Contagion as a Fiscal Problem

An allegedly new communicable disease enters our immediate community. We hear about it—cloaked in frightening metaphors—in the local newspaper and its existence is verified in the other publications within the state. Learned commentators then remind us of the mayhem wrought by prior pestilences and pandemics; and both our wise statesmen and clergy admonish us, perhaps urging a day of fasting and repentance, to prepare us for the worst.

Important questions necessarily arise: Is this an utterly new pestilence or merely a recurrence, such as influenza, of an infectious disease that has repeatedly arisen amongst humans in the past? Is the infection confined to humans, such as poliomyelitis, or does it transcend species barriers, such as with influenza, and concurrently infect swine, birds or other creatures?

We will assume now that this newly arisen pestilence affects both children and adults indiscriminately, is suppressed by no known antibiotic and results in a relatively high mortality rate. A local committee is then assembled to determine what the community might do. Their decision might be: (1) to do nothing beyond the customary use of private medical offices, clinics and emergency rooms; or (2) to appeal to the citizenry to participate in specified rooms; or (2) to appeal to the citizenry to participate in specified
days of prayer, sacrifice, humiliation and fasting; or, (3) to encourage the civic leadership to proactively invest in known preventive measures and community-wide educational interventions.

The decision is not a simple one: Community priorities must be examined. The past experience of other communities must be explored. And certainly a set of fundamental questions will demand answers before tangible steps will be taken.

• Is there certainty that the disease is communicable; that is, caused by a living organism such as a virus, a bacterium or a fungus? If communicable, how is it communicated? By air, by drinking water? By physical contact (including venereal intimacy)? Or by the intermediary of an insect such as a mosquito or tick?
• Have neighboring communities been similarly affected? And if not, have they been duly warned of the nature/characteristics of this new ailment?
• Has the United States Public Health agencies, particularly the Centers for Disease Control & Prevention, been appropriately notified and their active assistance requested, including their superb laboratory facilities and mobile epidemiologists?
• Is the disease of sufficient economic and social importance—for this community—to justify a formal preventive medicine campaign?
• Is there the political will to use public moneys to confront the epidemic? The United States, in the 1920’s and 1930’s was confronted with a near epidemic of venereal disease, particularly syphilis and gonorrhea. Many religious communities were strenuously opposed to any federal anti-syphilis program, contending that the core disorder was sinful behavior and hence not in the domain of public health and certainly not within the realm of federal responsibilities. By the mid-1930’s, a cautious public education program was instituted with posters in public bathrooms declaring: “Stamp Out Venereal Disease!” as well as an earnest program in the armed forces to combat venereal disease.
• Are there religious scruples that might cause sufficient numbers to resist the contemplated preventive medicine interventions (e.g., a recommendation for the use of condoms)? Or secular worries that vaccines might cause autism?
• Are there medical interventions (such as enhanced water purification methods or enforceable quarantines or vaccines) which have been shown elsewhere to be medically proven and cost effective for this particular pestilence?
• Do any of the preventive measures, such as a contemplated vaccine, carry significant morbidities and complications? (As an example, the original, crude Pasteur vaccine to combat rabies, devised in the late 19th Century, was clearly effective medically but its use carried a high frequency of serious, and sometimes fatal, neurological complications.) In the sphere of public health, there are no free lunches.

A communicable disease—whether it be new or recurrent—poses many challenges and choices for the affected community. Ultimately, of course, it resolves itself to a mixture of competing

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Correspondence

e-mail: joseph_friedman@brown.edu

Joseph H. Friedman, MD
Evaluation of Possible Inflammatory Bowel Disease: A Survey of Rhode Island Physicians

Sumona Saha, MD, Manuel Lam, MD, Erica Roberson, MD, MS, Samir Shah, MD, Neal S. LeLeiko, MD, PhD, Sheldon Lidofsky, MD, Renee Bright, MS, Nicole Flowers, MD, MPH, Marjorie Merrick, MA, and Bruce E. Sands, MD, MS

INTRODUCTION

The inflammatory bowel diseases (IBD), Crohn’s disease (CD) and ulcerative colitis (UC), cause significant morbidity to patients of all ages. Abdominal pain and diarrhea are common in patients with IBD, but also occur in non-inflammatory conditions of the gastrointestinal (GI) tract such as irritable bowel syndrome (IBS). As the initial presentation of IBD may be protean, a prolonged delay in diagnosis has been described. Patients with undiagnosed IBD particularly those with non-acute symptoms are often first evaluated by their primary care physician (PCP). Therefore, PCPs are often in the position of deciding if and when patients with non-specific GI symptoms require referral to a specialist. Despite the frequency with which abdominal pain and diarrhea are encountered in the primary care setting, little is known about how physicians approach these problems. Understanding the diagnostic decisions of PCPs in the evaluation of these common GI symptoms is important to determine whether they are taking the appropriate steps to differentiate IBD from other conditions and making timely referrals for definitive diagnosis.

We surveyed PCPs to understand how they evaluate common GI symptoms. We hypothesized that patient and physician characteristics influence the diagnostic evaluation of possible IBD.

RESULTS

Despite the frequency with which abdominal pain and diarrhea are encountered in the primary care setting, little is known about how physicians approach these problems. Understanding the diagnostic decisions of PCPs in the evaluation of these common GI symptoms is important to determine whether they are taking the appropriate steps to differentiate IBD from other conditions and making timely referrals for definitive diagnosis.

METHODS

Participants

This survey was conducted, in part, to validate information about referral patterns of IBD in Rhode Island as part of the Ocean State Crohn’s and Colitis Area Registry. A mailing list of all physicians in RI was obtained through the American Medical Association. Internists, family practitioners, pediatricians and obstetrician/gynecologists (Ob/Gyns) comprised our sampling frame. As a practical consideration 25% of PCPs were randomly selected for inclusion. Non-responders were contacted with two additional mailings. A five-dollar gift card was included in the first mailing.

This study was approved by the Institutional Review Boards at Lifespan/RI Hospital and at Massachusetts General Hospital.

Survey Instrument

Physicians were mailed a five-page, 26-item questionnaire in March 2008. Survey items included demographic information, questions pertaining to two clinical vignettes, and questions assessing the importance of various factors in the choice of specialist referral. Content and face validity were established by two gastroenterologists and four PCPs, respectively.

The vignettes described hypothetical patients presenting with chronic lower abdominal pain (vignette 1) and chronic diarrhea (vignette 2). The duration of symptoms was not provided. After reading the vignettes, respondents were asked to...