far he has not been a man of his word.

“My great concern with Medicare, however, is that if he follows through with what he says he wants to pay doctors for their services and hospitals for theirs, pretty soon you won’t be able to get a physician to take care of a Medicare patient. There is already a problem in Anniston. Reimbursement is so low nobody wants to take Medicare patients.”

Q. Recent stories out of Washington, which may be no more than Clinton trial balloons, said the Administration was considering a freeze on physician and hospital charges to private patients so that these providers could not raise fees to make up for contemplated cutbacks in the Medicare reimbursements. How does that sit with you?
A. "I think President Clinton simply wants total control over health care, either through caps or certain managed care plans. I don't think the federal government should involve itself with private insurance and private patients. He is talking about a preemptive strike, before health care reform takes effect. But I think he has already learned, or should have learned, in the case of ordering homosexuals accepted in the military, that you can't just order something done, and have it done, if it is wrong. But, looking at it another way, he may come out of that one smelling like a rose. That group gave him a lot of money and he can tell them that at least he tried."

Q. What can Alabama doctors do to check in Clinton?

A. "We have the same problem here as in other states. We must all speak with a single voice on this one. If everyone simply speaks his mind, and lets it go at that; or if we're so apathetic that we think resistance is futile because it's going to happen to us anyway, I can assure you it will happen. It may happen anyway, but we must certainly make a maximum effort to get our message across to our congressmen, as must doctors in every state. If we are not unified coast-to-coast, or if they succeed in their strategy of dividing us, playing off one specialty against another, or one region against another, we become virtually defenseless.

"But in all the excitement we cannot forget that our primary duty, here and now, is to take care of our own people here in Alabama, regardless of what comes down from Washington. Their need is immediate. How we are going to do that I am not sure, but we've got to develop a system of access to care in Alabama that will work and will endure."

Q. Other states are well along in similar efforts and some of the leaders say they have detected mumbling in the ranks to the effect that whatever states do will be subsumed in the reform program Clinton and Congress put together. Do you find that attitude a deterrent to movement here in Alabama?

A. "I don't believe it is the only deterrent, but it is definitely one. People may say they don't want to invest their energies in a state effort when it may be preempted by Washington. That's just an excuse; we can't do that. In that connection, I was glad to see that the Clinton Administration has lightened up on state Medicaid so that the states can take some initiatives on their own — that is, the decision to grant some of the requested waivers for innovative programs, in Oregon, Florida, and elsewhere."

Q. And there is even the theory going the rounds that the Administration might decide to buy time by letting the states be the laboratory for some programs before they are embraced by Washington. But changing the focus slightly, Mr. Clinton has indicated he wants to use the vast "savings" from Medicare cutbacks not to divert these funds to the uninsured but to be used for deficit reduction only.

I guess this is a leading question, but isn't that a double betrayal? ... First to take from patients, mostly those in the middle class, funds for their healthcare and use these funds to reduce the deficit they had little to do with. Does this strike you as a particularly cruel hidden tax on a vulnerable class of Americans?

A. "Yes. The debt and deficit were not brought about solely by health care. Many things got us into this fix. Number one was probably poor management in Washington — no effective budget restraints. I think it is grossly unfair, now, to try to balance the budget on the backs of people who need health care. The reason he has been making these statements is the numbers of physicians are low as compared to everybody else. Our clout is not as great as we would like to think it is. We are in a tough battle, heavily outnumbered. If Mr. Clinton attempts to cut as much as he says he intends to from Medicare, taking it from doctors and hospitals, he would destroy the program.

"By such measures, he can, of course, limit access for the elderly. A lot of hospitals would close. A lot of doctors would stop taking Medicare patients. All this would serve as a rationing system, brutal but effective. That is one way, perhaps the only way, to save money in American medicine — to ration the kind of care we deliver. Of course we have rationing now — not by admitting it and calling it by name, not by saying that we are not going to cover certain procedures, but by putting economic restraints on people to limit and even deny access. If Mr. Clinton wants to go this route, it will work, but it is hardly the kind of America he promised the voters last year. It makes a mockery of the very claim of 'reforming' health care."

Q. Do you feel that the "health care industry" has received a bum rap through the years — not just from Bill Clinton but from politicians in general?

A. "Absolutely. And it is maddening. The health care industry is the biggest employer in the United States. It generates $1 out of every $7 in U.S. goods and services. We stand alone in our good works. We make millions well again. We ease pain and suffering. We restore people to useful employment. But politicians of every stripe feel they can take cheap shots at us with impunity."
"Of all the health care expenditures, physicians gross less than $1 in every $5. And Mr. Clinton and others want to make us the villains. That’s shameless demagoguery. I just do not understand it.

"Another thing I don’t understand: who’s to say we’re spending too much on health care? In what should Americans be investing the substance of their labor that is more precious? Fancier cars? Wider TV screens? Here is another example of materialism taking precedence over necessity. One thing is certain: if Mr. Clinton has his way, we will be spending a lot more. Will he say then that it’s too much?"

**Q. Who best represents the interests of the public and the physician in Washington?**

**A.** "The AMA, as they have been doing since the last century. And I would like to emphasize the public advocacy provided by AMA. Too often the media and the politicians paint AMA as interested only in physician welfare. That’s slanderous. Let them read Health Access America, the AMA health reform plan. Let them read the back issues of *JAMA* over a century, published in every language now, and try to sustain that charge. Let them study AMA’s vital role in advancing public health, immunization, medical education, continuing education; its battles for child welfare; its campaigns against the abuse of women, and on and on. Then, having absorbed all that, let them show me another organization of even remotely comparable altruism.

"They accuse us of being elitist, as if that is a terrible sin. As if there is something un-American about our having filled our ranks from the best and brightest. They say that we are arrogant when we say we know more than any other group about the needs of the American patient.

"If these are our crimes, we are guilty. But if America has come to regard personal achievement and professional standards of excellence as qualities to be condemned and scorned, this country really is in bad shape. Mr. Clinton would do well to address his considerable talents to correcting these dangerous attitudes before the United States joins the other great powers of the past, now only ancient history."

**Q. The American Medical Association and the American College of Physicians have taken their disagreements over health care reform into acrimonious public debate. Is this good or bad for the rank & file of American physicians? Is it in the public interest?**

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A. “It is extremely destructive. ACP thought it was speaking for a large number of people who didn’t want those words spoken in their behalf. As a surgeon, I do not belong to ACP but if I did I would consider changing that membership. I don’t know how many resignations they had but I hope and believe it was a considerable number.

“The AMA develops policy by a democratic process that considers all viewpoints. ACP has apparently been taken over by a small coterie, which has now contributed to the very thing we should fear most this year — divide & conquer tactics. If Washington can split one group off from the pack, then another, by special concessions to that group, our combined effort will be severely weakened. If we can’t speak as a single voice on major portions of health care reform, we may have no voice at all.

“All specialties and subspecialties must put down their differences and get together on joint strategies. Otherwise we’re in deep trouble.”

Although reluctant to dispute his mother’s insistence that he had decided to be a doctor about age 7, Dr. West remembers only that it was in high school in Knoxville that his decision became final and irreversible.

It was in high school when he began dissecting doomed animals in the family basement, much to the chagrin and perhaps horror of his parents. He would anesthetize small animals, principally cats and goats, and learn what he could about anatomy in that makeshift amphitheater.

Needless to say, he had already decided on surgery as his specialty before completing high school. After receiving his M.D. degree from the University of Tennessee medical school in 1963, he did his residency in general surgery at the VA hospital, Memphis, July 1965 to August 1969.

Vietnam caught him, as it did so many during the period. Already board-certified he served a year in a fixed surgical facility at Quang Tri City. Unlike MASH units, the surgical hospital, left by the Marines, had concrete revetments four feet thick and metal roofing. “It was pretty good for the time and place,” he recalls — certainly preferable to the MASH tents.

The Vietnam experience taught him that he should be able to handle almost anything presented to him. “You couldn’t always do that, of course, but you had to have that attitude.” The injuries were from high-powered weapons, grenades, land mines, etc., intensive experience in trauma surgery that was to serve him well once he had returned to civilian life in Anniston, called then “the murder capital of the world.”

After his Vietnam tour, he was stationed at Fort Benning, Georgia, and thinking about where to locate after discharge. Fortuitously, the medical network came to his rescue. He received a call at Benning from Henry L. Laws, M.D. Dr. Laws and Robert Elliott, M.D., were looking for a surgeon partner.

Dr. Laws had learned of Dr. West through a mutual physician friend.

