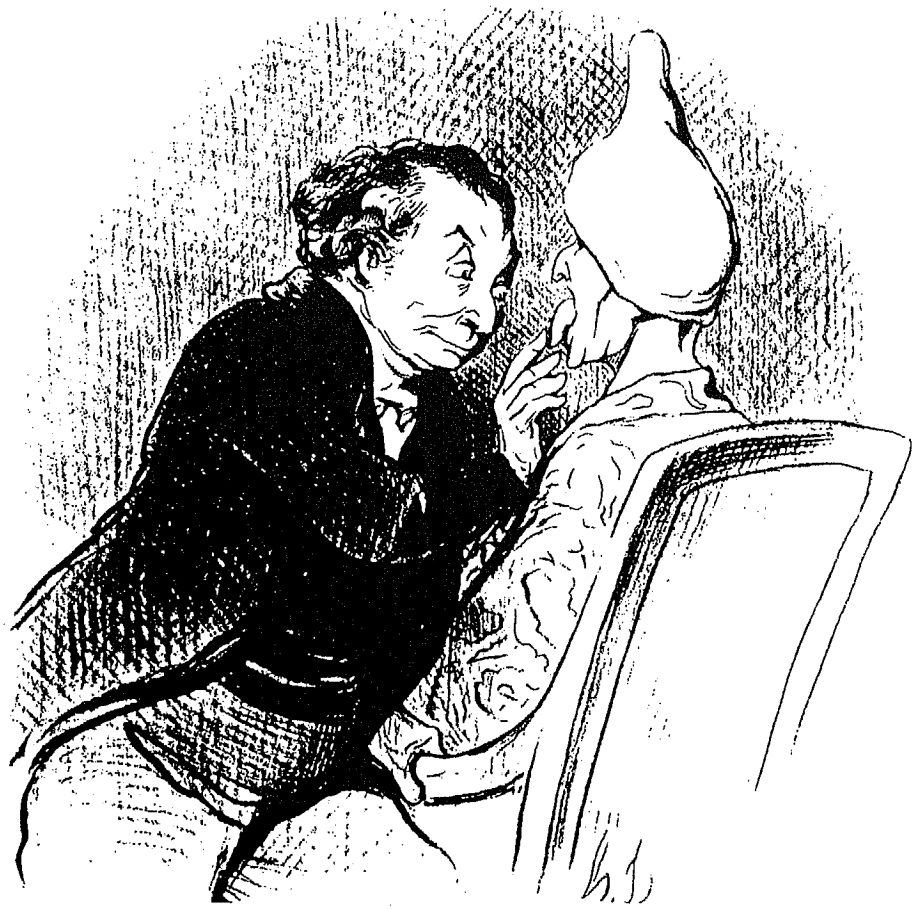
Shifting Bullness

December, 1993



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Inside this issue:

Clinton Health Plan: a radical solution to an exagerated problem

Greg Lucas

The Clinton health plan as written equates to socialized medicine, pure and simple. This basic and undeniable fact, although expertly couched in the doublespeak term, "managed competition," needs to be recognized before any real discussion of the issues can begin.

The plan promises to provide universal coverage for all Americans, regardless of their employment status. To do so, a wholesale revamping of health care delivery is proposed. The health care marketplace (i.e. hospitals, doctors and other providers) would be reorganized into local networks or "Health Plans" that would be structured on either an HMO, PPO or fee-for -service basis. On the purchasing end, small employers would join together to form large purchasing pools or "Health Alliances." An employer of greater than 5000 may form its own alliance or join with others. The cost of financing the system would come from employers, as they would be required to pay 80% of the premiums for all employees, and to a lesser degree sin taxes. The most important cost-control lever, however, would be the government's new found power to set prices and cap national spending on health care.

> But what can we really expect from this social planner? The answer is abuse and inefficiency.

Sound complicated? It is. The preliminary plan is 250 pages of complicated. The actual legislation promises to be over 1,000 pages and the specifying regulations 10 times longer than that. As a recent Wall Street Journal columnist commented, the 4-page Constitution has done a pretty fair job of running the country for 200 years, and we're lucky Hillary and Ira weren't around to author that.

