Rural Wisconsin
Health Cooperative

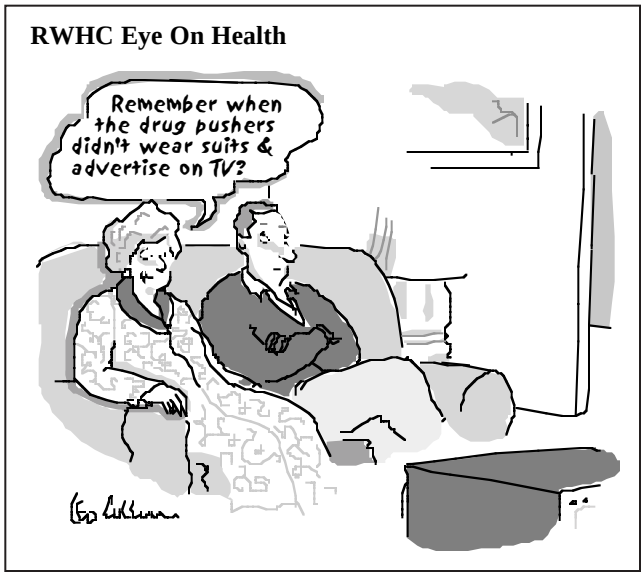
Eye On Health

Review & Commentary on Health Policy Issues for a Rural Perspective - March 1st, 2002

Triangulating Greed, Marketing & Hope

From "Selling Drugs to the Public. Should the UK Follow the Example of the US?" by John Frey MD, Professor and Chair, University of Wisconsin–Madison, Department of Family Medicine in the *British Journal of General Practice*, 2/02:

"A decade ago, I was complaining to a colleague of mine who was a professor at the school of Pharmacy about the sheer volume of pharmaceutical advertising in medical journals. I remember him replying, 'you don't have to worry, they are going to start advertising directly to consumers and bypass you.' One doesn't have to go far to find just how right he was."



"Perhaps the worst example, or at least the worst I have seen thus far, of how the pharmaceutical, advertising and newspaper industries have stretched and then broken the ethical boundaries came not from a local paper, which could be blamed for not knowing any better, but from the prestigious *New York Times*. Its national edition on Wednesday, November 14th, 2001, carried a story about the effects of Simvastatin on a large group of patients at risk for heart disease. The study was reported to have shown a reduction in heart disease and stroke - both reported in relative rather than absolute risk since relative risk figures are much more impressive to the public. The stroke reduction data were new as were the data about people not at risk based on their lipid numbers. Dr. Collins was quoted as saying that 'statins are the new aspirin', not pointing out of course that aspirin, showing reduction in recurrent heart disease at 2 cents a pill and statins at $9 a pill have some very different marketing strategies and financial implications for society."

"At the end of the article, Altman reported that '(Collin's) team conducted the study independent of the sponsors. The drug companies had no say in how the money was spent, in the day-to-day running of the study, analysis of the data or the way the findings were reported.' That is on page 14 of the *Times*. On page 15, directly facing the article, is a full page ad for Simvastatin, from Merck, the study sponsors."

"While Merck may not have had any role in the analysis, it definitely was going to take advantage of the results and couldn't even wait to see the results published where physicians could read it and draw their own conclusions. *The New York Times* has a high end market niche nationally and is more likely to be read by those who consider cholesterol over 200 second only to a falling stock portfolio as a threat to one's livelihood."

"Direct to consumer advertising in the U.S. has reached saturation, with television reruns at off hours having 75% of their adds for drugs, ranging from antihistamines, to anti-depressives. Rather than forcing viewers to listen to all the nasty side effects and contraindications, which might scare some people away, most TV ads carry 'ask your doctor' as the admonition. Since patients are often referred to as 'consumers' in the U.S. and since patient satisfaction surveys and their annual report to physicians from different HMO's are becoming a part of the life of practice here, there is great pressure to give the consumer what they want. And they want drugs."

Could spam (junk email) get any stranger?—"Our email is never sent unsolicited. Your name was purchased."

