Where is the best place to go for open-heart surgery? Should you go to a university medical center, or should you go to your local community hospital? The answer seems to depend on which publication you read. According to the Chicago Sun-Times (I can't help noticing that newspapers daily are becoming more like medical journals), only seven of the 22 Chicago-area hospitals where open-heart surgery is performed are qualified to do so. Only those seven meet the new HEW guideline of performing more than 200 open-heart operations annually. The 200 is considered a minimum requirement designed to ensure a smoothly working team of surgeons. An analogy is made to the ineptitude that might be displayed by a professional football team that plays only one game a year.

At first glance, this kind of argument sounds compelling, and I might buy it were it not for two considerations. The first is my experience of what happens when minimum requirements are established in terms of numbers of operations done. If a residency training program requires 200 tonsillectomies a year, or 200 vasectomies a year, or 200 cystoscopies a year, might there not be a temptation to extend the medical indications for these procedures to include a number of patients who really don't need them, but whose presence is vital for maintaining the requirements for qualifications? Might not HEW's magical 200 number serve as an incentive to increase the total number of hearts opened up, necessarily or otherwise? It brings to mind the image of the traffic cops who reputedly have quotas of tickets to write. Using HEW's guidelines, I predict it won't be long before every ambitious hospital in the country manages to join the elite "200 club."

My second concern arises out of my firsthand knowledge of the frequent fumbles that occur in large, impersonal teaching hospitals and medical centers, which further diminish the comparison to a smoothly running, efficient football team.

While the public is reading the Chicago Sun-Times, local doctors had the opportunity to read the August 1977 Illinois Medical Journal. As its lead article, it carried a report of the results of coronary bypass surgery in the first 413 patients operated on over a six-year period in Rockford, Ill., a city of 150,000, located northwest of Chicago. (Note that the figure is considerably less than the HEW minimum of 200 a year.) The two surgeons, Dr. Edward Sharp and Dr. Eugene Schmitt III, compared their mortality rates to those of 14 university
Should coronary bypasses be performed?

centers, finding them to be practically the same. The doctors point out that their patients remain in familiar settings where friends and relatives can visit and close relationships can be maintained between family physicians and hospital specialists.

So, if your doctor wants to send you to a distant large medical center, you might ask him whether there is a "Rockford" in your area. In other words, the mortality rates, not the frequency of operation, is the key. Or better yet, you might bypass the question of WHERE your bypass should be done in favor of the discussion on WHETHER it should be done at all, a question I will deal with next.

I can remember over a decade ago being amused at the idea of bypass surgery, at that time under consideration for initial clinical use in humans. It made no sense to me to ream out the fatty and hard deposits obstructing the larger heart vessels when the same inexorably deadly atherosclerotic process was continuing in the most important tiny blood vessels that nourish the heart muscle and that cannot be reached by even the most skillful surgeon wielding the sharpest knife.

I had watched a variety of operations designed to improve heart circulation come and go. For example, one operation, discarded after a number of years, tried to connect the internal mammary arteries to the heart. In another operation with the elegant French name "poudrage," talcum powder was sprinkled on the heart in order to stimulate blood vessel growth. This surgery also enjoyed brief popularity. I remember at least one surgeon who reported that the simple act of opening and closing the chest under anesthesia was enough to relieve anginal pain in many patients. Thus, on the basis of theory as well as history, I dismissed the then-emerging coronary bypass surgery as yet another flash in the pan. Was I wrong!

Although a minority of physicians has always questioned the coronary bypass, it has taken 10 years for the skepticism to become widespread. Early in 1976, two eminent heart specialists, Dr. Nicholas Kouchoukos and Dr. Donald Harrison publicly stated that this operation was probably overused and that patients with less advanced heart disease (the kind most likely to be operated on as time and technology progressed) had a better chance to survive if they were handled medically instead of surgically. More recently, Dr. Richard Ross, Dean of Johns Hopkins University Medical School, has said that one-fourth of these operations are based on incorrect assumptions (that patients will be less likely to have a heart attack or die suddenly after such surgery is performed).

In September 1977, a study from the Little Rock, Ark., Veterans Administration Hospital showed that the survival rate after three years for comparable patients treated with surgery was identical with those treated medically. The surgeons retaliated by claiming that even though the survival rates are the same, patients who were operated on have less anginal pain and better "quality of life." This line of defense collapsed when a University of Alabama study reported in the Journal of the American Medical Association (September 19, 1977) indicated that the same number of heart patients was able to return to work, regardless of whether they were treated surgically or medically. A report from Stanford University shows that the disease process continues relentlessly in the survivors of surgery (JAMA, June 13, 1977).