Such drastic measures are justified, Clinton has argued, because of the terrible mess the health care system is in today. Specifically, 37 million Americans are currently uninsured, a figure that has been drilled so effectively into our collective consciousness that virtually anyone with a T.V. can recite it. There are several qualifiers that help put this statistic into perspective. The first is that this represents only 13% of the population. The other 87% (twice as many as voted for Clinton) are insured and generally express satisfaction with their health care when polled. A second fact, rarely mentioned, is that in a 9 month period of time, fully 70% of people in the uninsured group become insured. Thus, this cohort of uninsured is actually very fluid and transient, representing in many cases young, healthy people in entry level positions or between jobs. This is not to say that having so many uninsured at one time is optimal, nor that insurance coverage for all who desire it is not an admirable goal. Rather, I would suggest that the scope of the problem is not so staggering that we must pursue the radical path outlined in the Clinton plan.

There are a myriad of major concerns that can be raised to the plan itself: the effect on small businesses and employment, the impact on quality of health care and research, the absence of real tort reform, and the implications for medical education - to name but a few of the more salient. For the remainder of this article, however, I would like to focus attention on a single more blanketing concern that I alluded to earlier, which often gets lost in the details; namely, that the plan represents a radical switch of 14% of the gross domestic product from a largely private economy to one controlled by the federal government.

(Please see "Health," pg. 7)

Most Humorous Ward Story: A Day at Umstead

Tony Friedman

Editor's Note: The following is the winning entry for the most humorous ward story. It was chosen from a total of six entries by a panel of judges who were blinded to authors' identity. Shifting Dullness would like to thank the judges and all who participated.

During my childhood many people expressed the opinion that some day I would find myself in a mental institution. Naturally, they were right, but not quite the way they thought. I was as surprised as everyone else to find myself holding the keys when I spent two months at John Umstead Hospital at the end of my first clinical year. Umstead is a state mental institution, which means that they specialize in the involuntary commitment of those individuals who are "harmful to themselves or others." Needless to say, this policy tends to bring some rather spicy characters within the walls of the facility.

I remember my first day vividly. With fresh visions of "Silence of the Lambs" dancing through my head, I dodged my way through the odd assortment of personalities flooding the hallway. It seemed that the only requirement for a hall pass was orientation to self and absence of criminal charges. The new admission was Clancy Yarborough, and that was all I knew about him. Dr. Tanner had asked me to see the patient first, and she would join me later.

I finally found the right ward. Nervously, I peered through the narrow window in the heavy metal door. I fumbled for the keys in my belt and let myself in. As I walked down the corridor, one or two patients looked up, but for the most part I was ignored. I found the nurses' station and explained that I wanted to talk to the new admission. While I waited for the patient to be brought to the interviewing room, one of the nurses explained the three cardinal rules: Never sit between the patient and the door, never turn your back to your patient, and never, never fall in love. I took a brief look at the admission history. Apparently this Yarborough character had had entered into a dispute with a neighbor, which had somehow ended with Yarborough buck naked, chasing his neighbor into the street with a carving knife. Fantastic. Reciting the rules to myself, I stepped into the interviewing room.

To my surprise, Clancy Yarborough wasn't a wild-eyed, tooth-gnashing maniac. Clancy Yarborough was actually a rather frail appearing elderly lady who seemed quite overwhelmed by her situation. I introduced myself and she told me that she wanted

"I'm sure there's a perfectly reasonable explanation for this, but why didn't you have any clothes on when you ran out into the street?"

to be let go as soon as possible so that she could see her grandchildren. She explained that her hospitalization was all the result of a terrible misunderstanding; that she had mistaken her neighbor for a burglar and simply been defending her home. I nodded sympathetically. This poor elderly woman was obviously a simple victim of circumstance. After asking her the standard battery of questions about voices, delusions, suicidal ideations and the like, to which she universally responded in the negative, I assured her that in my opinion she would be on her way home shortly. She smiled at me beatifically.

