Dr G's MediSense

Volume 1 Number 4

Enjoy, learn, think, ponder - Putting medical and nutrition news into historical, scientific and just plain practical context. You are free to copy, send or print any of the articles. Just have the courtesy to leave my name and sponsorship on each page.

Written and published by Ann Gerhardt, MD

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Blame the delay of this DrG'sMediSense on Medicare Part D, as in D for Disaster, Disorder, Dimwit, & Dumb. If you have Medicare and have already tried to deal with the morass that the President and Congress call helpful legislation, you will understand. In trying to make it simple for you, I've spent hours doing the research and correcting and re-correcting my own misperceptions. One would think that this program was intended for sharp, computer-savvy, 20-somethings who don't really need medications, rather than mentally-slowing 90 year-olds who don't have a computer, and might die without their meds.

Contents:

Getting the Most Out of Your Doctor	**- 1**
Herb/Spice of the Month: Nutmeg	**- 2**
Are You SAD?	**- 3**
Medicare Part D	**- 4**
Various and sundry	**- 7**

Getting the Most Out of Your Doctor #4:

By Ann Gerhardt, MD

If you are lucky enough to have doctors whose office staff treats you like you are special and in need of help, read no further. Too often doctor's offices treat only "VIP's" with deference, kindness, and as if the patient is the reason for the practice to exist.

Lynne Truss' book, *Talk to the Hand – The Utter Bloody Rudeness of the World Today, or Six Good Reasons to Stay Home and Bolt the Door,* would be a good training manual for many doctors' offices (both doctors and staff). She doesn't mention rudeness in medical care, however many of her observations might describe behaviors by medical professionals and staff that escalate patient anxiety, mistrust and feelings of helplessness.

On staff helpfulness she writes: 'In all our encounters with businesses and shops, we now half expect to be treated not as customers, but as system trainees who haven't quite got the hang of it yet. "We can't deal with your complaint today because Sharon only comes in on Tuesdays," they say. "Right-oh," you say. "I'll remember that for next time."

Rudeness and lack of caring unfortunately pervade some doctors' offices, particularly those run by people who have never been patients. There is no good way to deal with unkind, non-patient-oriented staff. The more one complains, the less likely staff (and doctor) will want to help in the future. Overwhelming staff with your own sweetness and kindness sometimes engages them in wanting to be helpful, but not always.

A letter of complaint to the doctor or head of the medical group might help to change the system, but don't hold your breath. **If you decide to leave the practice, be sure to write a letter to the doctor with your reason**: If you silently slink off into the netherland, the doctor and practice will never know there was anything wrong that should change.

Quote attributed to Voltaire:
"Doctors pour drugs of which they know little to cure diseases of which they know less in humans of which they know nothing."

Dr G agrees with the doctor part and adds:
People consume supplements of which they know little to prevent diseases of which they know less with consequences of which they know nothing.

NUTMEG *by Ann Gerhardt, MD (Request a free email subscription: algerhardt@sbcglobal.net, or send $15 for a paper copy to P.O.Box 19274, Sacramento, CA 95819. Reprints permissible if the entire page is kept intact.)*

Bottom line at the top: *Nutmeg is a perfect example of the adage that, "If a little is good, a lot can be really stupid."*

'Twas a holiday day, engaged in making cookies and fortifying myself with eggnog. Suddenly I felt an irresistible urge to nap. The only eggnog additive was an ample pinch of nutmeg (there was no alcohol, I swear). The cookies, sampled regularly to maintain quality control, contained a variety of holiday spices - cinnamon, nutmeg, allspice, clove and ginger. Wondering which ingredient might have turned my normal hyperactivity into near-paralysis, I hit the books. Nutmeg was the obvious culprit.

Herbalists and those looking for mind-altering experiences have experimented with nutmeg for years, reporting accounts of disease cures, disasters and hallucinogenic trips. Far too often unpleasant and even life-threatening events followed nutmeg ingestion - Surprising but true evidence that spices and herbs are not necessarily safe in non-spice-like quantities.

The 'therapeutic window' – the dose range that might be beneficial – overlaps significantly with the amount that causes toxicity. People differ in their susceptibility to chemically active substances, with no way of knowing how they will react or what a safe or toxic dose. In other words, there is no safe nutmeg dose to take as a supplement for any medicinal reason. The same is true for mace, which has similar chemical properties.

