from the Trenches

> [MOC] was a huge expense for me, and as much as I would like to say I'll never do it again, my hospital privileges and a few of my major insurance contracts hinge on my recertification. It is a grand mess.

Beth Renzulli, MD, MIDDLETOWN, DELAWARE

MOC IS A MONEY DRAIN, BUT NOT REALLY OPTIONAL

Thank you for your continued coverage of our ongoing frustration and disgust with the entire Maintenance of Certification (MOC) process ("MOC: An examination of costs and impact to physicians," July 25, 2014).

Regarding the cost of MOC, my greatest expense was actually the time I had to miss from my practice to study for the test and actually take the exam. I estimate that, in addition to the testing fees, preparation materials, etc, I lost about $7,000 to $10,000 in revenue.

That was a huge expense for me, and as much as I would like to say I'll never do it again, my hospital privileges and a few of my major insurance contracts hinge on my recertification. It is a grand mess.

I love medicine or would have been burned out by all of this many years ago. Keep up the excellent work. We really do appreciate the support.

Beth Renzulli, MD
MIDDLETOWN, DELAWARE

ULTIMATELY, MOC WILL FAIL

There is no preponderance of evidence to support the proponents of MOC.

I suspect that driving force behind MOC is the Institute of Medicine's 2000 report "To Err is Human" (National Academy Press, 2000) wherein it reported that 44,000 to 98,000 hospital deaths occurred because of medical errors each year. That study only looked at statistics from New York, Utah, and Colorado.

Clearly, even one preventable death is a tragedy, but rather than concentrate on making hospital care safer, MOC was and is applied to all specialties, many of which do not even treat patients in the hospital.

There is lots of continuing medical education (CME) available to physicians. Most self-direct their education. Many hospitals offer CME to their staffs and many good self-study programs exist. MOC detracts from the ability of those programs to survive.

Ultimately, MOC will fail. Its mandatory status, its pass/fail approach and its lack of practicality will appeal only to those in teaching positions in academia who are desirous of adding another accolade to their resumes.

Add to this the rumors that surround its profit-making success and it is clear that MOC will not succeed.

Edward Volpintesta, MD
BETHEL, CONNECTICUT

MOC DOES NOT FOCUS ON THE 'REAL MEDICAL WORLD' OF PRIMARY CARE

As a 64 year old primary care physician tak-

from the Trenches

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>
> **Edward Volpintesta, MD,** BETHEL, CONNECTICUT

ing the MOC exam for the third time in 10 year sequences, I read your recent cover article with great interest.

From my point of view, aside from its essential coercive and punitive rather than educational focus, there is a more central fallacy to the internal medicine exam.

It is essentially a sub-specialist created test that quizzes generalists by repeatedly asking them to make decisions after reviewing cardiac catheter data or viewing renal biopsies. These are responsibilities and decisions that simply do not exist in the real medical world of the primary care physician.

It not only makes the entire experience useless but in reality for an office based generalist invalidates any conclusions regarding physician competence or quality of care.

David C. Sobel, MD, FACP
EDISON, NEW JERSEY

PAYER OFFERS BIASED PERSPECTIVE ON PRIOR AUTHORIZATIONS

In a recent edition of *Medical Economics*, you quote Edmund Pezalla, MD, of Aetna Inc. in a discussion regarding prior authorizations (July 10, 2014).

He tells us that "until fairly recently most medical care was based on intuition and guesswork." I did not realize that I have been blundering in the dark for the last 20 years.

He also states that "we're trying to make sure this is the right thing for the patient." To think I imagined that was my task. Clearly, patients need to be protected from my misguided ways.

The remainder of his remarks suggest that most physicians requests are for unusual or unproven tests. Ninety-nine percent of my applications are for CT [computerized tomography] or MRI [magnetic resonance imaging] scans, and precious few of these.

Apparently profit has no motive whatsoever in prior authorizations.

I stand enlightened.

Russell Lee-Wood, MD
BARNESVILLE, OHIO

REMOTE MONITORING TECHNOLOGY STILL HAS WAYS TO GO TO REACH ITS POTENTIAL

Daniel Verdon may be right in that Google's blood sugar sensing contact lens might revolutionize medicine (July 10, 2014).

But why send the data to me? Send it to the smart insulin pump imbedded in the patient's abdomen so it can increase or decrease the dose accordingly. This is the real promise of technology.

Publish this quickly. I'll submit my patent on the idea tomorrow.

Charles Hamori, MD
SAN DIEGO, CALIFORNIA

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> "[MOC] is another example of the long arm of academia extending its grip over doctors. This also happened after the recommendations of the Flexner Report of 1910 were adopted by medical schools. Flexner lamented that the curricula of the medical schools were too rigid and [left students] too little time for personal development.

