Voices of Medicine

By Del Meyer, MD

Outlaw Oreos, supply (but not demand) economics, miserable medical writing, health care "rights"

Mert's Musing: Outlaw Eating?

Merwyn G. Scholten, executive director of the Fresno-Madera Medical Society and author of the monthly column "Mert's Musing," is amused and amazed at the ridiculous use of the court system trying to make society "better," or healthier, or safer or whatever. Recently he discussed the lawsuit to ban the sale of Oreo cookies in California. The attorney's legal argument claimed the filling contains a high amount of trans-fatty acids that engender obesity in children.

Filing a lawsuit to prevent the sale of a food product that has been around for years because its ingredients might make children obese is reaching the extreme. How could the attorney prove a client is obese because of eating Oreos? Is that all this person consumed? And how many cookies per day for how many years? What other factors contributed to the obesity? Are there hereditary ties or evidence that the child never exercised but rather sat immobile in front of a television munching Oreos?

Mert wasn't certain if the lawyer only sought attention or was legitimately concerned about the health of a young client. Thankfully, the attorney withdrew the suit after a few days. If the court ordered Oreos not be sold in California, how would the measure stand up in a higher court? How would it be enforced? Would we see a black market with interstate smugglers? Would we need to finance new border patrols to confiscate the illegal booty?

But Mert's most important question, "Would preventing the sale of a brand of cookies make any dent in weight reduction for California's obese?" As John Stossel would say, "Give me a break!" To which, Mert muses, "We got one when the suit was withdrawn."

Supply-Side Economics

Patrick D. Daley, MD, President of the Kern Country Medical Society Bulletin, speaks of supply-side economics. Many proposals in the last few years have addressed the health care crisis, managed care, increased deductibles, EPAs, PPOs, POS and cafeteria plans. All were meant to stop, or at least slow down, the rising costs of health care. In short, they're failing. All of these policies address only the supply side of the equation and ignore demand.

A problem on the demand side is the public's insatiable appetite for health care. You have a new MRI test? I want it. You have a new PET scanner? I want it. I don't want to pay the actual cost of the test, but I do want it done.

Our sense of entitlement is high, our sense of attendant responsibility is low.

We've certainly come a long way in combating illness and premature death. Fighting the spread of infectious diseases through immunizations, hand washing and antiseptics, sewer systems, water purification processes and ICUs have made a difference in our lives. But what have we actually done? Do we really believe there's a limited amount of disease in the world, and working hard and doing enough CABGs and cataract removals will cure them all?

I don't think so. In largely eliminating starvation in this country, we've substituted obesity. In lengthening life span, we're faced with dementia and Alzheimer's. In lessening poverty, we now deal with anxiety and depression. Where will this end? I don't see an end in our country. And, if the demand for health care is not controlled, all the supply-side efforts will surely fail, with ever more persons uninsured.

Supply and demand are related only if the supplier (physician, hospital, provider) is paid directly, even if only in part, by those making the demand (patients). This way, patients can never demand more than they are willing to pay the physician, hospital and provider.

Awful Medical Writing

A Guest Editorial, by Thomas Gegeny, MS, ELS, in the *Journal of the American Medical Writers Association (JAMWA)*, takes a look at physicians' writing ability. The average medical student today does not have the ability to express himself clearly and concisely in writing. Gegeny listed three possible causes of this inability.

"The first, though perhaps not the most important reason, is insufficient basic training in English composition in the liberal arts college. The second reason, and in my opinion the most important one, is the lack of practice in composition and the essay type of writing in medical college. The third reason is the greatly increased preoccupation of the medical student with textbook reading to the exclusion of reading of the current literature both general and medical. As lectures have given way to laboratory exercises, clinics, and bedside teaching, students have been driven by force to their textbooks for standard coverage. How else can they get ready for their State Board or National Board examinations?

"A few textbook writers like Osler, in medicine, Sir James Mackenzie in radiology and Edward Keyes in urology have written with unity, coherence and emphasis and, above all, conciseness in mind. Too many have, however, given up all ideas of readability, accepted their role as a producer of completeness of coverage.

"Continued preoccupation with the writings of such authors would naturally tend to develop in the student a style of writing which is ponderous, verbose, detailed, full of technical phrases, and little designed to attract or hold the reader….In my opinion, it is extremely important that medical men be able to communicate and perpetuate their thoughts in writing. I feel, therefore, that improving medical writing is a real responsibility of our medical schools which somehow must be met."

Health Care as a Human Right

John D. Longwell, MD, President of the Santa Clara County Medical Society, discusses human rights. In 1948, the United Nation's Declaration of Human Rights included health care as a human right. That certainly sounds good, but for many philosophers would be an impossibility. A "right" cannot be tangible, and since health care involves goods and services, it's certainly tangible, though provided by someone else.

If two or more people were on a desert island, they could still claim the "unalienable" rights of life, liberty and the pursuit of happiness in our Declaration of Independence. But who would provide health care, if it were a right? What if one of them happened to be a physician? Does it become his or her duty to provide care because another person has a right to it? Or is it his duty because as a physician he feels a moral obligation to provide it?

In most developed countries, our "expectations" have translated into "entitlements;" access to health care is mediated through some form of insurance. But health insurance is unlike any other insurance (although 60 percent of health care costs are paid for by taxes).

When you buy home insurance, for example, you expect coverage for major accidents, fires, leaks, structural defects, etc — but not for replacing the roof, painting the house, adding a room, and certainly not for cleaning the carpets, washing windows or changing light bulbs. Similarly, we buy car insurance to cover major accidents, usually collisions and unforeseen events. We do not expect it to pay for gasoline, 50,000-mile check—ups, oil changes or a new set of tires.

Somehow, though, we have the notion that health insurance should cover more than unpredictable major events; it should cover expected maintenance, minor sniffles and scrapes, and cosmetic enhancements. We want our insurance to pay first dollar, or maybe $100 deductible with a $5 co-payment. We want that insurance to be paid for by our employers, and we want immediate access to physicians of our choice.

delmeyer@healthcarecom.net

Sierra Sacramento Valley Medical Society
5380 Elvas Avenue #100 • Sacramento, CA 95819
916.452.2671 PH • 916.452.2690 FX • Email: info@ssvms.org

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