from the Trenches

> Hot topics such as maintenance of certification, sustainable growth rate, the Health Insurance Portability and Accountability Act, and meaningful use....have distracted physicians from their most important responsibility andlittered the practice landscape with confusion, frustration, depression, and downright anger.
>
> **William M. Gilikson, MD,** GREENWOOD, INDIANA

CHANGES IN MEDICINE LEAD TO RETIREMENT DECISION

I just finished reading several back issues of *Medical Economics* and am now certain my decision to retire at the end of 2013 was the correct one.

My heavens, the practice of medicine has mutated (not evolved—that connotes good outcomes) into a form unfamiliar to those my age (70). Hot topics such as maintenance of certification, sustainable growth rate, the Health Insurance Portability and Accountability Act, and meaningful use (or abuse, as I like to call it,) have distracted physicians from their most important responsibility and littered the practice landscape with confusion, frustration, depression, and downright anger. What's a fella to do?

Well, like me, when he could no longer keep up with the mandated changes in the "business of medicine," and could no longer afford to maintain a solo practice, threw up his hands and said, "uncle," and became an employee of a larger group. My patients hated it! But they had no say in the matter. I had to do it to stay afloat, financially. And for the next seven years, on a daily basis, my patients told me they wished the could go back to the "old office with Sandy, Alice, Jeannie, and Tricia." Yes, they knew their first names, and we knew theirs.

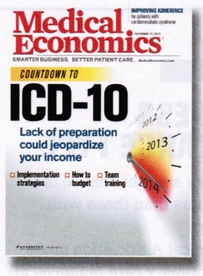
So by retiring, my patients got short-changed. They had to go through the troublesome process of finding a new doctor. In the letter I sent announcing my retirement, I listed the onerous intrusions into the practice of medicine and the multiple means by which the doctor-patient relationship had been subverted, as reasons for my decision. They were sympathetic to my plight because they recognized the change from a "homey" solo practice to the impersonal environment of a large group practice.

All those encumbrances distracted me from the important subject at hand, my patient. It's the way of the future, unfortunately.

I sincerely wish my patients well, and miss them and the relationship we had, the friendships we developed, and the confidence they expressed in me as their family physician. It's what being a doctor is all about. You actually see patients when they are sick and refuse to send them to the emergency department when their problems can be handled in the office. You stay in the exam room until he or she has run out of questions, and you make eye contact with them and ask them, how's the family? After all, they consider you part of their family, and it's only right to be interested in their children, grandchildren, spouse, etc. and their activities. "How did Johnny do in the state swim meet?"

All that's passé in favor of all the distractions that consume the time we used to have to be professional and caring human beings.

I originally started this letter ➔9



> We seem to conflate price with cost, and forget that long-term the price will correlate with the cost outputs or the business will soon cease to exist...Until we examine healthcare from a cost/benefit perspective there is no hope of containing healthcare expenditures.
>
> **Jim Maher, MD,** MARSHALL, MICHIGAN

➔8 with the intention of criticizing maintenance of certification, new payment models, meaningful use, etc., but who cares about that stuff anyway? To a patient it doesn't mean diddly. All they care about is having a physician who cares about them, responds to their needs, answers their questions, and gets them well.

Teach that in medical school.

William M. Gilkison, MD
GREENWOOD, INDIANA

CERTIFICATION IS WASTE OF TIME AND MONEY

I am board certified by the American Board of Family Medicine, but I agree with critics who believe that certification is a waste of time and money.

Critics need to voice this opinion with those insurers and hospitals that use board certification as a criterion for privileges or membership. Advising the credentialing boards themselves to self-destruct and end their gravy train will predictably fall on deaf ears.

Stuart Andrews, MD
BELLINGHAM, WASHINGTON

MORE SPENDING DOESN'T BRING GREATER VALUE TO PATIENTS

If society truly wishes to reduce healthcare costs, the first thing to do is to assess where the money spent on healthcare goes. In a physician's office well over 50%, and sometimes more than 75%, goes to overhead. Many of these costs either provide no benefit to patients or provide benefits far under their costs.

If a physician spends $225,000 to $250,000 doing what it takes to get paid, couldn't the process be made more efficient and simple? If the International Classification of Diseases-10th revision will cost $83,000, as cited in this journal, probably 15% of a physician's cash receipts, is patient care improved 15%?

At hospitals I have worked at, a huge amount of money is spent preparing for and dealing with Joint Commission visits, with recommendations of one surveyor frequently changed the next time they come. Couldn't the Joint Commission be required to make reduction in hospital costs an important part of their mission, and cost neutrality or savings a critical part of their assessment and recommendation?

We seem to conflate price with cost, and forget that long term the price will correlate with the cost outputs or the business will soon cease to exist. Is anyone really looking at the costs of provision of services rather than the number or price of the service provided? Until we examine healthcare from a cost/benefit perspective there is no hope of containing health expenditures.

Jim Maher, MD
MARSHALL, MICHIGAN

TELL US

medec@advanstar.com

Or mail to:
Letters Editor, Medical Economics, 24950 Country Club Boulevard, Suite 200, North Olmsted, Ohio 44070. Include your address and daytime phone number.

Letters may be edited for length and style. Unless you specify otherwise, we'll assume your letter is for publication. Submission of a letter or e-mail constitutes permission for Medical Economics, its licensees, and its assignees to use it in the journal's various print and electronic publications and in collections, revisions, and any other form of media.