"There's just one last question I wanted to ask," I said. "I'm sure there's a perfectly reasonable

(Please see "Umstead," pg. 8)

Service News

Katie Moynihan

Again this year, the medical school is participating in the **Share Your Christmas Program**, sponsored by the Durham County Dept. of Social Services. Last year this program provided more than 4000 Durham County residents - including many foster children - with a happier holiday season. With over 100 medical students participating, Duke was able to make a significant contribution to this very worthwhile cause. Already this year approximately 130 medical and physical therapy students have offered to help sponsor a needy child or adult. If you wish to get involved, it's not too late. All you need to do is call Katie Moynihan at 383-1211 with the names of a group wishing to sponsor a child. You will be given the name, age and family situation of a person as well as information regarding what that person needs or wants. We then ask that you purchase the gifts (around $40) and bring them to the HOLIDAY PARTY at Dr. Bradford's on Friday, Dec. 17. We will wrap the gifts at the party and also seek volunteers to help distribute them the following day. Hope you'll consider sharing your holiday joy this year.

Scuffle erupts in O.R.

Associated Press

WORCESTER, Mass. - It began when the surgeon threw a cotton swab at the anesthesiologist and ended in a brawl on the operating room floor. The patient slept through it. The Two doctors got up and resumed the operation. But they must pay $10,000 each.

The state Board of Registration in Medicine fined anesthesiologist Kwok Wei Chan and surgeon Mohan Korgaonkar last week and ordered them to undergo joint psychotherapy. Officials at the Medical Center of Massachusetts must monitor them for five years. Hospital officials wouldn't say what the two argued about.

Here, according to the medical board, is what happened on Oct. 24, 1991:

Korgaonkar, 49, was about to begin surgery on an elderly woman when he and Chan, 43 started to argue. Chan swore at Korgaonkar. Korgaonkar threw a cotton-tipped prep stick at Chan. The two raised their fists at each other and scuffled briefly on the floor while a nurse monitored the sleeping patient.

They resumed the operation, which was completed a half hour later without incident.

Shifting Dullness

Editors	Greg Lucas Fred Rimelle
Cartoonist	Chris Piller
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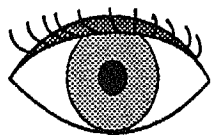
Correction

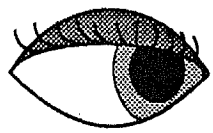
The follwing third year students were admitted into the A.O.A. honor society and were not properly identified in the original announcement last month:

Kristina Norvell
Mark Routbort
Steve Kent

Shifting Dullness regrets the error.