Thus, with coronary bypass surgery, the First Stage in the "development of the breakthrough"--wild and uncritical enthusiasm--now has been tempered by the Second Stage--doubt, skepticism and criticism--which will most likely soon enter the Third and Final Stage--outright rejection. Science marches on!
I feel I must respond to your somewhat smug skepticism over the use of bypass surgery to treat coronary artery disease. It is my opinion that this information does a great disservice to the many thousands of people who are leading healthier and happier lives as a result of the surgery as well as to the many thousands more who will have such surgery in the months and years to come. In all fairness, you should offer the same amount of space to a member of the medical profession who is qualified to present the counterarguments to your published position.

While it is correct that the doctor and patient must be absolutely certain that such serious surgery is necessary, it is more than a little distressing to think of the many people who have read your comments and who could also benefit greatly from bypass surgery. I know of the benefits: I have had the surgery. In addition, I am also a member of a visiting team from the Mended Hearts of America, Inc. I have seen and followed up on patients who range in age from 30 to 70, all of whom have experienced bypass surgery. The results, in terms of improved health and return to a normal or near-normal lifestyle, have been remarkable.

No doubt the time will come when medical treatment, or perhaps a new surgical technique, will replace the bypass procedure. In the meantime, it would be grossly unfair to deny a heart patient more years of healthy and happy productivity because of a skepticism based upon studies that are, in themselves, somewhat suspect.

I believe it is imperative that you provide equal time and space for a qualified medical opinion that can express the other side of this debate.-- R.D., Boulder, Colo.

As I read your letter, which tries to defend bypass surgery by attacking me, I thought for a moment that you were a doctor. However, it turns out that while you are not a licensed physician, you are a member of one of the many groups that support doctors. There are others: mastectomy patients have banded together; colectomy patients have banded together; kidney patients have banded together, etc. As a matter of fact, it's getting to the point where there is at least one group for every organ in the body and for every disease.

I am surprised and also a little flattered that you would insist that my rather small publication provide equal time and space for those who advocate bypass surgery. After all, bypass surgery has been promoted over the past 10 years or so by hundreds of doctors, medical centers and hospitals in millions of lines of type. In my publications, I try to bring to the attention of my readers the other side of the story—not merely my own opinions (which after all are those of only one person), but also the documented evidence from respected physicians published in authoritative scientific publications.

As I stated previously, the criticism of coronary bypass surgery came from eminent heart specialists from Stanford University and from the University of Alabama reporting at a meeting sponsored by the American Heart Association. Another of my references emanated from a highly regarded Veterans Administration Hospital in Little Rock, Ark. Still another critic of bypass surgery, the dean of Johns Hopkins University Medical School, told a Senate Health subcommittee, "We are dealing with a multimillion-dollar enterprise that is very hard to turn off." Other criticism of bypass surgery has appeared in an editorial in the New England Journal of Medicine (September 1977). Less than a year ago, (January 3, 1978) a New York Times editorial called to public attention the VA study and raised "the disturbing possibility that thousands of patients have needlessly undergone surgery that is
The latest information you have on coronary bypass surgery?

The big news development in 1978 has been the reaction of coronary bypass surgeons to the 1977 studies done by the Veterans Administration and the University of Alabama which questioned the value of bypass surgery. Not too surprisingly, the reactions were vociferous. Renowned heart surgeon Michael DeBakey defended the Baylor University experience with thousands of patients by presenting statistics which he said showed better results than those claimed by the opposition. He criticized scientists who recommend prospective (planned in advance) randomized (assigning patients equally and without bias to treated and control groups) studies for proper evaluation of open heart surgery as having "a naive obsession with this research tool," and he characterized the studies of his opposition as "an unrepresentative sample which is scientifically unsound."

Referring to the VA report, DeBakey states, "To insist that such a study is the only scientific basis for assessment is itself unscientific" (Journal of the American Medical Association, February 27, 1978). Instead, Dr. DeBakey cites the indispensability of clinical experience (managing patients) and in the final paragraph of his commentary, he uses the words "clinical judgment" three times in five sentences.

Another leading heart surgeon, Dr. W. Gerald Austen of Harvard Medical School contends that the VA study reported abnormally low survival rates which he attributes to the poor quality of open heart surgery as performed in many hospitals, and he argues (with, in my opinion, a Tooth Fairy-like belief) that the government should have authority to shut down these substandard surgical centers.

At an American Heart Association Conference for Science Writers, Dr. Austen compared bypass surgery to other operations designed to correct uncomfortable symptoms such as stomach ulcers and hernias!