At Dr. Laws’ behest, he visited Anniston a couple of times, liked what he saw and ultimately accepted the invitation, a decision he has never regretted.

Dr. West, blessed with a quick mind and a warm, friendly smile, seems to have a curiously unique definition of the word “hobby.” Ask him what his hobby is and he will say that he has two, surgery and organized medicine. If pressed, he will tell you simply that he loves surgery, despite the long and difficult hours, and considers it a hobby because he would never work as hard as he does if it weren’t his passion — or if he were working for someone else. He believes the art and science of medicine are so rewarding in themselves, he simply cannot conceive of doing anything else.

He has brought the same singular dedication to organized medicine, beginning 20 years ago with the presidency of the Calhoun County Medical Society. His society later played host to former MASA President Kendall Black, M.D., who was the catalyst for Dr. West’s decision to get involved at higher levels of organized medicine. He was appointed to a long-range planning committee headed by another MASA President, Jack Hyman, M.D. The committee functioned as a kind of think tank for the Association and that intrigued Dr. West.

A dozen years ago, Calhoun county colleagues asked him if he would be willing to serve on the Board of Censors. Dr. West:

“I said I would serve but that I would not run for the office. At the time, I did not know what the job entailed. But I was really flattered — until I learned that they had already asked two other doctors but both had refused to consider the offer.”

Given Dr. West’s characteristic modesty, this account may be just a touch apocryphal. He tends to gloss over, understate or trivialize his avocational achievements. Here are two examples of mysterious disclaimers:

1. He relaxes by playing the piano — badly, he
voice hardens and his normally relaxed eyes develop a sharp glint that is a sure signal that he is now speaking in italics — this is very serious business, friends. *Pianissimo,* his old piano teacher might have said, suddenly becomes *fortissimo.*

Dr. West keeps abreast of all the developments in the evolution of the health reform concept in Washington. What distresses him most is that whatever the final form, the buck stops with the individual physician, who must do his best by every patient even when hobbled by red tape and disguised rationing.

Government may attempt to suppress utilization in a thousand ways; insurance companies may introduce their own cost-cutting strictures camouflaged as quality control or whatever; but, in the final analysis, the doctor, bound like Gulliver among the Lilliputians, is still sworn to think only of his patient.

He will not even guess how it will all play out. But MASA members could not find a more conscientious leader for what may well be the most fateful year in the history of the Association, and all of American medicine.

One thing at least seems clear: Dr. West will need several kegs of nails and perhaps padded keys for that poor piano before his presidential year ends in April 1994.

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**Rural Health:**

**Putting the Pieces Together**

National Rural Health Association 16th Annual Conference on Rural Health May 12-15, 1993 Kansas City, Missouri

* Subsequent to the interview on which this article is based, Dr. West was asked to verify the quotations attributed to him. He wanted to amend the above in one particular, which may be significant. "I do have a saw," he admitted, *sort of,* as if by almost whispering the confession he hoped no one would hear. A hand saw, Dr. West? "Yes. Also [now almost inaudibly] a radial arm saw." Is he then a closet craftsman after all? Who knows?
The Alcoholic Physician: A Case Study

Gerald L. Summer, M.D.

Chemical dependency is the single most frequent disabling illness for the medical profession and as such poses a major problem for the professional. The failure of physicians and others to recognize colleagues with clear addictive behavior is related to a number of factors. Education in the disease concept of addiction and recognition of its behavioral symptoms needs to be addressed.

Alcoholism is a progressive disease characterized by behavioral symptoms. Individuals with alcoholism progressively become preoccupied with the drug alcohol. Anticipating “having a drink” after the last scheduled patient in the office to relieve stress is precarious “social drinking.” Increasing preoccupation with addictive drugs evolves over varying time—perhaps years with alcohol and benzodiazepines, months with opiates and a brief interval of time when using cocaine.

The preoccupation and the desire to alleviate unpleasant feelings and tremulousness lead progressively to seeking the drug (alcohol) more and more during the 24-hour day. Early withdrawal symptoms are misinterpreted as related to “stress.” The patient may deny this preoccupation or rationalize the need by assertion that he/she drinks no more than their friends. Accordingly, alcoholics tend to spend their time with other heavy drinkers. As problems from drinking become more serious, alcoholics drink alone, sneak drinks, and hide the bottle to conceal the amount they consume.

Guilt, remorse, anxiety, and irritability with depression in the mornings are tempered with drinks beginning earlier in the afternoon and perhaps around the clock as the disease progresses. Rapid intake to relieve unpleasant feelings or anticipation or perceived unpleasant events is common along with efforts to insure a constant supply of alcohol. Unplanned use may result in intoxication at social events accompanied with embarrassment for family members and friends.

Tolerance, the use of greater amounts of alcohol to achieve the desired effect, develops so that very large quantities are consumed on a daily basis without obvious intoxication. Amnesia or a transient “blackout” is not infrequent. Alcoholics may experience a specific short-term memory deficit in which they are unable to recall events that happened five or ten minutes before. Thus, others may observe that they appear to have lapses in conversation during normal conversations. Because other intellectual facilities are preserved, they can perform complicated procedures, even major surgery, and appear normal to the casual observer.

To recapitulate, “abnormal drinking” or “alcohol abuse” is associated with preoccupation with the drug alcohol, drinking alone, and rapid intake to achieve the desired effect, assured a constant supply, unplanned use, using to relieve uncomfortable feelings or physical symptoms (using as a panacea), increased tolerance, and blackouts. The diagnostic criteria for psychoactive substance dependence encompasses these concepts.

When the overwhelming “need” to drink dominates over the recognition of consequences associated with drug use, alcohol abuse has progressed to fully developed alcoholism. The “alcoholic” has progressed to a degree that he/she no longer has control over time, place, or amount of alcohol consumed. Physicians frequently self-medicate with other chemicals, especially benzodiazepines and opiates, which greatly contribute towards this progression.

When cocaine or the newer intravenous synthetic opioids are involved, the rapidity of the disease changes all the rules! The American Society of Addiction Medicine (ASAM) defines alcoholism, in part, as a primary, chronic disease characterized by impaired control over drinking, preoccupation with alcohol, use of alcohol despite adverse consequences, and distortion in thinking, most likely denial.

The family of the addicted physician is effected by the disease process. Loss of intimate communication, no sharing of honest feelings, family disruptions including disciplinary problems with children, separation and divorce are the usual scenarios prior to obvious impact on the professional’s practice. The disease in the individual and its effects upon the family can be arrested at any level in its progression. The antiquated idea that one has to “hit bottom” before he/she can be helped is no longer valid. The goal of the Physicians Recovery Network (PRN) is to raise the
bottom for the physician suffering from the progressively disabling disease of chemical dependency.

The following case study of a physician is true. Inserts describe behavior exemplifying loss of control over drinking, failure to recognize consequences related to alcohol use, and most importantly denial, the unconsciousness distortion of reality. The study also illustrates the effectiveness of a caring intervention and initiation of a recovery program resulting in the return of a productive physician in Alabama.

An Alabama physician was referred to the Physicians Recovery Network with complaints (3) by nurses suggesting the doctor was making rounds with the odor of alcohol. His colleagues considered him a "heavy drinker" but held his medical expertise in high regard. The physician was having difficulty with his professional relationships. There were rumors of marital discord associated with alcohol abuse.

During an intervention, the physician denied the "accusations" stated above. Denial was further evidenced by blaming family dysfunction on his former wife and the break up of his former partnership on his former partner. He could not relate alcohol use to the consequences associated with the concerns of his former wife, partner or the nursing complaints.

The physician denied abuse of alcohol during an interview with the Alabama Board of Medical Examiners. The referring individual withdrew his initial complaint and advocated for the physician. Insufficient information was available to the Board to recommend an evaluation.

The referring individual's enabling attitude reflected a lack of understanding of the subtle manifestation of this disease. The intense denial in the addict-alcoholic at times suggests an organic delusional disorder. The resulting subconscious dishonesty produces manipulative behavior towards others. The inability to be honest with himself, to be unable to objectively look at the real source of his behavior, promotes poor defense coping mechanisms as elicited further in this discussion.

The physician continued to practice with no signs of impairment in his professional performance. A chronic medical condition with incomplete relief of pain led to going on medical disability.

While on continued disability and in the absence of the demands of active medical practice, his alcohol consumption dramatically increased. He began to purchase alcohol by the case in one half gallon containers. Alcohol consumption increased to one quart a day with drinking beginning at noon each day.