Edward Volpintesta, MD, BETHEL, CONNECTICUT

Continued from page 9

MOC REQUIREMENTS REPEAT MEDICAL PROFESSION'S PAST MISTAKES

Howard Mandel, MD in his April 10 letter ("ABMS And Other Boards Force MOC On Doctors") was correct to point out the tyrannical move to force maintenance of certification on the medical profession by the very organization that physicians helped to create almost a hundred years ago. At the time sitting for the boards was voluntary.

But slowly the leadership of the boards has positioned themselves so that certification has become a credential for admission to hospital medical staffs, for medical licensure, and it has been used by medical insurers as an indicator of physician "excellence." It will not be long before insurers will decrease their payments to physicians who are not certified.

This is another example of the long arm of academia extending its grip over doctors. This also happened after the recommendations of the Flexner Report of 1910 were adopted by medical schools. Flexner lamented that the curricula of the medical schools were too rigid and forced students to march in lock-step, leaving them little time for personal development.

Sir William Osler, one of the founding fathers of Johns Hopkins Hospital, believed the changes overemphasized the science of medicine and trained medical scientists more than medical doctors because of the lack of attention to the social and psychological and personal factors that doctors also need in dealing competently and humanely with their patients.

By its increasingly mandatory status and its punitive pass/fail, MOC repeats the same deplorable "lock-step" defect and narrow-mindedness that followed the recommendations of the Flexner Report of 1910.

Edward Volpintesta, MD
BETHEL, CONNECTICUT

CLINICAL INFORMATION IN MAGAZINE IS WELCOME

Kudos on returning some clinical information to *Medical Economics*. While the business of medicine is the primary focus of your publication, many of us are far enough down the feeding chain as to have little impact on our organization's business decisions.

Some articles are relevant, e.g. personal finance and taxes, but if there were consistently some concise clinical updates such as the Rx of anemia in heart disease patients ("Recommendation addresses treatment of anemia in patients with heart disease," April 25, 2014), I would peruse the magazine more carefully and more often.

Douglas Butler, MD
CRUMPLER, NORTH CAROLINA

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"Although officials at the American Board of Medical Specialties proclaim that the boards are voluntary, they are being dishonest or confused because the boards are being used as credentialing requirements by insurers and hospital staffs.

Edward Volpintesta, MD, BETHEL, CONNECTICUT

honored qualities have become the exception rather than the rule.

Neil Berkowitz, MD
SAN DIEGO, CALIFORNIA

NEW ACP KIDNEY DISEASE GUIDELINES NOT NEEDED

The new American College of Physicians guidelines against screening for chronic renal disease ("Recommendations on the screening, monitoring, and treatment of early-stage chronic kidney disease," April 10, 2014) are really a moot point since every chemistry panel has three numerical indices for this very disease.

For the last five or six years, every laboratory in the U.S. includes: BUN (blood urea nitrogen), creatinine, and eGFR (Glomular Filtration Rate). The estimated GFR is even broken down for African-American patients and non-African-Americans. Therefore, when a patient receives a printout of his/her blood chemistries, implied is the actual stage of renal function and/or diseases.

"...false positives, unnecessary treatment and added healthcare costs" are now built into the system. I myself had three different chemistry panels done last summer at three different labs and my eGFR differed by 13 points!

Of course, those with long-standing hypertension, diabetes, obesity and other single- or multiple-risk factors can often be motivated into treatment and lifestyle modifications by these numbers. Others become quite concerned and I often have to perform a renal ultrasound to make sure the patient has two functioning kidneys. Some, with eGFR in the 50 point range do in fact have only one functioning kidney. Others are reassured that they have normal anatomy. Either way, often a follow-up evaluation is necessary to the data found on a routine chemistry panel.

Arnold Chanin, MD
EL SEGUNDO, CALIFORNIA

MOC BOARDS ARE NOT VOLUNTARY

Raj Patel, MD. in his letter of March 25 ("MOC has little value") resents, and aptly so, one of the most contemptible issues in the maintenance of certification issue, namely that MOC, despite what its proponents say, is mandatory.

Although officials of the American Board of Medical Specialties proclaim that the boards are voluntary, they are being dishonest or confused because the boards are being used as credentialing requirements by insurers and hospital staffs.

When the boards were created almost 100 years ago, they were voluntary. If they were mandatory physicians would not have supported them and the boards would not exist today.