There is no question that in this billion-dollar growth industry (a recent Vanderbilt University study showed that the average cost of coronary bypass surgery, including both hospital and physician cost, was $10,930), 1979 will see more controversy and more studies. Of course, all of these studies will be conducted in an honest, unbiased, fair, and objective manner. Both sides will collect data on both sides of the question. Proponents of open heart surgery will objectively select
those data that agree with their position. Opponents will objectively select those data that agree with their position. I would modestly propose an additional study to investigate the nature, not of the patients, but of the doctors who perform the surgery and the doctors who evaluate it in order to determine the biases based on motives for personal gain as well as deeper emotional factors that may explain why some doctors choose one side and some choose the other.

Since my Modest Proposal has about as much chance of being adopted as was Jonathan Swift's, I predict that in the matter of coronary bypass, 1979 will be a year of confusion and uncertainty, producing a tension somewhat analogous to that developed in political candidates after the time the polls close and before the time the returns are actually counted. Those of us who are not afflicted with pains in the chest will probably develop headaches as we seek to discover where truth actually lies.

**DEPARTMENT OF RE-INVENTING THE WHEEL**

The American Academy of Pediatrics now is urging that every newborn infant should be breastfed unless the child or its mother has some specific physical condition which would make this kind of feeding impossible. The Academy also has urged employers to establish breastfeeding facilities within day-care centers so that working mothers will be able to feed their babies conveniently.

The Academy's Committee on Nutrition has concluded that hospital maternity units should be modified so that mothers can breastfeed their children as soon as they are born and that mothers should be encouraged to let their babies establish their own feeding schedules, allowing them to nurse whenever they want. Mothers are to forget about rigid three- to four-hour feeding schedules. In addition, school sex-education courses should teach breastfeeding techniques and should persuade teenage girls to breastfeed children when they become mothers. Breastfeeding is even to be encouraged for mothers who live in areas where chemical contamination of breast milk has been reported. According to Dr. Jean Lockhart, director of the Academy's Health Service and Government Affairs Department, most incidents of contamination involve levels of chemicals too low to affect babies.

I cannot tell you how pleased I am to see that the American Academy of Pediatrics is finally catching up with the La Leche League!

**UPDATE ON PAP TESTS**

I have been fond of using a 10-year old reference, "Presymptomatic Detection and Early Diagnosis," by C. L. Sharp and Harry Keen (Williams and Wilkins) to question the worth of the highly-touted Pap smear. As Sharp and Keen so sharply and keenly point out, "Several studies have shown declining death rates from cancer of the cervix, but since these were evident even before cytologic detection (Pap smear) was commonly in use, there is as yet no conclusive evidence that this type of detection method has played a definite part in reducing mortality...
In none of the areas where cervical cytology has been in use for a considerable period has there been a significant fall in the death rate for the condition."

Now, ten years later, two researchers, Dr. Anne-Marie Foltz of New York University and Jennifer L. Kelsey, PhD, an epidemiologist at Yale University School of Medicine, once again have pointed out that it has not been well established that the screening of large numbers of women has any effect on the death rate from cervical cancer. Questioning the current medical practice of yearly Pap smears on all adult women, these researchers state that there is a 20 to 30 per cent incidence of false negatives in performing the Pap test. They point not only to the questionable accuracy of this test, but also to the fact that it became standard recommended policy without ever having been subjected to controlled trials to determine its efficacy.

I commend Drs. Foltz and Kelsey, and I hope that the appearance of more female researchers may lead to better research on females.

When a patient or his family is refused access to records, how can we know what action was taken or what treatment was given? Our son died from what was diagnosed as "malignant hyperpyrexia" following surgery. We were never allowed to see his medical records. Those on duty assured us that everything was done which could be done to save our son's life. We didn't want to go through litigation because this would neither return our son nor erase the hurt. After several years, we now realize that, if we had retained an attorney, we could at least have seen our son's records.

Why do organized medical groups strongly oppose legislation to allow patients access to their own medical records? It is my feeling that you do not agree with the stands these organizations have taken. It seems to me that such legislation would reduce malpractice suits. In many cases, I think the bereaved family sues just because they have no place to turn, and, in an effort to try and find out "what really happened," they hire an attorney.--No Name, Please

I can well remember my internship in a large charity hospital in which the patients' records hung from a small hook at the foot of each bed. While making rounds, it was not at all unusual for us interns to find a patient reading his chart. Sometimes, these indigent men and women would even ask us questions about entries which we had made. Nobody seemed to care very much about either the legality or the propriety of this kind of "patient access" to records.

