Percutaneous Tracheostomy
A Cautionary Note

In our enthusiasm to embrace new techniques, we must not forget the lessons of the past and adopt new ideas prematurely. New techniques must be judged on merit by their safety, ease of performance, cost effectiveness, and stand the test of time, not merely the rapidity with which the technique can be done. Most importantly, this must not represent a step backward and subject patients to unnecessary risk of complications.

Tracheostomy used to be performed in emergency conditions and under less than ideal circumstances. Early tracheostomy tubes had high pressure cuffs and poor design. These factors often led to numerous complications. Many authors, including the current ones, continue to perpetuate the opinion that tracheostomy is associated with a high incidence of complications. These opinions are based on old information. What is needed is a contemporary study to determine the current risk of tracheostomy. A meticulous tracheostomy performed under optimal conditions and carefully attended to postoperatively should be associated with few complications. Division of the thyroid isthmus to identify the second and third tracheal rings, the use of small tubes, low-pressure high-volume cuffs, avoidance of excessive leverage on the tube, and meticulous nursing care should minimize complications.

It is indeed hard to imagine how a procedure that is essentially done blind by uncontrolled dilation or disruption of the trachea under less than ideal operating room conditions can be associated with fewer complications in the long run. Just as importantly, if complications following tracheostomy do occur, such as tracheal stenosis at the stoma or cuff level, they are almost always surgically correctable. This frequently is not the case with prolonged oral endotracheal intubation (glottic injury), criothyroidostomy (subglottic or glottic stenosis) or tracheostomy through rings other than the second or third (subglottic stenosis if through first ring or tracheoinnominate artery fistula if through the fourth ring).

Other potential pitfalls of any new technique are that the indications for its use expand beyond the original intent and other specialties incorporate it into their practice. A “simple” bedside technique for tracheostomy will have obvious appeal in the intensive care unit setting. Because of the appeal of “simplicity,” indications for tracheostomy may be broadened, thereby performing tracheostomy when not appropriate. Many intensive care units are run by nonsurgical specialists. They cannot be expected to have the historic perspective of the results of emergency tracheostomy and what surgical precautions are now taken to ensure the fewest complications possible. The learning curve that is inevitable will be at the patient’s expense and can be avoided by ensuring surgical input from the beginning.

Schachner and colleagues (see page 1266) are to be commended for their efforts to evaluate the technique in the laboratory. This type of evaluation is crucial and so often lacking. Longer follow-up, more experience, and ultimately a randomized study will be needed to prove the superiority of this technique over conventional tracheostomy. Ultimately, the safety of the new technique is what is important rather than the rapidity and convenience of the procedure.

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Take a Doctor to Dinner

The scene—a physicians office. The telephone rings: “Hello, this is the doctor speaking.”

“I am calling on behalf of a public relations firm based here in New York. We represent a pharmaceutical firm and we are calling to tell you about a meeting which will take place next month in your vicinity. The subject will be on a difficult therapeutic problem and we wonder if you would be willing to give a talk on diagnosis and management of this clinical situation?”

Doctor: “Well, this is really not a subject that I prefer to lecture on. Perhaps, therefore, I would not be of assistance to you at this meeting.”

Response (in a rather worried and disappointed tone): “Oh, I see. Well, if you went to such a meeting, would you not be likely to learn something about the management of this problem?”

Doctor: “Now you are changing the ground rules of
"my attendance! By the way, what is the company and what drug will you be discussing?"
Public relations firm: "Well, I am not at liberty at this moment to tell you the name of the company or the drug. However, the meeting will be preceded by a nice buffet dinner and we will provide an honorarium for your willingness to attend."
Doctor: "Well, if this is to be a seminar to share new information, I will try to make time to attend."
The scene: one month later in a local hotel.
Public relations representative: "Thank you for your attendance. I see that the majority of individuals in this room are practicing specialists. As you know, until this moment we have not divulged the name of the pharmaceutical firm we represent nor the name of the product we will discuss tonight. The firm is _____________ and the drug is _______________.

We ask please that for tonight you consider yourself to be the product manager responsible for the marketing of this drug. Permit me to describe here on the blackboard and by slides the results of recent research which indicates that this is by far the most effective drug for the treatment of this disease." A presentation followed with details of research projects indicating the superiority of the company's drug.
One hour later.
Doctor: "You have not said much about the cost of this drug. I note that it is considerably higher than competitors' products."
Public relations firm representative: "I am glad that you brought up that subject. Do you suggest that we should mention the cost in our advertising, or should it be kept out of our material?"
One of the doctors in the room: "Well, if you are talking about getting the most sales, perhaps you ought not to consider cost in your brochures. Some physicians may not know that the cost of the drug is so much more than other compounds now on the market."
Public relations firm representative: "Thank you so much for your advice. I will share this with my colleagues in the pharmaceutical firm, particularly in the marketing division. Perhaps we could close this evening by a review of the beneficial effects of this drug as compared to other products now on the market for treatment of the same disease. Would you please review the pages that I am handing to you describing the drug's action and indicate please what you think the superior benefits are as related to other compounds."

Is the scenario described above fictitious? Actually, I was the physician contacted and was present that evening! Is there anything illegal about the proceedings described? No, but as a minimum, one can fault the lack of candor involved in every step along the way. The original invitation was presumably (to many physicians) to make a formal presentation. This was quickly followed by a dramatically different approach to entice attendance.

What can we conclude about the motives for structuring such an event? Perhaps the most insightful analysis was provided by several of those who attended. As we left the hotel I heard one attendee exclaim, "They are not interested in obtaining marketing information at a national level; they are interested in marketing to us so that we will use their product!" Most of us agreed with this assessment and decried the absence of a forthright approach.

Can this method of marketing a drug be the most beneficial approach to providing useful information for the clinician? The pharmaceutical firm confessed grave concerns about adverse publicity in major newspapers. It came somewhat as a shock to learn that at least some pharmaceutical executives believe that physicians' prescribing habits are based upon the latest news report on the evening news or in the local newspaper!

Perhaps a hidden agenda was indeed a direct marketing pitch to practicing clinicians. One can picture executives sitting around the conference table in this pharmaceutical firm.

Vice-President in charge of marketing: "I have just analyzed the cost of direct advertising of our products and I have also studied the cost of detail men and their daily rounds. I was stunned to learn that every call the detail man makes on a doctor costs us $225 and this cost is going up daily!"

Product Manager: "I have a terrific idea. Why don't we use the same amount of money that we spend on detail men to sponsor a dinner and then describe our product at the dinner?"

Vice-President: "How are you going to get a doctor to show up if he expects a sales pitch?"

Product Manager: "Well, you disguise the reason for this meeting by telling them that we depend upon their expert assistance in providing accurate information for the medical profession."

In unison: "What a terrific idea!"

What is particularly distressing about the machinations that characterize this episode is the insult to the intelligence of the practitioner. Did they think that we would complete the evening without being aware of some of their motives? Do they want physicians to begin thinking of marketing axioms and slogans instead of scientific data in identifying efficacy and safety?

Certainly, our College has always honored and respected the pharmaceutical industry. We have been proud to be partners in education with them in our publications, scientific assemblies, projects and programs. We believe the incident described above is an exception to the customary practices of most firms.

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