provided by increasing premiums, it would have to be explained why the marginal benefit of further hospitalization would be worth the cost to the other premium payers when a Professor of Medicine and Anesthesiology subsequently found it of too little value to purchase himself (ie, marginal benefit <marginal cost).

However, when uncovered care is worth its price, isn’t it reasonable to expect patients who save money (directly or indirectly) with the cheaper HMO premiums to act responsibly and to use some of the savings to purchase useful, but uncovered, health care? I do not hesitate to advise an HMO patient to pay out of his own pocket to get the special help that a doctor like Professor Block could provide.

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The Barbarism of Managed Care, Revisited

To the editor:

I wish to comment on the editorial, “The Barbarism of Managed Care.”1 In California over the past 10 years we have had extensive experience in dealing with what some of us refer to as “mismanged care.” The main difficulties with the concept of managed care are that patients may never receive the care or are denied access to proper treatment due to the gatekeeper’s inconvenience or financial disincentive to treat patients adequately.

We anesthesiologists, in our practice in San Diego, have learned to adapt to the concept of a 23-hour stay, or Mop as it is termed, and have changed our practice patterns to provide the best in patient management and pain control. As in most practices, the patients’ H&Fs are performed on a “short stay” format, with only the essential, “bare bones” preoperative testing; and, in many instances, no testing at all (ASA classes I and II). Extensive use of regional techniques, using epidural and spinal narcotic analgesia and local infiltration, as well as continuous plexus blocks, have provided the patients with pain-free surgery and excellent postoperative pain control during their hospitalization.

During the past 10 years all of my patients undergoing clavicular, shoulder, and upper arm surgery and/or procedures, receive continuous interscalene blocks. These blocks are often supplemented with IV sedation according to the patient’s wishes. Many times the patient’s desire to remain awake is granted, and thus receives minimal or no sedation. The blocks are maintained throughout the stay and the patient remains pain-free. At the time of discharge, the infusions is terminated and the catheter removed. During the next 24 hours the patient may utilize one or two Percocet tablets and, for the most part, require very little postoperative analgesia. At no time have my patients received a general anesthetic, avoiding the scenario you sighted in your editorial.1 In one instance, an orthopedic surgeon was sent home with the catheter in place and instructed in the use of intermittent local instillation. This physician never required any supplemental analgesia and resumed her practice, removing the catheter on the third postoperative day!

It is our firm belief that the longer the operative pain is delayed, the less pain the patient will experience. The “barbarism” you site in your editorial1 is not the fault of the managed care system, per se. Rather it points out the deficiencies of the caregivers who have not learned to live with the system and have failed to change practice patterns to provide the best care within the economic constraints imposed upon them. While we must all fight inappropriate managed care criteria, most of the economic confines imposed by managed care can be accommodated by alterations in clinical care that affect neither outcome nor patient satisfaction.

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This letter reflects the personal views of the author and not the official position of ASMG, Inc.

REFERENCES
2 Winnie AP. Interscalene brachial plexus block. Anesth Analg 1970; 455-66

To the Editor:

I applaud the editor and his family for their recent editorial regarding the barbarism of managed care (July, 1996).1 I find it interesting that we require a dose of “patient care” to truly understand how this new system of care works. You describe the aggrandizing of a family that is basically healthy and uses medical care for common orthopedic and obstetric needs. Imagine the frustration of our patients with chronic debilitating illnesses when they encounter this system. Devoid of a medical background and often lacking a family to act as an advocate, they are helpless to fight for more humane care.

Your editorial should encourage other physicians to speak out. We cannot be covered by the fact that these managed care systems will “disenroll” us for doing the right thing. “Barbarism” is a strong word, but these are dark times that demand strong words and strong actions.

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REFERENCE

To the Editor:

I don’t know if you remember me, but you and I have spent some time at meetings in the past. Congratulations on becoming a grandfather. I know this from your recent editorial. I am extremely pleased that I am also. We have a 9-month-old grandson that this letter will not be long enough for me to describe, and I know as a grandfather you understand. I can only applaud and confirm everything you said in your editorial. As a physician, as a grandfather, and as a husband, I have witnessed this particular barbarism too often. I’ve done some writing within our medical staff on the same topics, but I’m afraid that I’m preaching to the choir.

When patients react, policy makers may follow. The obscene amount of money made by these profiteers of the health-care industry is an enormous obstacle to overcome. The election of 1992 was for me a hope that government, with its flaws, could still be an effective counterweight, but the administration fumbled the chance,