# COMMENT & CONTROVERSY

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**"Pay for performance: We'll be better off,"**
by Mark DeFrancesco, MD, MBA (December)

## Let's avoid another trip down the primrose path

Let me see if I understand the concept.... With pay for performance (P4P), the insurance companies, Medicaid, and Medicare are going to give us a "bonus" for doing all the things we have been doing (ie, Pap smears, STD testing, and postpartum visits, just to name a few). They are going to do this even though we have had to battle in the past just to receive a pittance of what is owed us for providing these services!?! Any physician who has had to negotiate reimbursement schedules for obstetrics and gynecology in the current environment has to see this as the ultimate irony.

**"It behooves us to demand randomized, unbiased data [about pay for performance] that prove the worth of all this meddling"**

How many times must we be led down the primrose path? Fetal monitoring was supposed to decrease cerebral palsy and the incidence of birth asphyxia. We all adopted this premise without critical data to assess its efficacy. Now we are paying a high medicolegal price for this failure of due diligence. Then managed care was touted as a better means of delivering care and obtaining reimbursement. This never happened, and never will!

Now we are told that if we just do the "right thing" according to some nebulous set of parameters, we *might* get a bonus check once or twice a year. Oh yes, and with our dismal reimbursement monies, we should spend thousands of dollars from our own pockets on electronic medical records. This cash outlay will make what better and easier for whom?

When I see the first bonus check for 7% of my annual billings, I might, just might, give the idea some credence. Until that time, it behooves us to demand randomized, unbiased data that prove the worth of all this meddling. I have a healthy skepticism that pay for performance represents just one more ploy to prevent physicians from being paid in a timely and fair fashion.

When this bus goes over the economic cliff, don't say we weren't warned not to be on board.

**William H. Deschner, MD**
Lake Arrowhead, Calif




Dr. DeFrancesco responds:

## We already have evidence of the benefit of P4P

Dr. Deschner is correct: We should demand evidence that something works before blindly adopting it. The points presented in the article provided at least this "evidence": There are medical groups in existence right now that have already received enhanced compensation for their work in real-life P4P programs, and real providers in these groups have indicated that the quality of care they provide has increased as a consequence of their focus on certain measures. In addition, the electronic medical record is a clinical tool that will improve the quality of care and patient safety, and is not being promoted as a P4P tool with no other intrinsic value.

CONTINUED

**"Which is better at stopping acute uterine bleeding—oral MPA or combination OCs?"**
by Alan H. DeCherney, MD, and Belinda Yauger, MD (Examining the Evidence, December)

## Outpatient care is possible for acute uterine bleeding

Dr. DeCherney and Dr. Yauger reviewed a study by Munro and colleagues that addresses one of the more common problems I see in my general gynecology practice: how to manage acute uterine bleeding. In residency, we commonly treated this condition with Norlestrin (norethindrone acetate 2.5 mg, with ethinyl estradiol 50 mg) 2 or 3 times daily as an outpatient alternative to intravenous estrogen, but noncompliance was high due to nausea. It did lead to rapid cessation of symptoms, however.

Over the years I have found the use of oral contraceptives to be empirically better (in uncontrolled comparison with the medroxyprogesterone acetate used by 2 partners) for the treatment of menometrorrhagia. Most recently, since the introduction of femhrt (norethindrone acetate 1 mg, with ethinyl estradiol 5 µg), I have found that a twice-daily or, in more extreme cases, 3 times daily, regimen works nearly as well as the old regimen, with virtually no nausea, because the total day's dose of estrogen is lower than 1 standard low-dose pill and is divided over 24 hours. The small amount of estrogen, along with the estrogen-like activity of norethindrone, seems to elicit a more rapid response.

With increasing pressures to limit costs, outpatient alternatives become more important. I also use this femhrt dosage in acute, painful functional ovarian cyst suppression—our most common emergency department gyn consultation request—with excellent, rapid symptom control without nausea. I keep a couple of sample packs in my hospital locker, as it is not on the formulary and, as usual, most of the consults seem to occur in the wee hours of the morning.

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