"One of my favorite examples of the effect of direct to consumer advertising was from an eleven year old boy. Most of my patients are not *New York Times* readers but come heavily from the working class of our town. On a busy clinic morning, the boy and his mother came in for a visit and when I walked in the room and asked how I could help, the boy said 'I need Lamisil.' A bit taken aback, I looked to his mother who shook her head and looked at him. I asked why he wanted Lamisil (terbinafine) and he said that he had fingernails that needed treatment. I asked him why Lamisil and he said that he had seen an ad on TV for a condition that looked just like his fingernails. The ad had indicated a toll free telephone number to call for more information and when he did, they sent this eleven year old boy a videocassette with more information about the perils of onychomycosis and said 'ask your doctor for Lamisal.' So he did."

"The argument that direct to consumer advertising is a form of education is so specious as to not deserve serious consideration, except that is how such advertising is pitched to the public. Doctors in this country are still overwhelmed with the amount of information on new drugs in journals, direct advertising and the omnipresent drug reps (pharmaceutical representative). We are hardly above reproach, with increasing attention being paid in the press to the solicitation of practicing doctors by drug companies which offer fancy dinners, free family vacations matched with big speaker fees to academics who 'educate' doctors about new drugs. But Aldous Huxley would have been stretched to conjure up a world where reminders of allergy free, pain free, worry free, slim and sexually uninhibited eternal life were more in evidence than the U.S. media today. Soma in *Brave New World* was nothing compared to Zocor, Viagra, Claritin, Lamisil, and all the other keys to a happy future."

The **Rural Wisconsin Health Cooperative**, begun in 1979, intends to be a catalyst for regional collaboration, an aggressive and creative force on behalf of rural communities and rural health. RWHC promotes the preservation and furthers the development of a coordinated system of rural health care, which provides both quality and efficient care in settings that best meet the needs of rural residents in a manner consistent with their community values.

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An Alternative To High Cost & Low Quality?

From "Geography and the Debate Over Medicare Reform" by John Wennberg, Elliott Fisher, and Jonathan Skinner, placed on 2/13/02 at the *Health Affairs* web site: http://www.healthaffairs.org/.

"Medicare spending varies more than twofold among regions, and the variations persist even after differences in health are corrected for. Higher levels of Medicare spending are due largely to increased use of 'supply-sensitive' services–physician visits, specialist consultations, and hospitalizations, particularly for those with chronic illnesses or in their last six months of life. Also, higher spending does not result in more effective care, elevated rates of elective surgery, or better health outcomes. To improve the quality and efficiency of care, we propose a new approach to Medicare reform based on the principles of shared decision making and the promotion of centers of medical excellence. We suggest that our proposal be tested in a major demonstration project."

"We suggest that the first task for Medicare reform is to improve the quality of care. To address the unwarranted variation in quality and efficiency of care supported by the Medicare program, we propose the following goals for Medicare reform: (1) eliminate underprovision of effective care; (2) establish patient safety; (3) reduce scientific uncertainty through outcomes research; (4) establish shared decision making for preference-based treatments, chronic disease management, and end-of-life care; (5) establish accountability for capacity; and (6) promote conservative practice when greater care is wasteful if not harmful."

"While these approaches have led to improvements in quality of care, they are often piecemeal reforms. Also, the Medicare program is not structured to ensure that these efforts receive the support they deserve; indeed, conservative strategies toward health care are rewarded with lower Medicare reimbursements."

"We propose a new structure for Medicare reforms that focuses simultaneously on increasing the use of effective care and reducing medical errors, improving the quality of medical decision making, and reducing supply-sensitive care. We believe that this structure can help to meet Medicare's goals for medical

excellence as set forth above. In traditional FFS Medicare, bills are paid whether or not the service was appropriate and whether the hospital or provider is of high or low quality. Only in the case of outright fraud might Medicare shrink from paying. The idea behind our proposed Comprehensive Centers for Medical Excellence (CCMEs) is to allow Medicare to reward both quality and efficiency."

Wisconsin April 3rd Farm Health Summit

www.commerce.state.wi.us/cd/cd-phc-summit.html

"To qualify, hospitals, provider networks, or organizations representing regional coalitions would agree to establish 'best-practice' models to address the underlying causes of variation. The feasibility of the CCME program depends on the willingness of the leading US health care organizations and the federal government to establish a partnership. As the essential first step, we suggest that the federal government undertake a major demonstration project to test the hypothesis that the partnership can fruitfully address each category of unwarranted variations."