Spice companies tell only nice things about nutmeg, even hinting at medicinal properties. Other sources report herbalists' warnings and young druggies' harrowing personal accounts of toxic effects. Projectile vomiting, profuse diarrhea, paralysis, cardiac arrest, extremely rapid heart rate (which can cause shock), paranoia, delirium, hallucinations, disorientation, nightmares, sleeping for days, dry mouth, inability to urinate, muscle aches, eye pain, headache, sweating, hypothermia, numbness, shortness of breath, and burning lungs make those using nutmeg for medicinal properties just plain foolish.

If the potential adverse effects are not enough to make you avoid more than a sprinkle, remember what one individual said - "It's embarrassing to tell your friends you have a nutmeg hangover."

Using a dash of nutmeg in eggnog or pumpkin pie, or eating Middle Eastern or Asian dishes flavored with nutmeg seems to be safe and might even be calming. One never knows, however, the amount that could lead to trouble. Humans should take the hellaceous taste of pure nutmeg as a warning to moderate their consumption.

Oil of nutmeg has been used to conceal the taste of liquid medications. Reportedly grated nutmeg mixed with lard makes an excellent ointment for hemorrhoids, but I worry about absorption through bleeding hemorrhoids causing severe side effects: Try Preparation H instead. Claims by the herbal community that nutmeg improves skin ailments (most Myristica species cause skin irritation), acts as an aphrodisiac (which I can't understand, since it puts people to sleep) and cures headache, fever, bad breath and joint pain have no basis in fact. Avoid nutmeg infusion teas, as the dose is not controllable. Nutmeg may induce abortion, so women of child-bearing potential should not use it.

Both nutmeg and mace come from Myristica fragrans trees, which bear fruit containing a single nut-like seed. A red, lacy membrane, which is mace, covers the seed. The seed's shell encloses the kernel, which is the nutmeg. Nutmeg and mace have similar, piney, citrus-like, and somewhat bitter aroma and flavor. No other members of the Myristica family are used as spices – In fact, some related plants induce caustic skin and stomach irritation.

Nutmeg naturally contains myristicin, considered to be the most bioactive component, but the body may convert it to an amphetamine derivative which may be addictive. Nutmeg also contains bioflavonoids, eugenol and other volatile oils, elmicin, stearin, lignin, protein, starch and gum, all of which might induce either positive or negative effects. The spice mace has nothing to do with Mace brand pepper sprays, made from hot chili peppers.

Adulteration and fraud pervade the nutmeg industry, fooling the unwary consumer with inferior nutmegs and oils. The best nutmeg originates in the East Indies and is small, round and heavy with oil. It seems that some consider nutmeg to be akin to diamonds, judging by all of the efforts to pass off fakes at the real nut. Fakes come from trees that are not Myristica fragrans or from true nutmegs from which oil has been extracted.

Nutmeg found in stores does not specify its origin, so the consumer has no way of determining quality. Long ago, fraud was so prevalent that dishonest yankee peddlers sold wood whittled into shapes resembling nutmeg, earning Connecticut the name of "The Nutmeg State."

ARE YOU SAD? *by Ann Gerhardt, MD*

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(Request a free email subscription by emailing algerhardt@sbcglobal.net, or send $15 for printed issues to P.O.Box 19274, Sacramento, CA 95819. Reprints are permissible if the entire page is kept intact.)

Winter, a time to celebrate the holidays, then curl up with an afghan and good books and emerge in the spring. That's one scenario for whiling away the short, dark days. Others avoid the whole cold, dank scene by jetting off to Florida. For far too many, however, winter-time sun deprivation means months of gloom.

Though it has long been recognized that winter is associated with depressed mood, the National Institute of Mental Health first named the extreme version of seasonal moodiness **Seasonal Affective Disorder**, or "SAD", in the 1980's. The severe form afflicts millions of individuals, over 80% of whom are women.

Less intense depression, termed sub-syndrome SAD, descends on millions of others. Symptoms such as tiredness, moodiness and sleep and eating problems occur, but depression and anxiety are absent or mild.