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> **“** ‘Certified’ implies a guarantee of excellence, which is dishonest. It makes more sense to call a doctor who passes the boards a ‘diplomate,’ a term that merely means that a physician has passed a certain test.
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ernment and insurance industry to manipulate to deny payment and ultimately, care. Maintenance of certification data capture is leading states to institute maintenance of licensure, requiring more time and money for physicians.

Hospitals have never competed with each other on price, unfortunately, but now compete with its staff physicians, despite higher costs and increased reimbursement from insurance and government entities. Hospitals now own primary care and specialty groups to capture their referrals and ensure their continued unimpeded growth and profit.

Medical care tailored to the needs of each patient is being phased out by the “stakeholder” model, beholden to government, insurance industry and “organized medicine authority” bodies like the American Medical Association and American Osteopathic Association. Although patients are the ultimate stakeholders, they are last on the priority list in herd or population medicine.

The best physician I know doesn't practice medicine. He teaches anatomy to nursing students. This removes all the aforementioned pressures and stresses from him and his family. I'm sure the U.S. government, insurers, hospitals, and foundations are pleased. Nurse practitioners and physician assistants are cheaper to train and maintain to provide patient care.

Craig M. Wax, DO
MULLICA HILL, NEW JERSEY

CERTIFICATION TERMINOLOGY MISLEADS PUBLIC

In his February 25 letter, “MOC requirements will drive out experienced providers,” Benjamin Levinson, MD spoke for the majority of senior physicians when he suggested that the pressures of maintenance of certification (MOC) may force doctors to quit medicine.

But there is a side issue here that is rarely discussed, namely poor English usage. In his essay, “Politics and the English Language,” the English writer George Orwell said that “bad usage can be spread by tradition and imitation even among people who should and do know better.”

In the case of the American Board of Medical Specialties, the words “certification” and “re-certification” represent bad usage. Both words mislead the public because neither all members of the public nor all members of the medical profession agree on exactly what they mean.

“Certified” implies a guarantee of excellence, which is dishonest. It makes more sense to call a doctor who passes the boards a “diplomate,” a term that merely means that a physician has passed a certain test.

I suspect that if the ABMS substituted “diplomate” for “board certified” far fewer doctors would feel the need to sit for the ABMS exams.

Edward Volpintesta, MD
BETHEL, CONNECTICUT

from the Trenches

> Empirically and experientially, reduced accessibility through narrow networks in socialized systems leads to shortages and waiting lines. This leads to de facto cost-containment, but not value, since waiting in line costs the system nothing because they receive nothing in service.

Stewart Andrews, MD, BELLINGHAM, WASHINGTON

NARROW NETWORKS CARRY RISKS

The article on narrow networks ("Narrow networks: Obamacare's broken promise and how doctors and patients can fight back," March 25, 2014) briefly addressed the risk of imposing narrow networks solely for cost containment in quoting Donald J. Rebhun, MD. But it implied multiple times that tightening costs correlated, or even caused, the delivery of value. Low costs and value are far from synonymous terms, though used as such in the article.

Empirically and experientially, reduced accessibility through narrow networks in socialized systems leads to shortages and waiting lines. This leads to de facto cost-containment, but not value, since patients waiting in line cost the system nothing because they receive nothing in service. A politician can then proclaim, "You'll have the right to (wait in line for) healthcare, if you vote or me!"

Nurse practitioners and physician assistants will deliver future primary care, which may be OK, but it's a long leap from, "You get to keep your own *doctor,* period."

Stewart Andrews, MD
BELLINGHAM, WASHINGTON

MOC PROCESS ONEROUS, EXPENSIVE

I feel the maintenance of certification (MOC) process has become too onerous and expensive. It started (American Board of Physical Medicine and Rehabilitation) with the recertification examination every 10 years. Then they added CMEs Types I and II every year for a 10-year cumulative. Now there are practice improvement projects and other expensive, time-consuming requirements. Oh, and there is a yearly fee for participating.

I just took, and passed, my last recertification exam. I plan to be retired by the time it comes around again.

Dennis A. Ice, MD
AMARILLO, TEXAS

REPLACE SGR WITH HYBRID PAYMENT MODEL

While the Medicare Sustainable Growth Rate (SGR) cap is poised to be repealed, the proposed replacement does not solve the problem. The SGR was designed to cap Medicare spending, but has failed, while the cost of fixing Medicare has risen every year since the late 1990's. But what is to replace SGR and keep Medicare solvent and the healthcare industry from exploding under the weight of its costs?

The practical solution is a hybrid payment system that incentivizes doctors to be good stewards of the healthcare dollar as well as rendering accessible, quality care. It allows the doctor to concentrate on the patients rather than trying to document to get paid more.