"If successful, the demonstration project would provide real-world performance standards or best-practice models for achieving medical excellence. The next step would be to promote their wide implementation, which may require cooperative as well as competitive strategies. In regions where population density can support more than one integrated health care system, a market strategy could be used to encourage FFS patients to seek care from the higher-quality provider. Medicare could establish a 'preferred provider' through selective contracting. By choosing this option, Medicare enrollees would benefit through a reduction in premiums and copayments for services provided at the CCME. Under a premium support program like that in the Breaux-Thomas proposal, Medicare could subsidize the price of insurance policies (or FFS care) centered at CCMEs."

"In many nonurban areas the population is not large enough to support more than one integrated health care system. In such regions, cooperative rather than competitive strategies are required to build the infrastructure to assure that all segments of the population have access to high-quality care. Cooperative strategies also may prove effective in urban regions; one example is the Pittsburgh Regional Health Care Initiative, a coalition of regional hospitals, clinicians, health plans, and major corporate purchasers."

"We are fully aware that major political barriers will exist in the implementation phase. We believe, however, that lessons learned from the demonstration projects can reduce those barriers, and we therefore urge that the organizations selected for participation be located in both rural and urban settings. We also encourage the use of strategies that encompass both cooperative and competitive approaches. Perhaps the most difficult barrier to overcome is the lack of trust and the cynicism that pervades relations between doctors, patients, health plans, and government. A demonstration project may help to overcome these barriers."

"While incrementalism is more likely in the near future, at some point in the not-so-distant future major Medicare reform will be inevitable. We believe that this inevitability should add urgency to our suggestion of a major demonstration project. The more we know about what works and what does not, the brighter will be the future of health care in the United States."

The SUV-ification of U.S. Health Care?

From "The Ramifications Of Specialty-Dominated Medicine," by Kevin Grumbach in *Health Affairs*, Jan/Feb '02:

"Reading the paper 'Economic and Demographic Trends Signal an Impending Physician Shortage' by Richard Cooper and colleagues is like watching a television commercial for a sport-utility vehicle (SUV). 'Buy more physicians' is the marketing pitch—and not just any physician, but the four-by-four (as in four years of medical school plus four or more years of residency training), gas-guzzling specialist model that creates an irresistible buying frenzy among American consumers eager to spend."

"SUVs are an undeniably popular item in the United States, with sales continuing to soar. Lots of people desire them (some of my best friends even own them). As Sen. Trent Lott (R-MS) recently asserted, 'the American people have a right to drive a great big road hog SUV if they want to, and I'm gonna get me one.' "

"In the view of Cooper and colleagues, Americans also appear to have the right to an ever bigger and more expensive health system featuring a steadily increasing supply of physicians per capita, especially of specialists. Based on the historical association between trends in physician supply and economic activity in the United States, they calculate that each 1 percent increase in gross domestic product (gdp) per capita produces a 0.75 percent increase in physicians per capita. Of note, virtually all of the growth in U.S. Physician

supply per capita in the past half-century has been in the supply of specialists. The high elasticity between GDP per capita and specialist supply suggests that specialty care (like SUVs) functions as a luxury good."

"In the interpretation of the authors, this relationship is not merely a description of past trends but a rule for projecting future demand for physicians. Presented this way, the relationship between economic growth and increasing specialist supply takes on the properties of natural law."

"There are several reasons to take issue with this fatalistic view. Consumer demand for physicians is not the exogenous force implied by Cooper and colleagues. Physicians are able to induce demand for their services, creating a self-replicating cycle of more physicians begetting more demand begetting more physicians. Nor is the preponderance of health care purchased in an individual consumer market. Public funds pay for about 40 percent of health care, and funds pooled through private insurance purchase another 40 percent. The 20 percent of patients who generate 80 percent of health expenditures every year are for the most part spending someone else's money on health care. Collective financing of health care calls for collective decisions about how much to spend. Endowing individual consumer demand for health care with a preeminent role in determining the proper equilibrium level of health care spending and physician supply is as flawed a concept as promoting a universal automotive coverage plan that would give every household a third-party payment to purchase an SUV."