Daytime light strongly influences biorhythms by stimulating the hypothalamus in the brain. At the equator, with long sun-lit days all year, few people suffer the seasonal depression that occurs at latitudes farther north or south. Those with mild winter moodiness in temperate zones may acquire full-blown SAD if they move to arctic climates.

SAD's definition: Regularly occurring fall-winter depressions (at least two occurring during consecutive winters), alternating with non-depressed periods during spring and summer, with no other obvious cause of depression to account for the regular changes in mood. Symptoms include:

- desire to oversleep, difficulty staying awake, disturbed sleep and/or early morning wakening;
- fatigue and an inability to carry out normal routine;
- wintertime carbohydrate and sweet food craving, usually resulting in weight gain;
- feelings of misery, guilt and loss of self-esteem; sometimes hopelessness and despair; sometimes apathy and loss of feeling;
- irritability and a desire to avoid social contact;
- tension and inability to tolerate stress;
- decreased interest in sex and physical contact

Some sufferers ping-pong between depression and extreme happiness or short periods of hypomania. (Hypomania is a mild degree of mania, characterized by excessive, rapid-fire, mental and physical activity.)

Most SAD people experience fall-winter depressions alternating with non-depressed periods in the spring-summer. Rare variants, at times flip-flopping the season pattern, also exist: For example, some people thrive in the winter and slump into severe depression in summer.

Treatment – Let there be light:

Since the absence of light causes the problem, light therapy fixes it. It works for mild afflictions, as well as over 80% of severe cases.

Treatment requires exposure to bright light, at least 10 times the intensity of ordinary domestic lighting. The minimum effective light intensity is 2500 lux, and much brighter light (up to 10,000 lux) shortens treatment time.

As little as 30 minutes, or as much as a few hours every day may be necessary to induce improvement, depending on the symptom severity and light intensity. A specially designed light box, light visor or dawn simulator all work, as long as the light shines directly into the eyes. Looking directly into the light is not necessary, as long as the light path is not blocked by the newspaper, your head or any other object.

Treatment starts to work within 3-4 days and must be continued for the benefit to persist. Daily exposure to as much natural daylight as possible helps also. For some, light therapy eliminates the need for anti-depressants.

Although eye doctors have expressed concern about the long-term safety of light treatment, no one has reported evidence of eye damage from it. The FDA classifies light boxes as Class III medical devices, which may only be commercially distributed with pre-market approval or an Investigational Device Exception, a measure that restricts medical claims made in advertising.

People with the severe form of SAD depression should seek psychiatric help. Medications are often helpful for underlying psychiatric problems, such as bulimia, major depression or bipolar disorder. Psychological counseling does not replace light therapy, but may help to cope with the illness.

For more information, contact the National Organization for Seasonal Affective Disorder (www.nosad.org), the Society for Light Treatment and Biological Rhythms (a research group) www.sltbr.org, or the Circadian Lighting Association (manufacturers' trade association), which has a code of practice to protect consumers' interests www.claorg.org.

Deciphering Medicare Part D *by Ann Gerhardt, MD (Request a free email subscription: algerhardt@sbcglobal.net, or send $15 for a paper copy to P.O.Box 19274, Sacramento, CA 95819. Reprints permissible if the entire page is kept intact.)*

Best Laid Plans: Medicare's Part D prescription Drug benefit program rolled out on January first, or at least tried to. Many people still have no Drug plan because of the seriously Difficult process of understanding the system and choosing a plan. Now, Disasters of implementation have left millions of sick people without vital medication.

The new policy and variety of options has most people confused. This article attempts to simplify your approach to your Decision about drug coverage. It would help if you use a patient family member or eldercare advocate who cares enough to help you Disentangle the morass of information and choices. It also helps to read articles like this at least twice, to help break through the catatonia that occurs with the first reading. I really am trying to help.

Basics: With this new program, Medicare pays private insurance companies to provide medications to enrollees (minus some out-of-pocket costs from you, the beneficiary).

In **mid-October** Medicare sent to each Medicare beneficiary a "Medicare and You 2006" handbook. This handbook listed all the prescription drug benefit plans offered in the beneficiary's (your) geographic area. If you already had health insurance in addition to Medicare (called Medigap or supplemental – see below) that covered prescriptions, your insurer should have notified you to let you know if your coverage is at least as good as the standard (see below) Medicare prescription drug coverage.