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Frequent naps in the afternoon were followed by resumption of drinking alone when he awoke. On occasion, he would go four days without shower or shave. He withdrew from social affairs and long term friendships. Loss of initiative was accompanied by depression. His drinking continued despite expressed concerns from his wife that alcohol was interfering in their new marriage. Attempts to curtail or cut down on his alcohol intake were unsuccessful.

This sequence of events illustrate preoccupation and unplanned use of alcohol. Drinking alone, ensuring a constant supply of alcohol, and increasing tolerance are all evident. Depression is common accompanying the abuse of the sedative drug, alcohol.

At this point in the progression of his illness, profound denial is present as evident by an inability to correlate alcohol consumption with the disastrous consequences developing in his life. “I drink at noon simply because I like the taste of scotch!”

The pattern of daily drinking continued. He exhibited a personality change, becoming argumentative, quick to temper, verbally intimidating, more controlling, and blaming others for problems in his life. There was progressive deterioration in family communication and loss of family companionship.

As the disease progresses, more of the family’s resources are spent on the alcoholic’s behavior. Eventually, the chemically dependent physician will tend to rationalize, justify, and project blame onto others (particularly those around him/her). The family will begin to join in the addict’s denial, and consequently begin to feel hurt, anger, disgust, frustration, and guilt about feelings they have toward the addicted physician. Professionally, family members are likely to shield the addict and themselves from exposure and embarrassment. When family members protect the addict from the consequences of his/her disease, they enable the addict to stay sick.

The physician’s wife expressed concern about her husband’s alcohol intake to a physician friend. The Physicians Recovery Network was confidentially contacted. Discreet investigation revealed that other colleagues had noted transient periods during which the sick physician had lapses in memory during conversations and began slurring his speech. Increasing depression seemed more apparent.

These progressive events demonstrate “blackout” behavior suggesting advanced alcoholism. It is evident at this point that the physician no longer had control over time, place, or amount of alcohol consumed.

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With the Medical Director of the Physicians Recovery Network, other genuinely concerned physicians and the sick physician’s wife, a caring, impromptu intervention was done. Each participating individual expressed honest feelings, love, and concern for the sick physician citing specific behavioral signs and alcohol intake that concerned them. The physician continued to express defense mechanisms including denial, blaming others, minimizing alcohol intake, justifying and intellectualizing his actions, and attempts at manipulation through anger and intimidation. The intervening participants continued to express a caring and honest concern. When the sick physician’s attempts at justifying his actions were unsuccessful and there were no other reasonable alternatives, the physician agreed to enter into an evaluation by a treatment provider approved by the Alabama Impaired Physicians Committee.

An impromptu intervention was necessary with this physician in the morning hours as the remainder of the day revolved around the intoxicating effects of alcohol consumption. Active alcohol intake reinforces denial so that reasonable alternatives cannot be objectively considered by the sick individual. To delay further an intervention with this sick physician may have been associated with additional consequences including increasing depression, exposure to disciplinary Boards, automobile accidents, or death!

A major misconception among professionals is that they must be able to prove that someone is using alcohol/other drugs while on duty. It is unclear why that notion persists in the face of obvious nursing complaints of using while on duty. Still, colleagues and hospital co-workers feel immobilized until they have absolute proof. In physicians, the odor of alcohol during working hours can be a very late stage symptom. For an early diagnosis to avoid advanced disease as illustrated in the case history above, look to the behavioral symptoms in the individual as they are evident in the community affairs, church, social affairs, and the family.

Following evaluation, the diagnosis of alcohol abuse was established. The recommendation was for treatment to maintain a chemical free life style. The family has become involved in the treatment process. The recovery process for this disabling disease for the impaired physician and his family has begun.

A discussion of how to recognize possible addictive problems in physicians and patients would not be sufficient without a “pearl.” There is a simple but very useful diagnostic acronym for alcoholism that can be helpful. The “CAGE” test is well known in addiction medicine. A “yes” answer to two or more of the following questions offer a strong indication that the individual should be seriously considered for a more extensive assessment for alcoholism. Recent research suggests that brief interventions can change behavior of heavy drinkers validates the usefulness of the CAGE acronym.

C — Cut down? Have you tried to cut down on your drinking? It is important to realize that the alcohol content for a can of beer, a shot of whiskey, or a glass of wine is essentially the same. Individuals who may be concerned about their drinking will change from one to the other in the misguided attempt to “cut down.”

A — Annoyed or angry? Have you ever felt annoyed by criticism or comments about your drinking? For example, has your wife or children complained about your drinking?

G — Guilty? Have you ever felt guilty in connection with your drinking such as when you were intoxicated at a country club affair?

E — Eye opener? Have you ever had an eye opener (a morning after drink) to help with a hangover? How about on the weekend when you do not have to go to the office?

A “clincher” question: Does it take more alcohol now than it used to for you to get the effect that you want? How many drinks does it take for you to get high? An increased tolerance to alcohol is a very strong indicator of alcohol dependency. It means that the disease process has begun and the individual should take a close, honest look at his intake. Without total abstinence from alcohol and other mood-altering drugs, the disease process will get worse.

The primary goal of the Physicians Recovery Network is to intervene in the illness process prior to irreversible consequences. Many physicians have been helped by concerned colleagues in Alabama. Addicted physicians never spontaneously reach out for help. Their colleagues are needed to recognize their dilemma.

References
Understanding Leadership

The only aspect of leadership that is universally agreed upon is that most leaders are not born. People learn to be leaders. The place to start the process is by learning the styles, qualities and skills that can enhance your leadership role.

The autocratic style of leadership is one in which the leader makes all decisions, determines all policy, and assumes all responsibility. There are pitfalls in this type of leadership—most importantly, it doesn’t involve others within the organization, which is a key in keeping an organization alive and growing.

The laissez-faire or free rein leadership style is one in which everyone has input and control by the leader is minimal. This is a hands-off situation in which people make their own decisions and put their own ideas to work. The problems with the laissez-faire leadership style are that the leader can lose all control and that the organization will founder because it lacks a central force.

In the democratic style of leadership the leader is a moderator, drawing ideas or suggestions from the group. The leader directs activities, letting various views be expressed, while keeping in mind the goals to be reached. Ideally, this is the best leadership style, but it can’t be used in every situation.

The autocratic style of leadership would be most effective in dealing with hostile, aggressive people; with timid, shy people, and with disorganized people. The laissez-faire style would be appropriate when working with outgoing self-starters. The democratic style would be effective in dealing with strongly cooperative people, and sometimes with disorganized people.

Leadership is a combination of character, conduct and confidence, and each person has unique qualities that they bring to a particular job. To be an effective leader you need to understand your personal qualities and determine how you can use them in your leadership role.

Evaluating your personal traits can help you improve those that need to be improved. If you are impatient or inflexible, you will have to learn to change these qualities. Other qualities are not as easily dealt with—for example, the ability to make decisions quickly. Being able to make decisions quickly is important in some situations. There are times when it is better to be patient and not decide an issue in haste, and to draw others into the decision-making process.

Taking criticism well is a quality that every leader needs. Whether it is justified or not, criticism will come to those in leadership positions. If you can take comments people make as suggestions, rather than personal criticism, you will learn from them. At the top of the list of skills a leader needs is the ability to motivate others. Leaders motivate others to work with them. You need to know who you are, what you want from life, what you want from the organization you’re going to lead, and what your goals are. You need to know why you want to be a leader - what benefits you want from the experience. You need to know how you relate to others and how others see and relate to you.

A vital leadership skill is the ability to communicate. People need to feel that two-way communication exists or their interest will wane. Your verbal communication as a leader enables you to direct activities, seek cooperation from others, and work with others.
toward mutual goals. Body language, tone of voice, and personal image also enter into communication. Experts have said that 55% of the messages received are through body language, and 38% through tone of voice. Only 7% of messages are received through words.

One universal point of agreement is that leaders are made not born. Leadership is a learned art. If some of the leadership qualities don’t come naturally they can be developed. They must be developed to lead effectively.

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II. Efforts by Physicians to Counterbalance Perceived Payer Market Power (A Fractured Fairy Tale)

John J. Miles, Esq.

Mr. Miles is a member of the prominent Washington law firm Ober, Kaler, Grimes & Shriver. The following is the second part of a larger work presented at the antitrust meeting of the National Health Lawyers Association in Washington in February 1993. NHLA has granted Alabama Medicine permission for this one-time use of the material. Any subsequent use will require written permission from NHLA, 1120 Connecticut Avenue, NW, Suite 950 Washington, DC 20036.