"The 'Americans have a right to buy more specialists' view also raises the question of whether people are actually buying anything of benefit. Cooper and colleagues portray their analysis as one free of value judgments about what 'ought' to be. The consumer is sovereign; social planners are presumptuous to question this sovereign being about how it wishes to spend its (or in the case of health care, someone else's) hard-earned cash. But as a taxpayer contributing to Medicare and Medicaid, and as a subscriber in my employer's group health insurance plan, I do want to know whether the extra tariff on my income that Cooper and colleagues would levy to pay for more specialists will in fact purchase better health for me and for the nation. The evidence on this score is not reassuring. Many studies indicate that a greater supply of specialists is not associated with better population health. Leiyu Shi has conducted a series of studies comparing physician supply and health indicators across U.S. States and substate regions, controlling for a variety of population characteristics. The studies have shown that a greater supply of primary care physicians is associated with lower mortality rates as well as lower disease-specific death rates in some categories. A greater supply of specialists has either no association with these health indicators or in some instances an association with worse health outcomes."

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"That's great but to be sure, I'll have my psychiatrist talk with your psychiatrist."

"The future that Cooper and colleagues project is the SUV-ification of U.S. health care. It is a future of more specialists, more high-tech care, higher costs, and greater disparities, of a system built out of proportion to the true needs of the public for efficient and effective health care. It threatens the proper ecology of medical care. It may even be harmful. Many nations have people driving automobiles of modest size and excellent fuel efficiency. Many nations have health care systems that provide health care for all residents in a less specialty-oriented manner and with better health outcomes than is true of the United States. It is a mistake to believe that the future predicted by Cooper and colleagues is either preordained or desirable."

Rural Medicare Initiative Whose Time Is Now

From "Enhancing CAH and Adding RCH" by Tim Size in the National Rural Health Association's *Hospital Constituency Group Newsletter*, 3/02:

- "Grundy County Memorial Hospital (Iowa) made $9,933 last year, an accomplishment for the 50-year-old hospital, which has lost thousands of dollars each year for as long as records exist. 'The hospital made the profit after being given critical access designation,' said Administrator Janice McCart." (*Des Moines Register* 11/16/01)

- "As a result of our Critical Access status, the additional Medicare revenue for Mount Desert Island

Hospital (Maine) has allowed the hospital to increase staff in the Emergency Department during the busy summer season." (*Health Current*, Winter 2002)

- " 'The Critical Access Hospital isn't a cure-all,' said William Parrish, a certified public accountant whose firm focuses on rural hospitals. His accounting firm looked at 16 of the hospitals it represents in Texas to see how effective the designation is. 'Out of those, nine would have gains, but seven would have losses.' " (*San Angelo Standard-Times*,10/08/00)

"The above three news items from around the country says much about the Critical Access Hospital (CAH) program. The designation is erasing the red ink for many and is leading to substantive service enhancements for others, but as noted above, it is not a 'cure-all.' As in other issues related to health care reimbursement there is no one size fits all solution. The CAH program, however, shows the most promise for solving many of the issues related to stability of health care infrastructure in rural areas."

10th Annual $1,000 Prize For UW's Best Rural Health Paper—April 15th Deadline

Info at: www.rwhc.com/essay.prize.html

"According to the Rural Hospital Flexibility Program Tracking Project, <www.rupri.org/rhfp-track/>, as of January 1st, 2002, there are 1408 rural hospitals eligible, of which 1025 are expected to consider conversion over the next 3 years, have declined to convert at this time, or have converted. There are currently 539 certified CAHs with another 141 CAH Certifications Pending."

"But there is more work yet for all of us! After over a year's preparation, NRHA and AHA are proposing several enhancements for CAHs as well as a new program for Rural Community Hospitals (RCH). Congressional sponsors are expected to have introduced a bill, the Rural Community Hospital Assistance Act by mid February; the estimated cost is less than $500 million a year. This is only about one half of one percent of annual Medicare expenditures—a small adjustment to provide stable hospital services for America's rural communities."