Important dates: November 15, 2005 - Enrollment for drug coverage plans began.

January 1, 2006 - Coverage started if you signed up with a plan before December 31.

January 1 and May 15, 2006 – If you join a plan between these dates coverage starts the first day of the month after the date of enrollment.

May 15, 2006 – Deadline date for signing up with a plan.

After May 15, 2006 – Joining after this date means you wait until November 16, 2006 for your drug coverage to start and it will cost you more.

Between November 15 and December 31 - The enrollment period each year, when you can change your plan.

Picking a plan: Think about the whole program as you would home insurance: You choose a company, the type and extent of coverage that you want, and the costs that are acceptable to you. The only difference between drug coverage and home insurance is that, in addition to premium and deductible costs, you have to pay a co-pay for each medication purchase. Also drug coverage gets more complicated than home insurance by being linked to health insurance for some plans: Like getting home, car and personal liability insurance as an inseparable package deal.

Your choice of plan should depend on finding one that covers the drugs you already take (or could easily switch to), fits with your preference about health insurance, is accepted by your pharmacy, and accommodates the amount of premium, deductible and co-pay you are willing to pay. See the table at end of this article for help.

If you already have health insurance with drug coverage, in most cases that coverage will continue, with new financial support from Medicare. If you are happy with your current insurance and drug plan, contact your insurer to find out how Medicare Part D will affect you. You should have already received a letter.

If you have Medicare and MediCaid/MediCal, you may do nothing about drug coverage, and Medicare will assign you to a plan. If you want some input into your drug coverage, you must pick the plan you want. The new drug plan may not cover all of your current medications. Some of those may be paid for by MediCaid/MediCal and some may not.

If you don't currently have drug coverage or want to change your current arrangement, you need to decide if you want a drug insurance plan that is combined with or independent of health insurance. This is probably the greatest source of confusion for people. There are two types of drug plans:

Stand-alone Prescription Drug Plan offering drug coverage only. This pays for drugs only. Your Medicare coverage, supplemental health insurance coverage, HMO, major medical, long-term care or whatever else you have are all separate from this. It's like buying a flood insurance policy to supplement your home insurance.

Prescription drug coverage rolled into a Medicare Advantage or other Health Insurance Plan. Some of the new prescription drug plans come tied to health insurance. Understanding this requires an understanding of Medicare health insurance as it has existed prior to January 1, 2006. Here is an attempt to explain it:

You, as the Medicare beneficiary, may choose to use Medicare as *primary* insurer: Under this traditional arrangement, Medicare generally pays 80% of covered, allowable expenses, for which you pay a $150 yearly deductible and a small monthly premium. You can pay the remaining 20% of the allowable charges yourself, or you can purchase a *secondary* insurance policy to pay it. This is also called supplemental or MediGap insurance, and, for the purposes of this article, I will call this supplemental insurance. The supplemental insurance may be any type of HMO, PPO, EPO, retirement, union, VA or indemnity coverage that is given to you or for which you pay a monthly premium. The supplemental insurance may or may not cover drugs, depending on the terms of your policy.

Alternatively, you may *replace* Medicare as your primary insurer with an insurance plan, generally an HMO, that receives money from Medicare and a monthly policy premium from you. It acts as the only insurer, covering 100% of covered, allowable expenses, less any co-pays. This type of replacement for Medicare and supplemental insurance has been given the appealing name of *Medicare Advantage*, even though it usually restricts choice of providers more than do other arrangements. These policies usually, but not always, include drug coverage.

If you qualify for MediCaid or MediCal, your primary insurer is Medicare and your supplemental insurer is MediCaid/MediCal, which has paid in the past for drugs.

If you choose a drug coverage plan tied to an insurance plan, be clear about whether you are getting a plan that replaces Medicare as the primary health insurer or acts as supplemental insurance.

Cost: In most cases, you will pay a monthly premium for drug insurance. Some Medicare Advantage plans include drug coverage in the total health insurance premium. All of the plans provide *at least* basic coverage, for these costs:

$32 Monthly Premium: The amount you pay for the drug coverage policy, not the drugs, each month.

