Insurers get away with fixed reimbursements, yet raise their own rates

Dr. Robert L. Barbieri's April editorial, "How many days does it take you to pay for your liability insurance?" is very timely. Our specialty is restricted in its ability to charge appropriately for services rendered, mostly because we foolishly continue to "contract" with insurers. These companies have no problem raising their own rates, but they make sure reimbursements to physicians remain fixed. The result: Our specialty's reimbursements have actually declined over the years.

Do you receive higher payment for a delivery in 2006 than you did in 1999? I doubt it. We should be charging more than $5,000 for any delivery, and this amount needs to be adjusted with the cost of living. As for malpractice premiums, in the 1990s they were half their current cost, if not less—yet ObGyns' reimbursement remains static.

We need to wake up and remove ourselves from the insurance loop. Here is my reasoning: When a patient contracts with an insurer for health care, that contract is between her and the insurance company. We do not need to agree to accept reimbursement from the insurer as payment in full—particularly when the rates are inappropriately low. Rather, the patient should make up the difference. After all, she is the one who receives the care. If my car is damaged, I am expected to pay the deductible and any other costs not covered by my insurer. That should be the norm in medicine, too.

Although the sky-high rates of liability insurance have caused me to limit my practice, I feel I must speak out so others can continue to work and enjoy their profession.

Joseph C. Ptasinski, MD
Algonquin, Ill

If we assert ourselves, we can solve inequities

Maybe it has been for our own sanity that none of us has done the math to determine how many days we are working to pay our "mal-occurrence" premiums—until now. I think most of us intuitively knew the results, but I appreciate the cold slap in the face that Dr. Barbieri provided. The time has come for radical changes. Otherwise, we may regret our decision to become ObGyns.

Why are we paying such inordinate costs without reciprocal reimbursements? Litigation for malpractice (and I use the term loosely) is a societal problem in this country. Other than passivity, we are guilty only of choosing a profession we enjoy. If we assert ourselves and work collectively, ObGyns could wield more power than any other medical specialty.

I have 2 suggestions:

1. Have all specialties pay the same price for mal-occurrence insurance. Sharing the load would help us tremendously.
2. Set a date for all ObGyns to begin refusing insurance assignments for OB care. We could post this plan on a national Web site so that we have a common source of information. After

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"I'm mad as hell and I'm not going to take it anymore"

the set date, we would accept cash for OB care at a level of $4,000 to $6,000. Let the patients solve the reimbursement problem with their insurance carriers.

Once we have everyone's attention, we can discuss Gyn reimbursements, too.

These suggestions may seem ridiculous, but I do not see how we can afford to continue providing health care. Even with a government-backed single-payer plan in the future, neurosurgeons and orthopedists will still make more than we will if we do not demand more payment today.

Remember the movie *Network*: "I'm mad as hell, and I'm not going to take it anymore."

G. Walton Smith, MD, MBA
Knoxville, Tenn

Forget the cutting edge —First, "do no harm"

Tort reform and increasing reimbursement rates are only temporary solutions to the problem of rising practice costs. The only lasting solution is to modify our medical practices to meet the expectations of a world that demands no undesirable outcomes ever!

In obstetrics, this means no operative procedures except for a 100% C-section rate, since a common theme in litigation is: "You should have done a C-section."

In gynecology, we need to return to the basic principles of doing no harm and putting the patient's best interest first. This means forgetting about our egos, "exciting" technologies, ancillary income opportunities, marketing, and even plain scientific research. These are big temptations, but common elements in lawsuits.

Pablo A. Pinzon, MD
Oklahoma City

Complacency begets complacency

Dr. Barbieri's editorial eloquently describes the problems we all face in today's malpractice crisis. Over the past 5 years, my malpractice

premiums have doubled, while reimbursements have steadily declined.

Although I appreciate the editorial, I am in awe of Dr. Barbieri's complacency regarding this issue. We are in desperate need of strong leaders to guide us through this dilemma. ACOG and the AMA want my dues, but they aren't doing anything, either.

Joseph Livoti, MD
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"In the last 5 years, my premiums doubled and my reimbursements declined"

Dr. Barbieri responds:

Innovative solutions are clearly needed

I appreciate the time Drs. Ptasinski, Smith, Pinzon, and Livoti took from their busy professional and personal lives to write about actions ObGyns can take to improve the relationship between reimbursement and professional liability premium expenses.

As Drs. Ptasinski and Smith note, we could improve our situation by stopping our practice of accepting insurance and starting to "pass through" increases in professional liability insurance premiums directly to patients. Some surveys suggest that about 10% of physicians are now refusing to accept insurance contracts that prevent them from balance-billing patients. Many obstetricians are reluctant to take this step because of the financial burden it might place on some of their patients.

I agree with Dr. Pinzon that in our current liability environment a liberal use of cesarean section and cautious adoption of new surgical procedures is wise. Rather than persist in past clinical practices, we should focus on achieving no bad newborn outcomes, the chief cause of obstetrical liability risk.

Dr. Livoti concisely describes the complexity of trying to change a tort system that is broken, and the difficulty physicians face in leading political change.

Robert L. Barbieri, MD
Editor-in-Chief

Need for VTE prophylaxis often gets overlooked

Dr. Daniel L. Clarke-Pearson's article, "Preventing VTE: Evidence-based perioperative tactics" (April), is another fine summary of ongoing concern about thrombo-embolism after gynecologic surgery. In the past year, articles in both ObGyn and internal medicine literature pointed out the need for attention to this issue. Prophylaxis is probably the best way to lower risk. In my own survey,[1] I found a lack of consensus about or appreciation of venous thromboembolism and prophylaxis for C-section.

Dr. Clarke-Pearson's remarks on laparoscopy are also appreciated. In a literature review of 179,706 laparoscopic procedures, we[2] found 18 cases of thromboembolism, with 2 deaths reported. Despite apparent "low risk," the physiologic changes due to pneumoperitoneum and venous stasis probably still necessitate prophylaxis. My choice for most patients having extended laparoscopic procedures is sequential compression devices.

Thomas P. Connolly, DO
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1. Connolly T. Thromboembolism prophylaxis and cesarean section: a survey of general obstetricians. South Med J. 2003;96:147–148.
2. Connolly T, Jachtorowicz MJ, Knaus JV. Incidence of thromboembolic complications after gynecologic laparoscopy. A review of the literature. J Pelvic Surg. 2001;7:350–353.

A case of winning the battle vs the war?

A recent letter to the editor (April) described a legal case in which the plaintiff's attorney agreed to withdraw the suit after discovering that the plaintiff had been negligent in not seeking a mammogram. In exchange, the physician agreed not to countersue. This kind of agreement sends the wrong message: that it is OK to do sloppy diligence and to use a shotgun approach to attack physicians in the medical malpractice arena. I agree that this case represents a win of sorts, but it also represents a loss.

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