Journal Watch





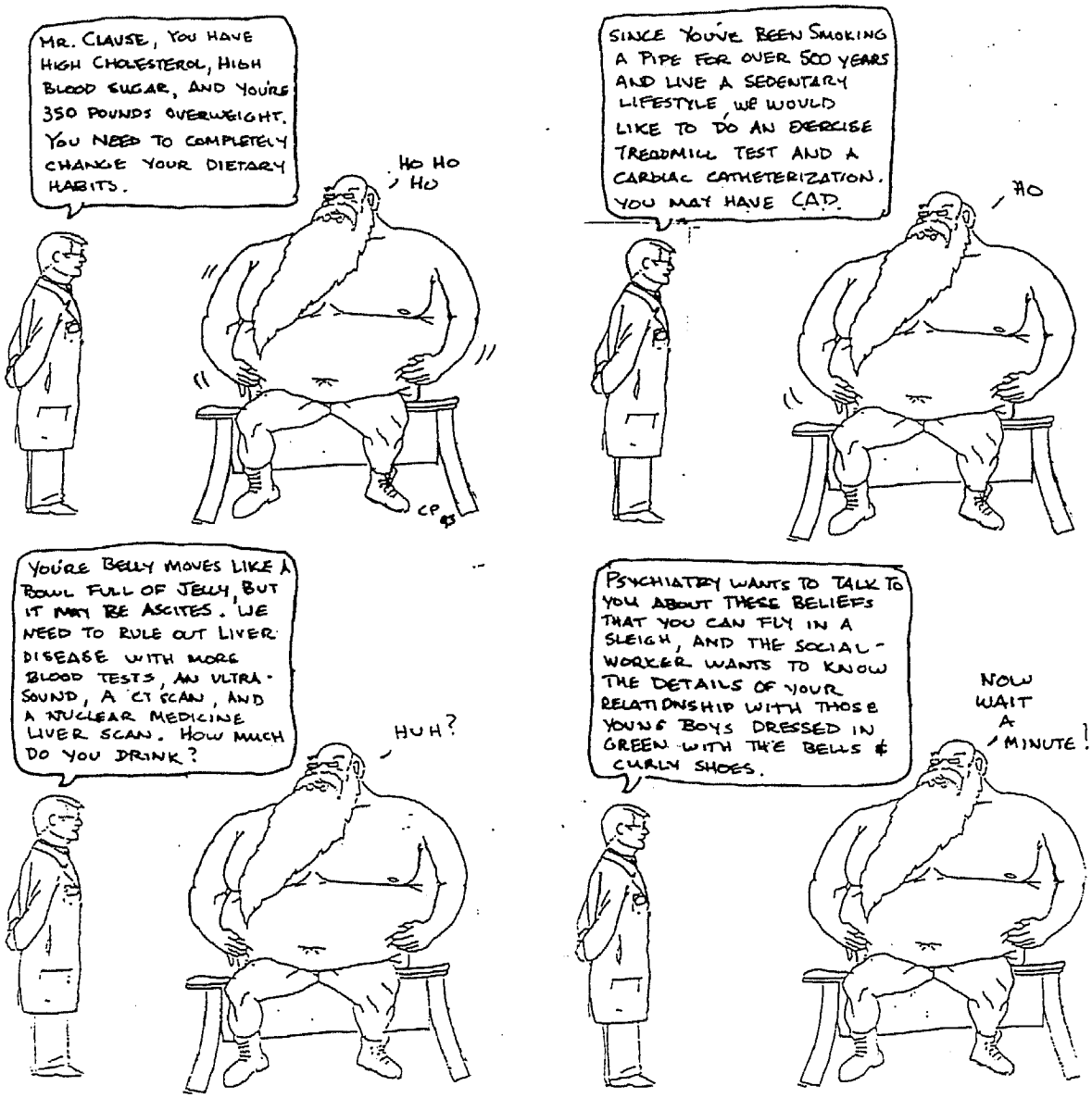
Greg Lucas

- The treatment of persistent patent ductus arteriosus has routinely been closed by surgical procedures requiring thoracotomy. Recently interest has been generated in the use of Rashkind PDA occlusion devices, which are implanted during catheterization, thus obviating the need for thoracotomy. Results form a retrospective cohort study are reported that suggest that the classical surgical approach is superior to transcatheter occlusion devices in success rate, major complications and cost. On the basis of cardiac auscultation, the initial procedure was successful in closing the PDA in 99.8% of surgical approaches, but only 77.3% of occlusion devices. Major complications occured in 0.2% of surgical patients and in 2.7% of occlusion patients. Moderate complications were roughly equal in the two groups, while minor complications were more common in the surgical patients. The mean estimated cost including follow-up for each case treated surgically was $8,838 as compared with $11,466 per case for the occlusion technique. (*The New England Journal of Medicine,* November 18, 1993)

- It is well established that cigarette smoking is associated with an increased incidence of duodenal ulcers, more complications occuring with ulcers and slower healing once ulcers have developed. The pathogenic mechanisms of these associations have been debated, but a recent study suggests that cigarette smoking may inhibit the ability of the duodenal mucosa to repond to acid from the stomach with appropriate secretion of bicarbonate. Thirteen subjects without prior ulcer disease participated in the study which involved the use of a double balloon device that allowed a section of duodenum to be isolated from both gastic secretions above and pancreatic/biliary secretions below. Following inflation of the balloons the region of duodenum could be monitored for basal bicarbonate secretion or peak secretion in response to acid infusion. Actual smoking was compared to "sham smoking" (puffing on an unlit cigarette). It was found that smoking did not alter the basal level of bicarbonate secretion when compared to sham smoking. However, it did reduce the acid-stimulated duodenal bicarbonate secretion by 80% ($p<.01$); a difference that was observed in each participant. (*Annals of Internal Medicine,* November 1, 1993)