We’re all aware of the concern of many physicians that they are small entities dealing with large managed-care plans able to exercise substantial market power as purchasers, and thus able to force physician reimbursement below competitive levels. In economic terms, physicians believe that managed-care plans exercise monopsony power.

How true is this? I frankly don’t know, but I’ve seen no published empirical studies showing that managed-care plans are able to wield monopsony power. Moreover, I think it important to keep in mind that “monopsony” is a technical, not a lay, concept. Not only must the purchaser (here, the managed-care plan) have a substantial market share (at least 35% according to rough Department of Justice guidelines relating to group-purchasing programs)14, but other conditions must be present as well.15 My point is that just because a managed-care plan is perceived to be “large” does not mean that it has monopsony power.

Physicians seem particularly upset about the economic power of the Medicare program. I remember meeting with a physician-client about eight months ago who, upset about low reimbursement from both Medicare and managed-care plans, began the conversation by asking me to bring an antitrust suit against the Medicare program, “the biggest price fixer of them all,” as he described it. I answered that “of course, anyone can sue anybody for anything, but it’s not the kind of case I’d take on a contingent fee.” I explained that the federal government, its instrumentality, and its agents enjoy federal governmental immunity from antitrust suits.16

My physician client then tells me, “OK, so I can’t successfully sue the federal government. File an antitrust suit against that Blue Shield plan with 80% of the market that hasn’t increased my reimbursement in ten years. And take the case on a contingent fee.”

I then try to explain, first, that my firm doesn’t take cases on contingent fees (at least not this one) and that, just as a firm with legitimately obtained monopoly power lawfully may charge a monopoly price,17 a firm with lawfully obtained monopoly power may pay a monopoly price without violating section 2 of the Sherman Act.18 Of course, I add, the answer is different if that price results from an agreement or understanding with other payers.

“OK,” my client says, “but I’m taking this problem to the medical society; perhaps if we make it clear to the payer that none of us will participate at this level of reimbursement, I bet then reimbursement will be increased.”

“Ever hear the stories about the Tucson dentists and the Boston allergists?” I reply.

“Are they jokes?”, he asks.

“Guess it depends on your perspective,” I respond.

After a short dissertation about United States v. A. Lanoy Alston D.M.D., P.C.,19 and United States v. Massachusetts Allergy Society20 (more about which later), I presented a chronological overview of antitrust cases involving collective efforts by providers to increase reimbursement. I began with the 1978 decision in DeGregorio v. Segal,21 in which the court indicated that an agreement

14 See generally Charles F. Rule, Deputy Assistant Attorney General, Antitrust Division, text of remarks before Chemical Manufacturers Association (Oct. 21, 1985).
For a more detailed discussion of all the material covered in this section of the paper, see HCLA, supra note 8, at Ch. 15.
16 E.g., Lawline v. American Bar Ass’n, 956 F.2d 1378 (7th Cir. 1992); Murphy v. Aetna Life & Casualty, 1988-2 Trade Cas. (CCH) Sec. 68,240 (D. Ore. 1986); Medical Ass’n v. Schweiker, 554 F. Supp. 955 (M.D. Ala.), aff’d sub nom. Medical Ass’n v. Heckler, 714 F.2d 107 (11th Cir. 1983).
19 974 F.2d 1206 (9th Cir. 1992).
among nursing home operators not to participate in the Medicaid program unless reimbursement were increased would constitute a per se violation of section 1. I then explained the Antitrust Division's challenges to the same type of conduct in United States v. South Carolina Health Care Association and United States v. Montana Nursing Home Association, which resulted in consent decrees.

I discussed the Commission's Michigan State Medical Society decision in some detail. Although the Commission refused to apply a strict per se rule to collective threats not to participate in both Medicaid and Blue Shield programs, I explained that its truncated rule-of-reason analysis amounted to almost the same thing. I noted specifically that the Commission rejected what might be called an "unequal bargaining power" defense but, importantly, that its final order permitted the group to express its collective views to payers, even with regard to fees, as long as there was no attempt to coerce the payer or to extract an agreement as to reimbursement.

I also mentioned United States v. North Dakota Hospital Association, in which an agreement among association members not to grant a discount on hospital services to the Indian Health Service was declared unlawful under the rule of reason and Pennsylvania Dental Association v. Medical Service Association of Pennsylvania, in which an agreement exhorting dentists not to participate in Blue Shield unless the upper limit on charges was changed was found unlawful. I noted that state attorneys general also have actively challenged collective efforts by physicians to increase reimbursement. Finally, I explored the Supreme Court's decision in FTC v. Superior Court Trial Lawyers Association in some detail. I emphasized that the decision there made it crystal clear that agreements among providers not to participate in payment programs unless the payor increases reimbursement are per se unlawful. My physician client commented that at least the case involved attorneys instead of physicians, but I assured him that the same principles applied to doctors and other providers of health care.

This discussion told my friend more than he ever wanted to know about antitrust law, and he expressed chagrin that, like most lawyers, I'd told him what he couldn't do but not what he could do. I responded with the typical lawyer answer: "That's not always clear. It depends."

He indicated that several years ago he'd heard a presentation by a physician extolling the virtues of physicians unions as a method of circumventing antitrust constraints on the ability of physicians to deal collectively over reimbursement with health plans. I explained that union activities, in most circumstances, enjoy a statutory or nonstatutory exemption from antitrust challenges, but that a group's simply calling itself a union did not make it one for antitrust-exemption purposes. Rather, there must be an employer-employee relationship; purported union agreements among independent contractors don't cut the mustard.

Thus, I explained, if he were an employee of a staff-model HMO, he and his fellow physician-employees could bargain collectively with the HMO. But his status as a solo practitioner, I noted, would preclude him from escaping the antitrust laws by joining with similarly situated physicians to bargain as a group.

The conversation next naturally turned to other types of collaborative efforts among physicians that might permit collective efforts regarding reimbursement. This led into the usual discussion about IPAs, PPOs, and economic integration. I explained to him generally that if he and other physicians partially integrated by combining some functions of their practices, then collective efforts might be possible. He obviously didn't like the word "might," calling it "wimpy." After I explained that integration in this context meant combining some business operations and sharing profits and losses, he asked the question that I had feared he would: "How much integration is necessary?"

I again gave him the classic lawyer answer: "It's not clear" (thinking to myself that if I knew the answer and could market it, I'd be a millionaire). I tried to assure him that my answer was not because I'm stupid but that not even the government enforcers know. Indeed, even the Antitrust Division and Federal Trade Commission don't seem to agree on the answer (more about which later). "You've got to understand," I tried to explain, "that the reason why agreements setting prices among physicians participating in PPOs and IPAs sometimes pass antitrust

23 1982-2 Trade Cas. (CCH) Sec. 64,852 (D. Mont. 1982) (consent decree).
29 See Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332 (1982); cf. Bouwarte v. Nevada, 960 F.2d 793 (9th Cir. 1992) ("We are somewhat surprised that members of the health care professions continue to press tired arguments seeking to avoid the clear competitive mandate of the Sherman Act . . . . Health care providers are exposed to the same liability and entitled to the same defenses as businesses in other industries.").
33 For a more indepth discussion of what follows, see 2 HCAL, supra note 8, at § 15.03[6][7] (1992).
muster is not to help competitors figure out a legitimate way to fix prices. Rather, it’s because these partially integrated groups of providers usually promote competition by competing against similar networks or groups, and the agreements as to price sometimes are necessary for the group to operate efficiently.”

I began by noting that there is very little case law on the issue, mentioning on one hand Hassan v. Independent Practice Associates. P.C., 34 which indicated that IPAs under capitation arrangements where risks are shared are sufficiently integrated to permit price agreements among providers. On the other hand is the ChoiceCare $32.6 million jury verdict35 based in part on a price-fixing agreement among IPA members seemingly like that in Hassan. I then emphasized that most guidance comes from Federal Trade Commission cases that resulted in consent orders (which, even though not litigated, provide insight into arrangements the Commission believes are unlawful), from Antitrust Division business review letters and Commission staff advisory opinions, and from speeches by enforcement officials.

Important Commission actions I mentioned were Preferred Physicians, Inc.,36 where the Commission alleged that a PPO was formed with little integration simply to negotiate reimbursement on behalf of members and to resist granting discounts, and Southbank IPA, Inc.,37 which involved similar allegations involving a “sham” IPA. Also worth mentioning, I thought, was the Antitrust Division’s proposed consent decree in United States v. Greater Bridgeport Individual Practice Association,38 where, when an integrated IPA and an HMO with which it contracted reached an impasse over reimbursement negotiations, the IPA and its members allegedly agreed that members would not negotiate with the HMO on individual bases.

