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Correspondence

Smallpox Vaccination Technique

I have been asked about the CDC-recommended technique for administering smallpox vaccine. I had considerable experience with the vaccination procedure in my former position as Chief of Clinical Research for the VD Branch at the Centers for Disease Control and Prevention (CDC), where I reported directly to Dr. Donald Millar, who oversaw the last smallpox eradication programs in the late 1960s and early 1970s in Eritrea and Bangladesh.

I too am puzzled about the new regimen. The objective was to deposit the vaccine in the papillary dermis and the basal area of the epidermis. Occasionally, a few drops of blood from the vessels in the papillary dermis will leak to the surface during this procedure, but we tried to avoid this. Indeed, some novices were so timid that they did not break the stratum corneum, resulting in failure. Perhaps the new requirement for blood to appear is to avoid inadequate penetration by unskilled personnel, with consequent failure. In the past, the routine appearance of blood was considered a sign of sloppy technique.

Regarding skin preparation, there is no question that alcohol quickly kills the vaccinia virus. Unless one waits a full 90 seconds after swabbing the skin to begin the inoculation, the rate of successful "takes" drops dramatically. Because the wait is cumbersome during mass inoculations, we used ether instead. This is probably why the CDC recommends no skin preparation. According to the *MMWR* of April 18, 2003, more than 33,000 civilians have been vaccinated without a single case of secondary pyoderma.

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Defeating "Universal Coverage"

In the years before World War II, physicians provided universal medical care. Patients who consulted a private physician paid for the service rendered. Those who had medical insurance submitted the bill to their broker or agent. Since he wanted to keep the patient as an insurance client, he saw to it that the insurance company paid the patient.

Patients who could not afford the cost of private care went to a clinic where doctors donated their time and skill and drug companies often supplied free "samples." Everybody could exercise the "right" to medical care without the interference of a third-party czar.

After WWII, lawyers became involved, writing specifications for companies that offered medical insurance to attract workers. Then, "preferred" lists arose, playing on physicians' insecurity and greed. Some joined the "preferred" list, abdicating their authority to a third-party master who made paper promises of economic advantage.

Another thrust toward socialism arises from an alliance of lawyers and insurers capitalizing on physician fear of malpractice liability.

Physicians must make a decisive move to checkmate this oppressive socialized, third-party system if they are to stop the thrust to universal coverage, socialized medicine, discussed in the last issue.¹

One possible move is to drop malpractice coverage—its cost now far exceeds its value. Lawyers are quite hesitant to sue a physician if there is no possibility of netting at least \$400,000. In the March issue, *Medical Economics* reported that an estimated 2,400 Florida physicians opted to go bare. This action brought about important legislative changes.

Assets can be protected. Bigger obstacles include hospital rules written by attorneys or State licensure requirements: Colorado, Connecticut, Kansas, Massachusetts, Missouri, Pennsylvania, and Wisconsin require \$1 million in professional liability coverage.

The drive to socialized medicine can be stopped only if physicians overcome the power of the lawyers and insurers. To do so, they must focus on serving their patients and refuse to trade their autonomy for the third-party dollar.

It is your move.

Donald McCabe, D.O.
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¹ Danehower CC. Universal coverage. *J Amer Physicians Surgeons* 2003;8:5.