- Autoimmune responses to a variety of beta cell antigens have been purported to play a role in type-1 or insulin dependent diabetes mellitus (IDDM). Most of these antigens, however, probably do not play a central role in the development of IDDM. It has been postulated that there is a primary antigen to which a first wave of T-cells become autoreactive. As insulitis or T-cell infiltration of the islet of Langerhans first occurs there is inflammation and progressive loss of tolerance to other beta cell antigens. Thus, most of the autoantigens that are detected in IDDM are dependent upon an initiating and spontaneous autoimmune response to a progenitor autoantigen. Several recent studies have focused the spotlight on glutamic acid decarboxylase (GAD) as the initial culprit autoantigen. Most of this early work has been conducted on the NOD mouse, an animal model which is felt to closely resemble the pathogenesis of IDDM in humans. Several pieces of emerging data suggest the GAD is the key autoantigen in the development of IDDM. First, the enzyme catalyses the production of GABA (the

(See "Journal," pg. 9)



Chris Piller

"Health," cont. from pg.2

The key phrase in Clinton's plan is the following: **"A provider may not charge or collect from a patient a fee in excess of the fee schedule adopted by the alliance." (pg. 62)** Furthermore, the total expenditure on health care would be brought in line with the consumer price index by the year 1999. These provisions are tantamount to price controls for physician services and national spending caps.

Such changes sacrifice a tremendous amount of freedom in many areas of society in order to deliver a watered-down, inflexible, government-issued brand of health care to the populace. Patients' choice of physicians would generally be limited to ones enrolled in the health plan of which they are a member. More importantly, the treatment options open to physicians and patients would be limited by bureaucratic decision making of the "Health Alliances" on the one hand, and rationing on the other. Rationing is the inevitable consequence of attempting to hold down supply in a system with fixed or growing demand. This has played true everywhere from the bread lines in the U.S.S.R., to gas lines in the U.S. during the OPEC oil crisis of the 70's, and it will occur in health care if we permit it. The demand for health care will not be held in check in the upcoming years simply because Clinton proposes to cut down the supply with price controls and national spending caps. Rather, there is every indication that demand will grow for two essential reasons. First, our population of baby boomers is growing older and older people require more care. Second, the better that health care becomes at saving lives, the more it costs. Case in point, every diabetic who is living today with those costly daily insulin shots, would have died not long ago and saved us all a lot of money.

The most devastating affront to personal freedom would occur in the area of health care itself. The professional choices of doctors and other health care workers would be limited and regulated in ways novel to any American profession. The Clinton plan dictates that after a five-year phase-in, at least 50% of new physicians must be trained in primary care rather that in specialty fields. Residencies would no longer determine the number of positions in their programs. Instead, the Dept. of Health and Human Services would dictate the number of training positions in each area of medicine and regional councils would distribute these positions to individual residency programs. Students planning to match in radiology this year have already gotten a taste of this type of control. Primary care doctors will be limited in the number of well-baby checks they're allowed to make in the first year, and the type of office equipment for which they can be reimbursed. Consider the likelihood that legislation

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of a similar nature will be introduced in the near future to regulate the legal arena, a field that is, in general, more saturated and less efficient than the medical field.

Many of the important decisions regarding health care would no longer be made by the people most directly involved. They would all be made centrally. As Robert Barro, Harvard economist, writes, "The Clinton Health Plan is written from the perspective of a benevolent social planner."

But what can we really expect from this social planner? The answer is abuse and inefficiency. One only has to look at the V.A. system or Medicare or Medicaid to understand how socialist policies, no matter how well intended, become unwieldy and unresponsive to needs as they arise. By placing 14% of the GDP in the hands of government

(Please see "Health," pg. 8)

"Umstead," cont. from pg. 3

explanation for this, but why didn't you have any clothes when you ran into the street?"