"RCH is a cost-based option for rural hospitals not eligible to be a CAH with 50 or fewer acute care beds as reported on the cost report. CAHs would gain a 'return on equity' adjustment, cost-based reimbursement for post acute care services, including skilled nursing, home health and geriatric psychiatric service (15 or fewer beds) and elimination of the 35-mile test for ambulance services. RCH would provide a 'less rich benefit' than that available to CAHs but would do the following: cost-based reimbursement for inpatient and outpatient services plus a 'return on equity'; cost-based reimbursement for home health services where the provider is isolated, cost-based reimbursement for ambulance services and restores Medicare bad debt payments at 100%."

"There are hundreds of small and rural hospitals across the country that are 'too busy' to be eligible for the Critical Access Hospital (CAH) program but not 'busy enough' to have a PPS margin. Many of these hospitals don't have Medicare-dependent Hospital or Sole Community Hospital status and of those that do, many don't receive significant assistance. As a group, these hospitals are heavily Medicare dependent with negative Medicare margins and meager or nonexistent operating margins."

"RCH protects the core infrastructure of rural health in America that does not undermine or contradict the public policy inherent in the Medicare Prospective Payment System. Rural hospitals, on average are paid 9.6% less than their reasonable costs (as defined by Medicare) for providing services to Medicare beneficiaries, 14.2% less for 'other rural hospitals under 50 beds.' In 1999, 54.5% of hospitals designated as 'other rural hospitals under 50 beds' had a negative inpatient Medicare margin. Rural hospitals under 50 beds account for just 2% of inpatient PPS payments. NRHA has long led the way for rural hospital equity, and speaking for many of us, we look forward to a very proactive year in Congress."

Defined-Contribution Plans—The Next Wave?

From "Defined-Contribution Health Insurance Products: Development and Prospects" by Jon B. Christianson, Stephen T. Parente, and Ruth Taylor in *Health Affairs*, Jan/Feb, 2002:

"Defined-contribution health insurance products (DCPs) have garnered an enormous amount of attention. They have benefited from aggressive marketing by their developers and other proponents and from substantial premium increases by managed care organizations (MCOs). At the same time, policy analysts have expressed concern about whether these products will further segment the employer insurance market, expose employees to unanticipated financial consequences of their health care decisions, facilitate

the shifting of a greater portion of health care costs from employers to employees, and require new state or federal regulation."

"These products remain in very early stages; the enthusiasm of employers and employees for them remains largely untested; and their eventual impact on the health insurance market, much less 'American health care,' is highly uncertain."

"The term *defined-contribution health insurance product* is itself ambiguous, being only one of many terms used to describe similar but not entirely overlapping concepts. Part of the confusion arises from different historical uses of the 'defined contribution' idea. Three decades ago Paul Ellwood and colleagues advocated a type of defined contribution in their proposed 'health maintenance strategy,' while seven years later Alain Enthoven advocated defined contributions on the part of employers as a component of 'managed competition'. Employers were encouraged to contribute the same amount toward any health insurance option chosen by an employee, offer multiple options to stimulate competition, and play an active role in evaluating health plans and managing the competitive choice process. In contrast, DCPs emerging in the current marketplace respond to employers' desire to reduce their involvement in managing health benefits and shift more decisions to employees."

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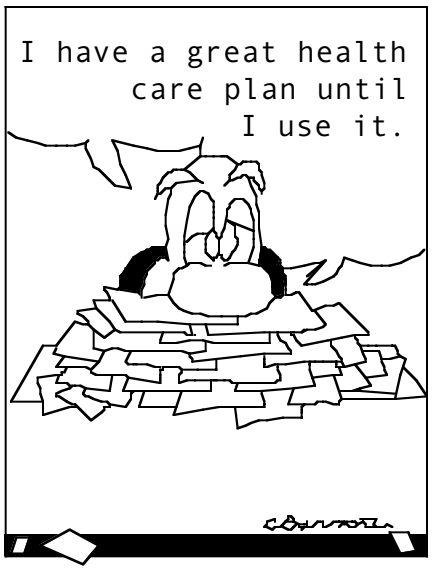

"DCPs that are being closely followed by employers include Definity Health, Destiny Health, HealthMarket, Lumenos, MyHealth-Bank, and Vivius. These products differ from traditional managed care products in several ways: (1) A portion of the employer's contribution toward employee health benefits is placed in an account from which the employee purchases services with tax-advantaged dollars. (2) A major medical or some other type of 'wraparound' insurance policy is purchased with a portion of the employer's contribution. (3) Employees could, in any given year, need to spend their own dollars to cover an 'actuarial gap' between the cost of services purchased using dollars in the 'health spending account' (the DCPs use different names for this account) and the services covered by the insurance policy."