I noted that most Antitrust Division consent decrees and Commission consent orders dealing with purported IPAs and PPOs include a provision making clear that providers can deal as a group if they form an integrated joint venture and also remain free to deal with health plans on an individual basis. The decree in United States v. Massachusetts Allergy Society,39 entered last year, is representative, defining an “integrated joint venture” as “a joint arrangement to provide prepaid health care services in which physicians who would otherwise be competitors pool their capital to finance the venture, by themselves or together with others, and share substantial risk of adverse financial results caused by unexpectedly high utilization or costs of health care services.”40

Most guidance, I explained, comes from Federal Trade Commission staff advisory opinions and speeches from both enforcement agencies. With regard to IPAs with risk sharing through capitation arrangements and significant capital contributions, the most important staff advisory opinions are those to Gilbert Frimet in 198441 and to Maryland Eye Associates in 1987.42 Both provide strong indication that if the IPA is capitated, it is sufficiently integrated that an agreement among participants as to price will trigger analysis under the rule of reason rather than be condemned under the per se rule.

I explained that, in general, PPOs are less integrated than IPAs and thus that the antitrust significance of price arrangements among otherwise competing physicians is more difficult to analyze. Here, I began with the Department of Justice’s 1983 threat to challenge the Stanislaus Preferred Provider Organization, where the PPO contained over 90% of physicians in the area, it was formed to preempt capitated plans from entering the area, and participants agreed not to participate in other alternative delivery systems.43 Simply put, this PPO, according to the Department of Justice, was a sham. I also mentioned the Commission’s 1986 staff advisory opinion to Michael Duncheon,44 in which the staff could not tell whether the PPO there involved sufficient integration for a price agreement among participants to escape per se treatment.

On the speech front, I related the history of PPO analysis at the Antitrust Division, beginning with then Assistant Attorney General McGrath’s 1985 speech indicating that price agreements among participating PPO physicians would not be challenged if there were some integration of business functions and the PPO did not include more than 20% of area providers.45 This 20% safe harbor was increased to 35% in a 1988 speech by then Assistant Attorney General Rick Rule.46 In 1991, however, these participation-percentage safe harbors were scrapped by then Assistant Attorney General Jim Rill, who indicated that the Division would simply apply the Department of Justice’s 1984 Merger Guidelines to the formation of PPOs.47

38 Trade Reg. Rep. (CCH) Sec. 50,741 (D. Conn. 1992) (proposed consent decree).
No one is sure, I explained, what the rules are now. Will the Division apply the new 1992 Merger Guidelines? In its most recent speech on the issue, a Division official appeared to espouse a joint venture-type analysis. Supposedly, the Division has been examining how PPOs should be analyzed for over a year now, but there is no indication that it will provide any guidelines in the near future.

The Division has seemed to take a more lenient approach to price-related agreements among physicians participating in PPOs than the Commission. Division speeches, for example, have suggested that less integration might be required to escape per se treatment than the Commission seems to think. In particular, the Division appears to believe that sufficient integration to escape per se treatment could result without the participants actually sharing financial risk in some form, while the Commission appears to believe that risk sharing among participants is essential. While this apparent disparity of views can be somewhat confusing, it's fortunate at least that the Division takes the more lenient view since it, and not the Commission, can bring antitrust cases criminally as well as civilly.

Finally, I discussed with my physician client some of the mechanisms that lawyers have dreamed up to circumvent the potential price-fixing problem of price agreements among physicians participating in PPOs, including having an independent party or committee establish the level of reimbursement; the "message"-model PPO, in which the PPO simply ferries offers back and forth between individual providers and payers, and each provider makes a unilateral decision whether to participate in a particular contract; the "super-message model," in which the PPO performs a similar function with respect to price offers but does negotiate nonprice terms on behalf of participating providers; and the "attorney-in-fact model," where the PPO negotiates ranges of fees with the payer and sometimes contracts on the providers' behalf. My client said that these Rube Goldberg-type machinations seemed both very inefficient and like a facade to him, and he wondered how they had fared in court. I had to admit that none have been challenged, but I did note that the consent decree in Maricopa specifically permitted the physicians group there to use fee schedules prepared by "an insurer, government agency, or other third party payer." The messenger model seemed to have been approved in a Commission staff advisory opinion.

After having heard this one-hour dissertation about integrating with other physicians through some type of IPA or PPO, my client said, "Forget about the integration route because it hardly seems worth the trouble, especially since no one knows what the rules are anyway. What can our local medical society do as a group?"

I thought, "Oh no, he's going to ask how far the group can go in negotiating collectively."

His next question was, "Exactly how far can we go in dealing with payers as a group?" I thought to myself, "How many angels can dance on the head of a pin?"

I began with the extremes: "Well, on one hand, members of the group can't reach any understanding not to participate, or to threaten not to participate, in a plan unless reimbursement is increased. On the other, the group should be able to espouse its collective view about the plan to the payer, including its views about the level of reimbursement, but it had better be careful that there is no implicit understanding not to participate unless its view are accepted. The antitrust ramifications of collective actions between these two extremes are unclear."

With this, I went to my shelf and pulled paragraph 69,962 of 1992-2 Trade Cases — the Alston decision — and outlined the facts there: that three dentists had been indicted for price fixing where they allegedly were ringleaders in a scheme in which some thirty dentists in Tucson sent letters to payers threatening to withdraw from their health plans unless the co-payments they could charge for particular dental procedures were increased; that a jury convicted them; that the district judge granted motions for acquittal for two defendants and a motion for a new trial for the third; that the Ninth Circuit, in a somewhat strange opinion, indicated that the conduct charged indeed would constitute price fixing but that it was not clear that the defendants had the requisite criminal intent; that the Ninth Circuit reversed the judgment of acquittals and affirmed the granting of a new trial; and that my reading of the opinion was that the court, notwithstanding its protestations to the contrary, was not happy with the government's decision to prosecute the matter criminally instead of civilly.

I noted that the court seemed to commiserate with individual providers having to deal with large payers:

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50 Charles F. Rule, Assistant Attorney General, Antitrust Division, "Antitrust in the Health Care Field: Distinguishing Resistance from Adaptation," text of remarks before the Connecticut Bar Association and Connecticut Health Lawyers Association (Mar. 11, 1992), reprinted in HCAL, supra note 8, at App. E11 ("it has been suggested that . . . to form a legitimate PPO, the providers must contribute capital and share a substantial degree of the risk of adverse financial results. The Department believes that PPOs can achieve substantial procompetitive benefits through integration that falls short of financial participation and sharing of risks.").
53 See Letter from Mark J. Horoschak, Assistant Director, Bureau of Competition, Federal Trade Commission, to Martin J. Thompson (June 20, 1991) (Staff Advisory Opinion appearing to approve messenger-model PPO).
54 See, e.g., FTC v. Superior Court Trial Lawyers Ass'n, 493 U.S. 411 (1990); Chain Pharmacy Ass'n, Dkt. No. 9227 (FTC May 17, 1991) (initial decision).
55 E.g., American Soc'y of Internal Medicine, 105 F.T.C. 505 (1985) (full Commission opinion indicating that providers can present collective views about reimbursement to payers); American Academy of Orthopaedic Surgeons, 105 F.T.C. 248 (1985) (consent order permitting group of physicians to provide views on use of particular reimbursement methodologies); Michigan State Medical Society, 101 F.T.C. 191 (1983) (consent order permitting physician group to express its views about reimbursement to payers).

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“[H]ealth care providers who must deal with consumers indirectly through plans . . . face an unusual situation that may legitimate certain collective actions. Medical plans serve, effectively, as the bargaining agents for large groups of consumers; they use the clout of their consumer base to drive down health care service fees. Uniform fee schedules—anathema in a normal, competitive market—are standard operating procedure when medical plans are involved. In light of these departures from a normal competitive market, individual health care providers are entitled to take some joint action (short of price fixing or a group boycott) to level the bargaining imbalance created by the plans and provide meaningful input into the setting of the fee schedules.” 58

Like others reading this opinion with whom I’ve talked, my physician client was quite happy with the court’s position, but the emphasized passage above simply didn’t register in his mind. It was obvious to me that he took the quotation as a carte blanche for the medical society to deal as a group however it wished.

