To the Editor:

Dr. Block's editorial (CHEST 1996; 110:1-2) echoes the resentment heard broadly among physicians who have to deal with the vagaries of managed care and see it in direct conflict with what they conceive of as compassion and quality patient care. Physicians have experienced a sense of loss of control and are frustrated, as they are progressively stripped of their autonomy and ability to practice as they have in the past.

The past shows us, however, that physicians were among the first to adapt and change their practice patterns in response to advances in patient care and technology. Those of us who have been in practice for awhile can remember, in the not-so-distant past, cholecystectomy patients hospitalized for 5 to 6 days, and prosthetic hip replacements performed in clean rooms that could only be found in certain selected medical centers. Why is it then, despite the willingness and ability to change that we have demonstrated adequately in the past, we are unwilling to accept the changes asked of us by payors? It is time, I believe, for physicians and managers to understand that they share in common the desire for good outcomes. After all, what else is health care about? If we can't produce good outcomes, both we and the insurance companies will be out of business. Neither the medical profession, nor the insurance business can afford to forget that, nor can they afford to ignore the often-maligned so-called bottom line.

It is clearly time for physicians to stop preaching to the converted and to get involved at every level, seeking an equity position in patient care decisions. As managed care evolves toward systems that assume more financial risk, physicians indeed will be making all of these decisions regarding appropriate utilization. Until then, we need to have our professional societies and appropriate committees interact with managed care organizations to bring about change that provides cost-effective, quality health care.

One of the big stumbling blocks has been the paucity of physicians who are willing or able to communicate with managed care organizations. They are interested in outcome data, statistics, and extremely interested in anecdotal evidence. From their perspective, medicine has, for too long, been a cottage industry with every physician adhering to practice patterns that they, themselves, find acceptable with little outside support. Although that may not generally be the case, we are all aware of instances in which it frequently is. Many of us, therefore, have stepped up to the plate and are actively seeking the education that will empower us with the skills to become effective physician managers, and attempt to restore some equity in the system. Simultaneously, it would behoove large representative organizations such as the American College of Chest Physicians to establish mechanisms for channeling complaints regarding difficulties with managed care into a structure that has the ability to communicate with these companies and to effect change.

Kenneth L. Toppell, MD
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To the Editor:

A 40-year-old white man was diagnosed with α1-antitrypsin deficiency by an astute referring doctor after 5 years as being labeled with asthma. The man is an ideal candidate for replacement therapy as he has an FEV1 of 40% of predicted and is still employed as a postal worker walking approximately 10 miles per day. Given the rate of decline of his respiratory function, one would predict that it would not be long before he would become disabled.

I was hoping that replacement therapy with α1-proteinase inhibitor (human) would stem his steep decline in this respiratory function. Based on its size, the replacement dose as calculated by the manufacturer's recommendations comes to 6,000 mg intravenously infused weekly.

I found out through the home infusion company that had been arranged to administer the medication that there were problems getting the medication. Instead of being able to administer 6,000 mg weekly, the company only had enough medication supplied to allow administration of 4,000 mg twice monthly.

I contacted the Bayer Corporation, the only supplier of α1-proteinase inhibitor (human) (Prolastin). They reported that new patients have been diagnosed at a rate faster than the product can be supplied. With demand outstripping supply and without the availability of rapidly increasing the supply, they have initiated a monthly allocation system based on estimated customer purchasing patterns. The distributors will receive 80% of what they had received in the prior year.

With patient and physician awareness increasing such that between 20 and 25 new cases are diagnosed monthly, a backlog will continue for some time. Other biological pharmaceutical companies may start producing the product, and Bayer is investing in expanding its existing facilities.

It is unfortunate that this shortage of α1-proteinase inhibitor (human) comes at a time when optimism is generated for its use. Preliminary results from the registry of patients with severe deficiency of α1-antitrypsin showed that there was a reduction in mortality and a slowing in the decline of lung function in some groups who received replacement therapy compared to groups who did not (unpublished data, Alpha1 National Association, 1996).

As physicians prescribing this medication, we will be faced with questions about its efficacy at reduced dosages that we will not be able to answer.

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To the Editor:

Dr. Horowitz's thoughtful letter regarding α1-antitrypsin deficiency augmentation therapy with α1-proteinase inhibitor (human) (Prolastin; Bayer Corp.) raises an important question that we at Bayer are dedicated to resolving. Namely, how can physicians hope to meet the needs of existing patients and previously untreated patients if product shortages such as those described in his letter make adequate dosing supplies problematic?

I am pleased to report that Bayer has been able to move forward on three fronts to address this key issue and that the shortages we currently face are being minimized. For one, we have been able to complete an agreement with another biological manufacturer.