"DCPs point out that in the current system consumers have little knowledge regarding the cost of medical services and minimal incentives to consider cost in purchasing decisions. MCOs have failed, in their opinion, because they insulate consumers from the cost of care and, to control costs, impose restrictions and limitations that are objectionable to both consumers and employers. They argue that placing more decision making in the hands of employees, with appropriate tools to support that decision making, would increase employees' satisfaction with health care benefits, constrain medical care cost inflation (since consumers would be 'spending their own money'), and ultimately reduce employers' administrative costs."

"DCPs differ in the emphasis they place on various dimensions of product design and strategy. However, any attempt to capture those differences should, at best, be considered a snapshot of a moving target."

Provider networks and payment. "The most common provider network strategy has been to sign contracts with a variety of companies that offer 'ready-made' networks with specified discounts. Four of the six DCPs planned, from the beginning, that providers would be paid on a fee-for-service (FFS) basis. Consumers essentially built their own care networks, choosing from among providers holding contracts. Providers set their own fee schedules, which are then converted, using actuarial techniques, to a per member per month price seen by consumers. Enrollees select providers based on this price, but providers are paid FFS."

Spending accounts. "All DCPs offer some type of consumer directed spending account. The spending accounts offered by the DCPs vary by services covered and consumers' 'ownership' of account balances at the end of the benefit year. For instance, Definity Health establishes a 'personal care account' for each member, funded by the employer. Consumers can spend from this account for standard medical services and, depending upon employers' customization of the Definity Health product, a wide range of other services, including acupuncture, hearing aids, laser eye surgery, and dental and vision care."

"However, only spending on more conventional medical services 'counts toward' the deductible in the member's major medical policy. Any dollars remaining at the end of the year can be carried forward in the account for the following year. Under Definity

Health's contract with Medtronic, a large employer in the Twin Cities, the balance of the account is forfeited if the employee leaves the company (the fund is considered a 'retention tool' in this respect) or switches to another insurance option within the company."

Beyond Generic Gender Health Care

From "The Sicker Sex: Men's Health a Serious Problem" by Samara Kalk in *The Capital Times* (Madison, WI), 2/09/02:

"Men's health is the most serious health problem in the United States today, a local doctor argues. Dr. Robert Alt, an internist at Dean Medical Center-East Madison Clinic, is becoming a leading expert on men's health issues. 'The fact is that actually men have a life expectancy six years less than women,' he said. 'Men smoke more frequently than women, we drink more and suffer all of the stigma that accompanies alcoholism. We have a great excess of heart disease, accidents, suicidality.' "

"Local women's health experts applaud Alt's work and the attention he is bringing to men's health issues. University of Wisconsin Medical School Professor Molly Carnes, who directs the Center for Women's Health Research, said she is thrilled that Alt is recognizing the need for 'gender-specific medicine.' There are gender-specific issues that relate to health across the life span, from birth to death, she said. Male babies who are born with problems don't do as well as female babies, and girls go through puberty earlier, she said. Both have health impacts."

" 'The women's health movement backs the men's health movement,' said Carnes. 'In fact, it was the women's health movement that began to promote men's health issues 10 years ago. The Journal of Women's Health changed its name about five years ago to the Journal of Women's Health & Gender-Based Medicine, recognizing that the old way of just treating one gender was not scientifically sound.' "

"Marianne Whatley, who chairs the UW-Madison women's studies program, agrees that men's health has been neglected. 'There have been women's health movements for many years. If you think back to *Our Bodies, Ourselves* men didn't produce a similar work,' she said. 'A lack of attention to women's health issues in the 1970s created a massive grass-roots movement of women's health activists,' said Whatley, 'a focus now on men's health is entirely appropriate as long as it isn't opposed to women's health.' "

Academic Hoops Know No Boundaries

A periodic *Eye On Health* feature are excerpts of letters from Dr. Linnea Smith from the Yanamono Medical Clinic in the remote Amazon basin of northeastern Peru. Donations are welcomed c/o: Amazon Medical Project, Inc., 106 Brodhead St., Mazomanie, WI 53560. AMP is a non-profit, tax-exempt organization.