Reading on, I listed the actions that the court had indicated “might be perfectly legal”:

“dentists commiserating over the low fee schedules; or impugning the motivations or integrity of the Plans; or even sabre-rattling about economic retribution at some indefinite time in the future if their grievances remain unaddressed.

. . . .

“Thus, health care providers might pool cost data in justifying a request for an increased fee schedule. . . . Providers might also band together to negotiate various other aspects of their relationship with the plans such as payment procedures, the type of documentation they must provide, the method of referring patients and the mechanism for adjusting disputes. Such concerted actions, which would not implicate the per se rule, must be carefully distinguished from efforts to dictate terms by explicit threats of mass withdrawals from the plans.” 59

“Ah hah,” my client exclaimed, regretfully again disregarding the emphasized portions of the quote, “I guess the government got its ears pinned back in this case. The court did provide physicians with some antitrust relief.”

I explained three things that those reading the decision through rose-colored glasses seem to overlook: First, the court made it crystal clear that the conduct challenged by the government constituted a per se violation; second, the defendants were subject to retrial criminally; and third, none of the activities listed by the court, by itself, would have constituted a per se antitrust violation (or probably a violation under the rule of reason) even prior to the decision. I also opined that I thought the decision unfortunate in one sense because its general sympathetic tenor (although not its specific language or holding) may encourage physicians to engage in concerted activities that cross the line from the lawful to the unlawful.

Still buoyed by his overly optimistic perception of the Alston decision, my client queried me about other potential collective activities. First, he asked whether the medical society could formulate a “suggested advisory fee schedule” and provide it to payers as the society’s views of “fair” reimbursement. (Whenever I hear the term “fair” used in the antitrust context, I think about Milton Friedman’s quip of some years back: “Businessmen who sing the glories of free enterprise and then demand ‘fair’ competition are enemies, not friends, of free markets. To them, ‘fair’ competition is a euphemism for a price-fixing agreement.”).60

The question brought to mind a number of decided cases and also a number of challenges filed by the Federal Trade Commission. I began with the Supreme Court’s decision in Goldfarb v. Virginia State Bar, which, in dicta, indicated that a purely advisory fee schedule would not constitute a per se violation of section 1.61 I mentioned, however, cases such as United States v. National Association of Real Estate Boards62 and Northern California Pharmaceutical Association v. United States63 (a criminal case), as well as the Commission’s opinion in American Society of Internal Medicine,64 which indicate how easy it is for an understanding to arise to abide by the “suggested” or “advisory” fee schedule. Moreover, I noted the position of the Antitrust Division that “competing providers who agree through their specialty society or other ad hoc group to develop a fee schedule for use in negotiations with [payers] are engaged in price fixing.”65

Related to this, I mentioned all the challenges by the Commission and Antitrust Division to the formulation and dissemination of relative value guides by provider groups,66 also noted, however, that in the only decided case testing the formulation and dissemination of relative value guides, United States v. American Society of Anesthesiologists,67 this type of conduct was found lawful, primarily because the Society made no effort to coerce payers to adopt the guides. I also emphasized that this decision seemed consistent with the view of the Commission:

58 974 F.2d at 1214 (emphasis added).
59 Id. (emphasis added).
60 Milton Friedman, Fair Versus Free, Newsweek, July 4, 1977, at 70.
63 306 F.2d 379 (9th Cir.), cert. denied, 371 U.S. 862 (1962).
66 66 F.A.C., United States v. Illinois Podiatry Soc'y, 1977-1 Trade Cas. (CCH) Soc'y. 61,767 (S.D.N.Y. 1979); California Medical Ass'n, 93 F.T.C. 519 (1979) (consent decree), modified, 105 F.T.C. 519 (1985) (permitting CMA to discuss health care financing with payers, but continuing to prohibit it from preparing and distributing relative value scale).
“No agreement in restraint of trade . . . occurs if a third-party payer decides to adopt a relative value scale as the basis for its reimbursement system, even if its decision results from discussions with [the group], so long as the third-party payer’s decision is a unilateral one, i.e., is not the result of coercion by [the group] or of an agreement, coerced or voluntary, between [the group] and the third-party payer.”

This led to a discussion of the Antitrust Division’s case in United States v. Massachusetts Allergy Society, about which I had some understanding because my firm represented one of the targets. The matter (which was referred to the Division by the Commission) began as a grand jury investigation of actions taken by allergists to increase their reimbursement from an HMO. Since this was a grand jury investigation, I explained to my client that I couldn’t be sure I had all the facts (and the government, hiding behind Rule 6, won’t tell you what the facts are), but that it appeared the allergists had formulated a suggested advisory fee schedule and transmitted it to the HMO as its recommendation of reasonable fees for allergy services. As best I could tell, however, the Society didn’t pressure the HMO to accept its proposals, although it did express unhappiness about current reimbursement and pestered the HMO from time to time to ascertain what action on fees the HMO intended to take. It also commented on proposals developed by the HMO. Ultimately, the HMO increased the level of reimbursement paid allergists, but to an extent unrelated to the suggestions made by the allergists.

The staff conducting the investigation recommended that the Society and several of its members (those most involved in developing the suggested fee schedule) be indicted for price fixing. It was easy to see why this investigation began as a criminal matter, but I still don’t understand why the staff ultimately recommended criminal prosecution. There must have been information before the grand jury relating to pressure by the allergists on the HMO of which I was not aware. In any event, higher-ups in the Division apparently disagreed with the staff’s recommendation, and the Division ultimately brought a civil case, terminated by a consent decree. The investigation, however, showed me first-hand how absolutely terrifying a grand jury investigation can be for physicians, and I emphasized as strongly to my client as possible that he stay far away from conduct that might lead to a criminal investigation unless he obtained specific legal advice from an antitrust specialist before proceeding. He thought to himself that at least I’d go to jail with him.

Recognizing the dangers of developing suggested fee schedules, even if agreements to do so aren’t per se unlawful, my client next asked whether problems would arise if he and other physicians compared their fees, as long as they reached no understanding to charge the same fees. This called to mind the Supreme Court’s decisions in Container Corporation and United States Gypsum Co., as well as the Antitrust Division’s recent complaint and consent decree in United States v. Burgstiner, the so-called “Savannah ob-gyn” case.

Although Container Corporation is somewhat vague on this point, it and Gypsum read together make clear that an agreement to exchange price information, by itself, is not a price-fixing agreement per se violative of section 1. Rather, the rule of reason applies, and the issue is whether, given the economic characteristics of the market and the type of information exchanged, the agreement likely will result in interdependent conduct that raises or stabilizes prices. In Burgstiner, for example (which began as a grand jury investigation), obstetricians in Savannah, in formulating a proposal for a PPO, exchanged information about their fees for deliveries, and this allegedly resulted in the price for deliveries in the area increasing significantly.

I also explained two other, related, antitrust problems that can arise from agreements to exchange price information. First, in an environment where fees are being discussed, it is quite easy (and natural) for the discussion of what providers are charging to evolve into an understanding to price in a particular way. Second, even if no explicit agreement about the prices to be charged is reached, discussion among competitors about their prices is strong probative evidence from which, together with other evidence, a per se unlawful agreement to fix prices can be inferred. I mentioned specifically an antitrust grand jury in Utah now investigating a situation in which hospitals supposedly exchanged information about nurses salaries. Thus, I cautioned my client that, although exchanges of fee information are sometimes appropriate (and even procompetitive), he should not discuss his fees with other physicians without first seeking specific antitrust advice.

He then explained to me that, in many cases, proposals from managed-care plans were “greek” to physicians, and he wondered whether the medical society could retain a consultant to advise the group about various proposals and then negotiate with the plan on behalf of the society’s members. I told him that both the Antitrust Division and the Commission took a dim view of a single individual negotiating reimbursement on behalf of providers.