Perhaps the above laissez-faire attitude had something to do with the fact that this was the pre-malpractice era. Things changed in my later years which were spent mainly in private hospitals where patients' records were kept tightly sequestered. In recent years, as legal action of patients against doctors has escalated, the attempts to preserve secrecy of records from patients has escalated even faster.

Paradoxically, while the patient often has to retain an attorney to get a peek at his records, confidential information from patient records has seeped out into many kinds of government agencies, insurance companies, schools and private organizations, all of which
practically everyone agrees have no right to these intimate details of a person's medical history. As a matter of fact, I have often facetiously suggested that, in these days when the confidentiality of records is practically non-existent (for everyone except the patient) physicians who desire to provide the highest quality care might well keep no records at all!

You have correctly gauged my strong opposition to keeping records secret. I don't know whether open records would lead to more or fewer malpractice suits. But I do know that if doctors knew that patients might read their records, the doctors might be more careful about their written expressions. Furthermore, we might have an opportunity to return to the status quo of my internship days when the record served, not as a barrier between doctor and patient, but rather as a vehicle to improve communication and to enhance the patient's understanding about his own condition.

**UPDATE ON DRUGS**

Cimetidine (Tagamet) is a new medication used in treating ulcers and for other purposes, such as preventing and treating hemorrhagic gastritis in critically ill patients.

In a West German study of 71 patients with duodenal ulcers, at the end of four weeks the healing rate was 88 percent for those treated with cimetidine and 79.4 per cent for those who received a placebo. Only during the first day was ulcer pain significantly reduced in the patients treated with cimetidine.

In a second study of 39 ulcer patients treated in a double blind study, a faster healing rate among patients treated with cimetidine was considered statistically not significant. The medication was found to have no effect on ulcer pain, pentagastrin-stimulated acids and pepsin secretion.

And, in the U.S., Dr. Shashi K. Agarwal, writing in the July 21, 1978, issue of the *Journal of the American Medical Association*, reports cases of mental confusion among older people treated with cimetidine and draws attention to visual hallucination which he links to possibly adverse effects of cimetidine therapy.
Whether for an acute heart condition, major surgery, or a complicated birth, there are times when we are indeed grateful for hospitals. But often, we find that gratitude is quickly outweighed by frustration. We feel boxed in by a system that doesn't speak to our particular fears or needs.

When faced with this kind of situation, my first suggestion is: If it's important to you, don't easily take no for an answer. When I was scheduled to have surgery several years ago, my husband was especially worried because his mother had died of hepatitis after receiving a blood transfusion. He was determined that any blood I received should come only from friends. Yet it took several go-rounds with the director of the hospital's blood bank, additional support from our physician, and the threat of a lawsuit before my husband's conditions were met. Demanding that blood come only from known donors may seem like a strong stand to take, but the rightness of our position was again confirmed when a physician friend ended up in the hospital with hepatitis which had resulted from transfusions.

Let me give you another example. When our friend Christine recently delivered her baby, she had nothing but praise for the obstetrician. In spite of a complicated delivery, a healthy baby boy was born. But from that point on, the situation deteriorated. First, Christine developed a fever and was told she could not breastfeed until 12 hours after her temperature returned to normal. Then her baby developed jaundice and was kept in the nursery under bilirubin lights. Then she was told that her milk might not be good enough because of her low hemoglobin, so couldn't they give the baby some formula? By this time she had had enough. But before signing herself and her baby out, she decided to talk to the floor supervisor. Christine explained how the hospital's rules were creating problems for her and her baby. She was offered a private room where both her baby and her husband could stay with her. If needed, a bililight would be furnished in the room.

This goes along with my second suggestion: Learn everything you can about your particular condition and the situation you will be facing. Don't be afraid to ask questions. After a couple of "why's?" your doctor may decide on a different treatment. Working in this way, you have a better chance of getting medical care that fits your needs.

Doctors today are caught in a bind. With development of many "technological advances," they often find they are much more likely to be faulted for doing nothing than for "doing something," regardless of the possible risks involved. As the pediatrician handling Christine's baby later admitted, ten years ago no one ever would have thought of "treating" normal jaundice.

Children in the hospital are a special concern and there are a number of organizations which aim to keep sick children and parents together. For more information, you can write Children in Hospitals, 31 Wilshire Park, Needham, MA 02192. A pamphlet I highly recommend is In Hospital: The Child and the Family by Betty Ann Countryman, R.N., M.N. (24 pages, 50¢ from La Leche League International, 9616 Minneapolis Avenue, Franklin Park, IL 60131).