…*continued from last month:* "The final step in the course was to defend the monograph, again as though it were a doctoral thesis. This seemed a little inflated to me; after all, it was really just a term paper. However, defending it is in keeping with the spirit of pomp and ceremony, and besides, Edemita had informed me that many of the students had purchased their papers from one of the computer whizzes; having to 'defend' the papers meant that at least they would have to study what they were supposed to have written."

"We showed up at the auditorium at the appointed hour. As more and more people filtered in, and as we looked at the stage set with podium and table for the judges and a machine to show transparencies, and as the guy set up and tested the microphone, Edemita's palms were getting sweatier and sweatier, even though she was outwardly tranquil. It appeared that no one else really knew, either, what this ordeal would be like, so their fellow students had come en masse in order to see what would be awaiting them when their turns came."

"The judges filed in, and the mistress of ceremonies made the opening remarks, and she said that 10 minutes would be allotted for each of them to speak, with 10 more minutes for questions afterward. Juvencio had already taped his poster to the wall at the side of the podium. He took the microphone and began with a rambling greeting to all those present, then sort of froze, announced he would start with the life cycle of Ascaris, looking at the poster briefly but not approaching it or referring to it further, presented a somewhat abbreviated version of that cycle, then turned to the manuscript, where he read in a blurringly rapid voice as much of it as he could until his time was up and most of Edemita's as well. The judges finally stopped him and told Eda to take the microphone."

"It was undoubtedly the first time in her entire life that she has been on stage, and the first time holding a microphone, and the first time with an audience of 50 or so people hanging on her every word. She began hesitantly, then froze, said a few more words, then froze again. Long pauses came between her few sentences, and the sentences themselves didn't really make a lot of sense. Fortunately, the allotted time was nearly at

an end, and I kept giving her encouraging smiles from my seat next to the judges, who finally took pity on her and suggested that she wrap it up. She attempted a conclusion, then sat down."

"Now came the question period. There was another delay, as no one in the audience had questions, then one of the other students asked something and Juvencio responded. The judges added a few more questions, all of which he answered, until finally they instructed him to turn the microphone over to Eda. She did much better when facing the judges than when she looked at the audience, and although her answers were still far from fluent, and some of the questions difficult ('what do you do when you have told your patients not to drink raw river water, and they don't listen?').

"When they finally gave up on questioning, there was an additional wait, equivalent to the condemned man awaiting sentence. The judges retired to a side room to confer, while Juvencio, Edemita and I remained sitting on the stage. After a long 10 minutes or so, the judges filed back in, resumed their seats, passed a piece of paper among them, then summoned the mistress of ceremonies. She took the paper and went to the microphone, and asked everyone to please stand. She then read the paper: 'Whereas the sworn judges Licensed Nurse Maria Paredes, Licensed Nurse Zoraida Silva, etc., etc., having convened a meeting at the Facultad de Enfermeria of the Universidad de etc., etc., on the 20th of August of the year 2001, and whereas in this meeting the students Juvencio Nunez Pano and Edemita Peterman Pano presented their monograph, and whereas the judges find that the students have presented their thesis and their conclusions in a reasonable and believable manner and etc., and etc., and etc., it is hereby announced that the degree of Tecnica de Enfermeria is hereby awarded to Juvencio and Edemita etc. in the name of the University of etc., etc., etc.' The audience and judges then broke into applause, Juvencio and Eda were summoned to the judges' table, and with one hand on the table and one hand in the air were solemnly sworn to their duties as Nurse Technicians."

"I knew there would still be bureaucratic hurdles. But the work of the course was finally completed. And after years of wanting to find some way to recognize the clinical skills of these two people without whose efforts the clinic as it now exists would have been impossible, I am more than thrilled to know that finally, finally, that goal is achieved."

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