68 American Soc’y of Internal Medicine, 105 F.T.C. 505, 511 (1985) (emphasis in original).
70 For the standards applied by the Division in determining whether to prosecute a violation criminally or civilly, see U.S. Dep’t of Justice, Antitrust Division Manual III-12 (1987).
71 Don’t laugh about this. Attorneys may become coconspirators with their clients when they help formulate business policies violating the antitrust laws rather than simply providing legal advice. See, e.g., Pinhas v. Summit Health Ltd., 894 F.2d 1024 (9th Cir. 1989), aff’d on other grounds, 111 S.Ct. 1842 (1991); Brown v. Donco Enters., 783 F.2d 644 (6th Cir. 1986). Even criminal liability is possible. See United States v. Buzzard, 540 F.2d 1383 (10th Cir.), cert. denied, 429 U.S. 1072 (1976).
74 1991-1 Trade Cas. (CCH) Sec. 69,422 (S.D. Ga. 1991) (consent decree).
76 See, e.g., Morton Salt Co. v. United States, 235 F.2d 573 (9th Cir. 1956).
On the other hand, I saw no problem with the society obtaining objective advice about contract provisions from an independent third party as long as certain guidelines, disseminated to members prior to any such discussions, were followed. Most important, individual members should not discuss with other members how they may react to the proposal — that is, whether they will participate or not participate — because discussions and identical responses, together with little other evidence indicating concerted rather than individual action, might be sufficient to permit a jury to infer that conduct resulted from conspiracy rather than from independent action.79 The physicians’ decisions in this regard must be unilateral.

Second, the consultant’s advice should be objective — that is, it should explain the meaning, pros, and cons of particular provisions in the proposal but should not “rally the troops to action” (especially to establish a “united front”) or even include any recommendation as to action the group should take. Specific antitrust advice should be sought before the consultant is employed to advise the group.

At the end of our conversation, my physician friend exhibited both frustration at my advice and, indeed, apparent animosity toward me. “Don’t kill the messenger” was my second thought. (My first was whether I’d gotten a retainer.) He made it plain that he didn’t like answers with wimpy legal hedges like “it’s not clear,” “it depends on the circumstances,” “you might be able to do it, but get good advice first” (which he took to mean, “pay me and I’ll tell you”), “it depends on the degree of integration,” “how much market power does the group have?”, and “gee, antitrust is so fact-specific that I can’t answer that in a vacuum.” Continuing, he concluded, “What you seem to be saying is that I can’t do anything with ‘teeth’ to solve the problem of this low, ‘unfair’ reimbursement. You simply want me to dance around the problem — fish without cutting bait — with legalistic games that might make me feel better but do nothing to level this tipsy playing field with health plans that we’re about to fall off of.”

Being somewhat tired by this time, I gave it to him straight: “I agree that nothing I’ve suggested has teeth that will force a payer to increase your group’s reimbursement if you can’t convince the payer that your reimbursement is below the competitive level. The basic problem here is that you want to figure out a way to do something that section 1 of the Sherman Act specifically is meant to protect against — agreeing with your competitors to raise prices. Of course all this is a facade; we’re trying to figure out a way to do what the law is aimed at preventing. Tax avoidance is always less effective than tax evasion. The problem is you go to jail for the latter. The same is true here.”

I knew that he still wanted an answer to the “how far can we go collectively?” question, and so I tried to explain: “The cardinal principle is that the payer always must be the decision maker as to reimbursement. Most want input about fees, both collective and individual, from their participating providers to help ensure that their level of reimbursement will be competitive in the sense of drawing the number of participants they need to fill their network. It seems to me that as long as providers merely furnish that information, their activities are procompetitive. When, however, the providers attempt the usurp the decision making function, whether by refusing to participate unless reimbursement is increased, by threatening not to participate, or even by more subtle means that convey the feeling to the payer that providers might refuse to participate pursuant to some understanding, then the line is crossed, and their activities are anticompetitive rather than procompetitive.

“The problem is that this line is impossible to draw precisely, resting as it does on the payer’s state of mind. The providers won’t be able to tell exactly when the payer begins to feel ‘coerced.’ Thus, providers shouldn’t walk so close to the edge of the cliff that rocks begin the cave in under them and they begin to fall in. The cost, ‘the crushing consequences of a criminal conviction on the lives and careers of [professionals] singled out for such treatment’—is too high.”80

The meeting seemed to end on a semi-high note. He wasn’t happy with the advice, but I think he understood and would follow it (the part about a felony conviction, a possible $350,000 fine, around four actual months in jail, and possible revocation of his license by the state seemed to sway him a little), although he did mutter something about dropping out of medicine and going to law school as he went out my door. It was not the most pleasant client conference I’ve had, but nothing that several gins and tonic wouldn’t cure.

79 Decisions going most far in this regard probably are Interstate Circuit, Inc. v. United States, 306 U.S. 208 (1939); United States v. Foley, 498 F.2d 1323 (4th Cir. 1979), cert. denied, 444 U.S. 1043 (1980); and Esco Corp. v. United States, 340 F. 2d 1000 (9th Cir. 1965). The extent to which these decisions survive the Supreme Court’s later decisions in Matsushita Electrical Industries Co. v. Zenith Radio Corp., 475 U.S. 574 (1986), and Monsanto Co. v. Spray-Rite Service Corp., 465 U.S. 752 (1984), is not clear.
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Lynn M. Cleary, M.D.*

A bigail found the moon last night.

It was a quiet discovery, like most of hers have been. I, on the other hand, heard an orchestra. These are secular miracles to me, her realizations. This one was especially magical because it was so unexpected. Yesterday was full-till, non-stop. I finally left the hospital after a late admission and went to pick her up at her grandmother’s house; it was quarter till ten when I arrived, and she hadn’t been able to fall asleep in her portable crib. She was edgy, of course, as if she resented the fact that I’d left her all day but at the same time resented my intrusion at returning; she’d had her grandmother’s undivided attention. Once we were outside she was quiet, attentive. The air was clear and cold, the moon was almost full, and it was surprisingly bright out with all the snow. She pointed up and said, “Deesh?” stared for a moment, then looked at me and smiled with the unmistakable delight of making a connection. All those hours of reading Good Night, Moon somehow fit together with her ability to select and then point to something and finally to show me what she had found. We both rode that wave for miles on the way home. Her car seat was near the window, so she could look out and contemplate her discovery. She was quite content with it, checking for its presence at intervals and then just resting or humming with the sound of the motor. The last few miles were along the lake, where the moon’s reflection was so lovely. We were both quiet then.

Much of the time my emotions are so private that I’m not certain of them, but motherhood has articulated very clear feelings. I am happy to be feeling what millions of mothers feel, what my mother and grandmother and sister have felt. Part of being a new mother is essentially instinctive, connecting me to ancestors and descendants. Another part is having body and emotions merge, as when milk stains my shirt when she cries. It is hard to describe what it is like to be kicked from the inside out, to nurse, to cry instinctively when she is in pain. I quite like this intimacy.

Motherhood has been remarkable in so many ways; I am only beginning to learn of its effects on me as a physician. It is not just being a patient, going through labor and delivery, healing wounds, or putting up with hemorrhoids. Nor is it learning how to nurse together, mix formula, or figure out if the baby has otitis media. Something in my brain is connecting differently now. Like Abigail, I find things right in front of me that may have been there all along. My neurons are redirected by hormones, my sensibilities have different receptors—more of some, less of others, perhaps new ones. It is not a new language or a different culture, and it is more than a simple renewal.

I have begun to sense that dimension of a patient-doctor relationship that relates to giving in a different way. Traditionally, one thinks of a patient receiving a diagnosis, information, treatment, of a doctor giving care, time, advice. I have been uncomfortable receiving gifts from patients; it was different receiving their gifts as a mother. I must feel motherhood is different from my other roles with them, perhaps more comfortable, perhaps more deserving. Maybe it is the nature of the gifts that made it easy. I have sensed the strength of good feeling when they gave me a blanket, or a rattle, or a bib. Giving gifts empowers the giver, and the usual doctor-patient relationship empowers the doctor in that way. As physicians we assume that power, usually with good intentions, but it does shift the fulcrum of the relationship. It feels very right to readjust that balance, to receive booties, or a stuffed bear, or genuine concern and good will. It feels right to respond to their inquiry about my family, to spend the time sharing that gift of affection. Somehow my child has helped me realize and accept a very important dimension to patient-doctor relationships, before she can even talk.

Another of her silent instructions is to appreciate time. She is my little yardstick, measuring off days

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and months with each new pound, new skill, new tooth. I am better organized and seem to accomplish more in less time. No doubt there are other ways to learn these skills, but motherhood does hasten their acquisition. Cooking and holding the baby at one time, reading while nursing her—these are good exercises and readily transferable to reading abstracts between returning phone calls at work or eating a sandwich while waiting for the file room clerk to find an x-ray. Although doing two things at once is often necessary at work, it feels more natural now and less of an imposition.

