"MEDICARE AND MEDICAID ARE ON THE BRINK OF INSOLVENCY, AND YOU'RE NOT JUST A BYSTANDER"
ROBERT L. BARBIERI, MD (EDITORIAL; OCTOBER 2011)

Health-care reform means fewer dollars for physicians

A great editorial! At last, someone in our field is "getting it" and letting others know the consequences of health-care reform for physicians, including the fact that savings will be attained only by reducing payments to doctors and hospitals. I applaud Dr. Barbieri's knowledge and honesty.

Regrettably, no politicians are willing to be as forthcoming. The public continues to believe that it can get everything it wants when it wants, and that it will be perfect and cheaper, too! Eventually, physicians and the public will have to wake up to the fact that the health-care system cannot continue the way it is—and the proposed fixes are untenable, too!

In my opinion, universal, basic health care—with options for those who can afford it—will have to be developed and will have to incorporate restrictions (i.e., rationing) of resources based on clinical guidelines. Another proviso: if clinicians adhere to these guidelines, they will be indemnified from lawsuits.

Arnold W. Cohen, MD
Chairman, Department of Obstetrics and Gynecology
Albert Einstein Medical Center
Philadelphia, Pa

›› Dr. Barbieri responds

Health-care reform "savings" come at a price

I agree with Dr. Cohen that health-care reform is likely to produce "savings" by reducing reimbursements to physicians and hospitals, a plan that is likely to adversely impact the health of patients.

OCTOBER 2011

"IS PRIVATE OBGYN PRACTICE ON ITS WAY OUT?"
LUCIA DIVENERE AND JANELLE YATES (OCTOBER 2011)

Problems in private practice are longstanding

This was a very informative article. I am the husband and practice manager of my wife's solo ObGyn practice. Eleven years ago, we moved to a small rural community to help provide quality health care to an underserved population.

It is a shame that there is no support from anywhere to help us sustain a viable business. Not only is there a lack of loyalty from employed individuals in the community, but employment taxes, malpractice insurance, supplies and equipment, and recertification and credentialing are too expensive.

Being in private practice is a deplorable position to be in, in the current economic environment in the deep South, and I doubt that it will ever be advantageous to open a solo practice in a rural community as long as this financial climate prevails.

The problems didn't arise solely with President Barack Obama; they started in President George W. Bush's second term and declined from that point as private insurance companies lowered reimbursement.

Jeffrey Evans
Baxley, Ga

Private practice is the best way to care for patients

I worked in both large and mid-sized groups before deciding to switch to solo private practice. I know my patients as well as the back of my hand. If Mrs. Smith calls to report a pain, I know who she is, whether the problem is likely to be an emergency, and other details pertaining to her care.

My patients trust me and believe in me. Private practice is the best way to care for patients because no one knows my patients as well as I do. If the government takes the ability to maintain this familiarity away from me, and others like me, it will destroy medicine completely.

Stephanie Singer, DO
Park City, Utah

Let's not go the way of the airline industry

The Patient Protection and Affordable Care Act seeks to regiment, standardize, automate, and demote the status of medical care. We are told that this will lead to greater patient safety, just as automation in the airline industry improved the safety of flights—a fact used to browbeat doctors and nurses. Now, the airline industry is fighting "over-automation," and pilots are "forgetting how to fly"; automation now accounts for the majority of serious airline accidents.

We should not stand by idly while our system becomes a standardized computer-automated public health utility designed to save money—lest we forget how to practice medicine.

John Sand, MD
Ellensburg, Wash

No business can survive with fixed reimbursements

There is a simple solution to the challenges faced by physicians in private practice: Insist on payment at the time services are rendered. For the past several years, as reimbursements have declined, physicians in many specialties have begun to opt out of insurance contracts. These physicians have done consistently well. It is senseless to believe that a business can survive without adjusting for escalating overhead expenditures. "Global reimbursements" are emblematic of poor-quality medicine and are supported by physicians who either don't work hard or devalue the quality of medicine, or both.

Most physician charges are extremely affordable, and the vast majority of physicians allow for adjustable payment methods when appropriate.

Any physician who supports "ObamaCare" (i.e., the Patient Protection and Affordable Care Act) either doesn't know the specifics of the law or doesn't practice medicine full-time and has other sources of income.

Joann Somers, MD
Livingston, NJ

Let's get rid of insurance

The entire specialty is deteriorating because of physician apathy and devaluation of their specialty science. The people who stand to make money from this development? Information technology specialists and business administrators.

It is time to revert to the traditional fee-for-service model. Patients should pay their doctor the designated charges and get rid of all private insurance, Medicare, and Medicaid. Our charges are very reasonable.

Barbara Lombardi, MD
Montclair, NJ

SEPTEMBER 2011

"DOES ELECTRONIC FETAL HEART RATE MONITORING REDUCE THE RISK OF NEONATAL DEATH?"
ERROL R. NORWITZ, MD, PHD (EXAMINING THE EVIDENCE; SEPTEMBER 2011)

"Expert" commentary was incomplete and unprofessional

In his assessment of our study of electronic fetal heart-rate monitoring and neonatal death,[1] Dr. Errol R. Norwitz simply rehashed the results of a 2006 Cochrane review of electronic fetal monitoring during labor.[2] He did not provide a critical analysis of the individual randomized, controlled trials included in that review. In our view, this kind of "assessment" does not qualify as "expert commentary."

With the exception of the Athens trial,[3] none of the other trials in that Cochrane review involved a direct comparison of electronic fetal monitoring and intermittent auscultation as the primary and only method of intrapartum fetal surveillance. All the randomized, controlled trials—except the Athens trial—involved comparisons of policies or protocols allowing for back-up methods, such as scalp pH level, and cross-over from intermittent auscultation to electronic fetal monitoring when fetal heart-rate abnormalities were detected by auscultation. However, such back-up and cross-over methodologies will mask any true clinical outcome differences that exist between the two primary monitoring techniques.

In the Athens trial, where there was a direct comparison of electronic fetal monitoring and intermittent auscultation, without cross-over or back-up methods, perinatal mortality in the electronic fetal monitoring group was significantly reduced (odds ratio [OR], 0.20; 95% confidence interval [CI], 0.05–0.76) because of the decrease in hypoxia-related perinatal mortality.[3] Furthermore, a subsequent meta-analysis of the randomized, controlled trials also showed that electronic fetal monitoring was associated with a significant reduction in perinatal death due to fetal hypoxia (OR, 0.41; 95% CI, 0.17, 0.98).[4]

Everyone who practices obstetrics knows that intrapartum fetal death has virtually disappeared since the introduction of electronic fetal monitoring.[5–7] As the only prospective controlled comparison of the two monitoring techniques showed, the prevention of fetal death by electronic fetal monitoring is due to its improved detection of fetal acidemia in labor.[8]

Dr. Norwitz is concerned that the lawyers will use the information about the benefits of electronic fetal monitoring against physicians. In our view, an expert's conclusions should not be driven by medicolegal concerns but by what is best for our patients.

Last, we are surprised by Dr. Norwitz's use of unprofessional language, including "the authors missed the boat entirely." The use

of such language when discussing the work of some of the most widely published authors on the subject of electronic fetal monitoring undermines the credibility of the "expert" commentator and reflects poorly on the journal.

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