With this, an amazing change came over her features. Her smile turned into a distorted mask of fury, and she jumped out of the chair and leaned over the table. "Who told you that? They're lying! They're lying about me!" She followed this with a sting of four and twelve-letter words that would have nauseated a longshoreman.

"Please sit down," I offered weakly. I cast my eyes nervously to the observation window, but no help would be forthcoming. The nurses' station was empty. Mrs. Yarborough began to pace up and down, muttering to herself. Because I had followed the rules faithfully, she was positioned squarely between myself and the door. I tried to assume as non-threatening a posture as I could, but it was to no avail. By this point, her rage had definitely been redirected toward me. "You're lying about me! You're saying I'm crazy! I'm going to cut you up!" With this she lunged at me and my legs suddenly found the life that had deserted them. I'm not the type of person who is easily frightened, but one look at the expression on that woman's face had me running around the table like a jackrabbit, turning over chairs behind me and screaming for my life. Displaying an athletic skill that, in my opinion, made her a strong candidate for the 1996 Olympic hurdles, Mrs. Yarborough remained a few feet behind. I could feel her hot breath on my neck as she flung curses and personal remarks at me. Finally the door opened and the nurse walked in.

"Mrs. Yarborough!" The patient stopped in he tracks and looked up inquisitively. "Mrs. Yarborough you're making too much noise."

An apologetic look came over the patient's face. "Oh, I'm sorry," she said. She sat down in one of the few remaining upright chairs. "I feel awfully tired all of a sudden." The nurse picked up the chairs and gathered my papers off the floor. Without a word, she handed me the papers and left the room. With a wary eye on Mrs. Yarborough, I tried to follow her out, but was intercepted by Dr. Tanner.

"Ah, you must be Mrs. Yarborough. I see you have already talked with the medical student." Mrs. Yarborough smiled at her beatifically.

"Well lets let's find out what's going on here," Dr. Tanner said. "What's all this about running into the street naked?"

"Health," cont. from pg. 7

bureaucracies, the stage is set for special interest groups to lobby the "Health Alliances" to approve their own agendas. Medical interest groups not possessing this type of clout would be gradually forced out and as years passed, health care delivery would less and less resemble the actual need. Moreover, as the government attempted to hold down costs with price controls, rationing would become even more of a problem. Eventually new taxes would be launched to feed the hunger of an ever growing bureaucratic monster. Witness the way in which the welfare system in Britain, in which socialized medicine is a major component, now consumes a whopping 40% of government spending.

None of this is to say that health care in America is perfect. Far from it. However, the magnitude of our problems has been exagerated. Thus, in approaching health care reform, we should consider plans with more modest scopes, like Gramm's tax free "Medical Savings Account Plan." Nor is there anything wrong with passing laws to facilitate health insurance purchasing pools of small businesses. Also, important issues need to be addressed specifically by the medical community; like more humane and cost-effective ways to deal with the monumental expenses acquired by the terminally ill in intensive care units. With the national attention focused on health care reform as it is, we are in a position to approach the manageable problems that do exist with small and careful steps.

"Skeptic," cont. from back

"I haven't asked my question yet."

"We don't know anything!" they repeated in syncronicity.

"Yes, yes," I said impatiently, "I've known that for a long time. But what do you know of..." (and here I paused for dramatic purposes before pointing my finger and spitting out),"The Engles Society?!?"

A bolt of lightning arced down from the ceiling and nearly hit Dean Gianturco, who didn't seem to notice. Dean Pounds spoke up, in a soothing calming voice. "Listen carefully, Fred. There has never been, is not, and never will be a You-know-what Society at Duke." She looked up nervously, waiting for another bolt to hit.

A cover up! They were involved! I became enraged. "I want the truth," I shrieked.

"You can't handle the truth," barked Dean Kredich.

"Can too!"

"Can not!"

"Can too!"

"Can not!"

This went on for several minutes. Finally, Dr. Puckett held up a slip of paper. I realized with horror that it was my diploma. "The truth is that any further questions would be detrimental to your career here," he said, pulling out a lighter, "if you know what I mean."

I left, reeling at the implications.