I am also learning to let circumstance direct me. Life is so much easier if I let her show me how she can untie her shoes rather than insisting she keep them on, and much more fun when she chooses between the tambourine and castanets than when I try to teach her a tune on the xylophone. It matters less what antibiotic the resident chooses for treating the pneumonia than that he or she decided to admit the patient for care in the first place at two o'clock in the morning. If Mr. Smith chooses to talk to me about his car mileage and snow tires, why should my own poor sense of timing force him to discuss his wife's terminal cancer that day? There is a time for direction and a time for appreciation. My daughter is helping me sense the difference.

Not long after returning from maternity leave, one of my patients entered the terminal stage of a prolonged illness. She and her husband had been patients for several years, and we had all been aware of the inevitable. Nonetheless, each dying process is a little different, each family circumstance unique. Most physicians process death objectively (Write the DNR order, be sure the morphine drip is adequate), but most also occasionally find it jarring, sometimes even unacceptable. This woman's terminal illness was uncomfortable for me. Perhaps it was the juxtaposition of my daughter's recent birth with this patient's impending death, my identification with her as a mother and grandmother, with them as loving parents. It may have been her stoicism, the unfairness of all her suffering.

We were able to have the hospice become involved in her terminal care. During the initial interview among family members, hospice staff members, and me, her husband asked specific questions about how she would die. They were good questions, hard ones to answer, but one of the answers from the hospice inpatient coordinator hit home for me. She explained that patients often labor before they die, just as women labor before giving birth. This patient had been laboring. She had sensed the process and was proceeding with an inner direction. "Don't fight," recommends the labor coach in the birthing classes. Somehow, this process of dying became less uncomfortable for me, and, I think, for the family. The patient had just celebrated a 75th birthday the week before entering real labor. She was ready to labor at the other end of her life. It was less a concept of her leaving than a natural transition from one place to another. The notion of hospice staff working as labor coaches seemed ridiculous, but oddly appropriate, sort of like whiskey and laughter at an Irish wake. No doubt the next of my patients to die will be very different, another disease, a different family. But the concept of laboring as part of dying will now be part of my framework to deal with it.

Motherhood shares so much with the practice of medicine; as Osler described the latter, it is "a way of life." It will be part of my awareness now, an inseparable part of my medical experience. No doubt little Abigail will show me the sun, the stars, and the planets some day.

Breast-Conservation Treatment

**AT LEAST ONE-THIRD OF ALL BREAST CANCER PATIENTS COULD HAVE LUMPECTOMY FOLLOWED BY RADIATION THERAPY**

The American Cancer Society, the American College of Surgeons and the American College of Radiology have agreed that women whose early breast cancer was detected by mammography are candidates for breast-sparing treatment. According to new standards, women with small lumps, those with tumors as large as two inches, and even some women with positive nodes may be candidates for this treatment.

Stage for stage, patients treated in this manner have the same longevity and the same freedom from local recurrence as those treated with mastectomy.

For copies of the standards please contact Keri Sperry, American College of Radiology, 1891 Preston White Drive, Reston, VA 22091.

acar

American Cancer Society

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PRAVICOF (Pravastatin Sodium Tablets)

CONTRAINDICATIONS

Hypersensitivity to any component of the medication
Acute liver disease or unexplained persistent elevations in liver function tests (see WARNINGS). Propranolol should not be given with other cholesterol-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Other products of cholesterol biosynthesis are essential components of cell membranes. Serotonin metabolism is partially dependent on cholesterol synthesis, and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause a more rapid depletion of serotonin in the platelets of pregnant women. Pravastatin should be administered to pregnant women or nursing mothers. Pravastatin should be administered to women of childbearing potential who are likely to become pregnant during therapy. Women of childbearing potential should be apprised of the potential hazards, if the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS

Liver Enzymes: HMCo-reductase inhibitors, like other lipid-lowering drugs, have been associated with increased serum aminotransferase levels, and a rare incidence of hepatic failure. In 2 of 10,000 to 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported. The enzyme levels return to normal when therapy is discontinued. Serotonin abnormalities were not associated with cholesterol and did not appear to be related to treatment duration. In those patients, it is advised to stop therapy, in patients who develop jaundice or dark urine from therapy, the transaminase values usually slowly fell to pretreatment levels. These biochemical findings are usually reversible, and complete recoveries, without evidence of residual damage or fibrosis, and, in some cases, it has been observed in patients without evidence of liver disease, the transaminase values returned to normal within 4 to 6 weeks of therapy discontinuation. No hepatic disorder was reported in patients who were continued on therapy and liver function tests were repeated, and monitored at least every 6 months. These changes were usually mild and reversed on discontinuation of the drug.

Muskoskeletal Events: 2.7

Anti-coagulant, 0.0

Other, 0.0

A chemically similar drug in this class produced optic nerve degeneration (Wallenbergian degeneration of retinal ganglion cells) in clinical normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced a plasma drug level of 10 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced dose-related increases in hepatic transaminase levels in dogs (treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose). Carcinogenesis, Mutagenesis, Impairment of Fertility: in a 2-year study rats fed pravastatin at doses of 150, 300, and 600 mg/kg/day, increased liver weights and/or increased hepatic triglyceride levels were noted in the highest dose group (5 to 9% of the control value). Although rats were fed up to 125 times the human dose (94 mg/kg body weight based on dose-normalized body weight) liver weights only were 6 to 10 times higher than those measured in human adults treated with pravastatin as measured by AUC.

Additional information: 10. 30, and 100 mg/kg (seduced pravastatin dose levels) approximately 0.5 to 5 times human drug levels at 40 mg/kg of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of lymphangiosarcoma in treatment groups exposed to and compared to control (p < 0.05). The incidence of death was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight (this is the mean serum drug level in a woman on a 40 mg/day dose of pravastatin). Micronuclei were seen in bone marrow cells of treated mice, and the incidence of micronuclei in bone marrow cells in treated mice were increased compared to control (p < 0.05).

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or reproductive performance. However, in a study with another HMCo-reductase inhibitor (inhibitors), there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when the same dose was administered for 11 weeks (the entire cycle of spermatogenesis), including epididymal maturation. In rats treated with this drug, the reduction in sperm count was seen at 180 mg/kg/day, serum transaminase elevations (excesses) and loss of spermatogenetic epithelium was observed. Although not seen in pravastatin, two drugs in this class caused related testicular toxicity, decreased spermogenesis, spermatic degeneration, and granule cell formation in dogs. The clinical significance of these findings is not known.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported during pravastatin therapy. The risk of rhabdomyolysis during pravastatin treatment is very low (0.00001%). It may be caused by the concomitant use of statins and gemfibrozil, given separately or in combination with drugs that inhibit CYP3A4 or hence decrease pravastatin levels, and it is usually associated with patients at high risk for rhabdomyolysis (e.g., elderly patients, patients treated with drugs that cause myopathy, patients with a history of rhabdomyolysis, especially if they have taken drugs that cause myopathy). This risk of myopathy is further increased in patients with renal impairment (see WARNINGS).

In the clinical trials, the percentage rate of adverse effects was 25% in patients given pravastatin and gemfibrozil showed a trend toward more frequent CKP elevations and patient withdrawals due to muscle-related events

Other REACTIONS: 10.0

The following adverse reactions have been observed in pravastatin recipients: 1. Peripheral nerve damage: One patient developed transverse myelitis, and the patient was studied in a previously well-tolerated regime. The adverse reactions were similar to the adverse reactions in patients treated with gemfibrozil and pravastatin. The use of fibrate drugs has been recommended to be discontinued in patients with transverse myelitis. The adverse reactions were similar to the adverse reactions in patients treated with gemfibrozil and pravastatin. The use of fibrate drugs has been recommended to be discontinued in patients with transverse myelitis. The use of fibrate drugs has been recommended to be discontinued in patients with transverse myelitis. The use of fibrate drugs has been recommended to be discontinued in patients with transverse myelitis. The use of fibrate drugs has been recommended to be discontinued in patients with transverse myelitis. 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Effective cholesterol control

Consistently and significantly reduces total C and atherogenic LDL-C; positively affects other key lipids

![Graph showing mean percentage change from baseline after 8 weeks of treatment with 10 to 40 mg of pravastatin.](chart.png)

Each arrow represents a range of means derived from a single placebo-controlled study that included 55 patients treated with pravastatin.

PRAVACHOL® (pravastatin sodium) is indicated as an adjunct to diet for the reduction of elevated total and LDL-cholesterol levels in patients with primary hypercholesterolemia (Types IIa and IIb) when the response to diet alone has not been adequate.

Active liver disease or unexplained transaminase elevations, pregnancy and lactation are contraindications to the use of pravastatin.


PRAVACHOL® pravastatin sodium 20 mg tablets

Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.