$250 Yearly Deductible: The amount you pay out of pocket for drugs each year before the insurance policy starts paying.

Co-payments: The amount you pay for each prescription, *after* you have paid the yearly deductible.

> **25% of total cost of drugs,** up to $2250 per year. Then there is a **Coverage gap: You pay 100% of the cost of your drugs** between $2250 and $5100 for the year.
>
> Then you pay **5% of drugs cost** after the total drugs cost for the year has been $5100.

Covered Medications: Part D plans do not cover all medications. Medicare has stipulated that every plan must cover at least a basic list of drugs. Some companies have a plan with a formulary that includes only the basic, mandated drugs. Many vitamins and potentially habit-forming, but common drugs, such as sleeping pills, pain medications and anti-anxiety medications, are not part of the basic list. You pay for them out of your own pocket and the drug cost is not applied to your deductible. More comprehensive plans do include these drugs, but that is their choice and you will pay more for the plan.

There are also medications that are called "Part B" drugs. Medicare, by Congressional mandate, pays for these as part of your medical expenses and they are not covered by the new Part D plans. Examples of this type of drug are vaccines, chemotherapy agents and anti-rejection medications for transplant patients. You should not have to worry about coverage, as long as the pharmacy or provider bills Medicare, not the drug insurance company.
If you have a chronic medical condition (such as lupus or cancer or kidney failure), and your medications are not Part B drugs, you should find out which plans in your area have formularies that cover typical drugs used for your condition.

To help you decide on a plan, make a table (use the example at the end of this article) and fill in the specifics of each plan in order to be able to compare them. You should have received information in the mail from insurance companies offering drug coverage. You may also go on-line to http://www.medicare.gov/medicarereform/map.asp (Medicare's "Landscape of Local Plans") to find out which plans are available in your area. This site contains a table with basic information. You may then go to each company's website to find out the specifics of each plan. Or you can call Medicare at 1-800-MEDICARE for a list of available plans, then call each company for plan details. You can access information at the **Medicare Prescription Drug Plan Finder** at **www.medicare.gov** , **or www.eldercare.gov** to find out about local counseling and assistance available in your area. If you do not have on-line access, you may call a customer service representative at 1-800-MEDICARE. With your name, birth-date, Medicare number and Medicare effective date (on you card), they will give you information specific to you. The customer service representative can help you to decide if you qualify for extra financial help, if your employer/union is continuing your current coverage with a Medicare subsidy, and if you are already enrolled in some type of drug coverage plan. If you are happy with the coverage that your secondary insurance offers, **make sure that it still covers your current medication.**

People with limited income: Choose a drug plan, but you may be able to qualify for a financial break, called "Extra Help", from Social Security: You are supposedly the people for whom the program was developed. Medicare wants you to be able to get your medications so that you can actually treat your medical problems to keep them from becoming worse. The copayments, deductible and monthly premium are low if you qualify for "Extra Help Level II" and much lower or zero for "Extra Help Level I." Do not apply for assistance if you already have MediCaid or MediCal. If Social Security has not already sent you a form, call for one at 1-800-772-1213 or go to www.socialsecurity.gov. Send in the form and Social Security will send you a letter telling you whether you qualify or not.

What happens after you decide on a plan:

Enroll: You can enroll at Medicare's online Enrollment Center at www.medicare.gov; by calling your chosen plan's toll free number, by mailing in an application to the plan, or by visiting the plan's website. If you are a couple, **EACH** of you must enroll.

Get a card: The insurance company will send you a bill for your premium and an insurance card. **Make sure you get a card – There are so many problems with implementation of this program that you are guaranteed trouble without one.**

Fill a prescription: When you need a medication, you present the card to the drug store. Be sure you have checked to see that your plan covers the prescription. You may think that this is not your responsibility, but you will save yourself, doctor, and pharmacist from many headaches by doing so, because a pharmacy does not have access to your plan's formulary list: The pharmacist must enter each prescription online to see if it is covered. If not covered, the doctor is notified to write for a different drug, with the possibility that the sequence will require repetition until a covered drug is found. Of course you always have the option of paying outright for any prescribed medication, whether it is covered by your plan or not.