Now that this has been published, I have reason to suspect that my life is forfeit. Right now I'm in hiding, sitting at a bar in a small South American country drinking margaritas with Salman Rushdie and Jim Morrison. I beg you who read this, pray for my life, and be ever vigilant for that unnamable horror that is insinuating itself into the very fabric of Duke Medical School.

"Journal," cont. from pg. 5

inhibitory transmitter), a process that is confined to beta cells in the pancreatic islets. Second, in humans, antibodies directed against GAD are the earliest observed and typically precede autoimmune reactions to other beta cell antigens. Third, in NOD mice, a T-helper response to GAD corresponds to the histologic onset of insulitis. Additionally the immune response is first confined to a limited region of the enzyme, then spreads to other regions of the enzyme and finally to other antigenic components of beta cells. Fourth, and most interestingly, when GAD is injected intratymically into neonatal NOD mice, a procedure that promotes T-cell tolerance of GAD, diabetes, insulitis and autoimmune responses to other beta-cell components do not occur. The theory that GAD occupies a more pivotal role than other antigens is highlighted by the fact that when this same tolerization was attempted with other antigens, only specific tolerance to the antigen used was observed. Diabetes, insulitis and autoimmune reponses to GAD and other antigens continued to occur. (*Nature*, November 4, 1993)

Septic Skeptic

BY FRED RIMMELE

"I was just made a member of a secret society," a good friend recently confided to me.

"I didn't know the Masons accepted women."

"No, no, no," she said, "I mean a secret society right here at Duke Med School."

I scratched my beard, ignoring the particles of food that fell out. "At the med school?" She nodded. "I didn't know there was a secret society at the med school."

"That's because it's a secret," she said, rather conspiratorially.

I nodded sagely, wondering what insidious and vile situation she had gotten herself into. Probably another effort by the administration to poison young minds. I began to pry for information, realizing that I would have to be subtle to drag out any closely guarded secrets. "So. A secret society." I paused, searching for the perfect opening gambit. "What's up with that?"

Finally, Dr. Puckett held up a slip of paper. I realized with horror that it was my diploma.

She took a quick look around. Seeing nobody in sight, she leaned closer and whispered, "It's called the Engles Society." A huge bolt of lightning split the sky as she uttered the hushed words, which I thought was kind of odd, since there wasn't a cloud in the sky.

"The Engles Society?" Another bolt of lightning hit the quad, slightly closer, but fortunately hitting only a Dukie undergrad. In the interest of continuing good health, I decided not to repeat the dread name. "What do you guys do besides stock that little reading room in the basement of the library?"

"A bunch of students and faculty just get together for dinner and schmooze."

"Yeah? Do you wear black robes, burn candles, and chant incantations in tongues long forgotten by man?"

"No, we just schmooze," she answered. I could tell she was getting nervous, avoiding my questions. There was something she wasn't telling me. Seeing my innate skepticism, she quickly volunteered, "Tonight we're eating at Papagayo's."

I realized she wasn't coming clean with me, since I knew for a fact that Papagayo's specifically prohibits chanting and candle burning in its dining rooms (although they do allow it at the bar). I made another gambit, contorting my arms and hands into a near pretzel. "Is this your secret handshake?" I immediately got a bad cramp in my left suppinator.

"You need to eat more bananas."

Ha! She had inadvertently disclosed their secret password! I was making progress! Encouraged, I continued. "How come I wasn't invited to join?"

"They only ask people who have done outstanding work contributing to various Duke service organizations."

Hmmm. Well, I conceeded, that would exclude me now, wouldn't it? I was about to ask who the mastermind was behind this diabolical sect, but she interrupted. "Look Fred, if I told you any more I'd have to kill you." She left, leaving me shivering in the cold daylight, alone but for the crisped Dukie on the quad.

I had to find out more, for her sake, lest she be drawn into something depraved and sinister. I imagined that the Engles society might be similar to the David Koresh cult in Waco. The image of Duke Med engulfed in a raging conflagration entered my mind. I must admit that I smiled at the notion.

I went immediately to the deans, who I found clustered together in a meeting. They looked up as I entered, and sang in chorus:

"We don't know anything!"

(Please see SKEPTIC, p. 9)