If the medication is covered, with any luck, the drug store will be able to access your information online and tell you your cost for the co-pay and deductible. You pay the store and take your medication home. The tally of your year-to-date medication costs is automatically updated, you hope.

Try to maintain hope: The computer systems are not fully implemented yet. This is a major government program that was rolled out in a very short period of time. Of course it will have problems.

DECISION TABLE:

	Your Current plan	Brand X HMO with drugs	Brand Y PPO with drugs	Brand Z drug only
1. Monthly premium				
2. Yearly deductible				
3. Co-pay for generic drugs				
4. Co-pay for brand name drugs				
5. Amount of 'coverage gap'(the drug cost that is solely borne by me)				
6. After what $ amount does it pay 100% of drug cost?				
7. Maximum out-of-pocket drug expense				
8. % of the top 100 drugs used by Medicare patients that are covered by the plan				
9. Covers all of my current medications?				
10. Does my pharmacy accept the plan?				
11. Requires me to use a mail-order pharmacy?				
12. Combined with supplemental insurance?				
13. The plan replaces Medicare health insurance (Medicare Advantage)				

TO QUALIFY FOR FINANCIAL HELP YOUR FINANCES MUST BE:

Extra Help Level I	**Extra Help Level 2**
Singles - Income below $12,919 AND cash & investment resources below $7500	Singles - Income below $14,355 AND cash & investment resources below $11,500
Couples - Income below $17,320 AND cash & investment resources below $12,000	Couples - Income below $19,245 AND cash & investment resources below $23,000

Click and Clack, of NPR's Car Talk, are offering a support group to regain self-esteem for recovering SUV owners.

Dr G received the Sacramento Sierra Valley Medical Society's 2005 Medical Honor award at the Society's annual installation and awards dinner on January 13, 2006. The Society gave her the award for founding and working with We Insist On Natural Shapes, a non-profit dedicated to preventing eating disorders, including obesity.

Author's Notes, Disclaimer and other assorted details: Please read at least once.

The focus of DrG'sMediSense is to put medical news into a context of medical knowledge and practicality. Some of you have requested articles about broad subjects that don't relate to any recent news and would require huge articles. I'll oblige from time to time, but will bite off pieces of each subject over a number of issues, rather than writing a single dissertation. If I don't address your idea readily, it's because I don't feel I can do it adequately or I have to figure out how to do it without being too long-winded.

Approximately 10 issues per year.
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Disclaimer: Because you are an extraordinary manifestation of a tangle of unique genetic material, think first, before applying any or all of these articles' information to your life choices. Dr G's just trying to pass along some information. I'll try to interpret medical and nutrition news reports for you - within the framework of information already known and the limitations of how the studies were done, with a little of my gut feeling (clearly identified as such) thrown in. Articles this size can't possibly contain every bit of information that was ever published on a subject. Distillation may leave some things out: Hopefully not crucial pieces. Don't crucify me if some new tidbit of information comes along that contradicts what I wrote. Let me know about it and I'll research it, stir it into the mix of general knowledge and see if something logical gels. This newsletter offers some insight, not The Cure: It's not a doctor's prescription. PLEASE discuss any changes in therapy or lifestyle with your doctor. Subscribing to this newsletter presumes that you accept your own risk when making decisions about your health.

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Reader input: If you want any particular subject to be discussed in Dr G's MediSense, just let me know. If I'm clueless about it, I'll let you know. If you want me to publish an alternate point of view, write to me. If I don't think you are off your rocker, I'll print it: I like controversy. But remember, it's my newsletter. **Contact** algerhardt@sbcglobal.net.

Dr Gerhardt's qualifications for presuming to think you might want to read her newsletter:
Board Certified, Internal Medicine and Clinical Nutrition
Clinical Professor of Internal Medicine, University of CA, Davis
Medical Director (Internal Medicine), Cardiac Transplant Program, Sutter Community Hospitals
Medical Nutrition Director, Mercy General Hospital
Recipient of numerous awards for work with eating disorder patients
Founder of the non-profit organization, We Insist on Natural Shapes
Has done research and realizes that one study raises more questions than it answers
Practices what she preaches