

➤ **Imagine my surprise when I saw the bill—\$676 for the drug screen alone.**

Health care reform: Market forces can do better

In his editorial, "Setting the record straight," (*J Fam Pract.* 2010;59:615), Dr. Susman correctly observes that health care reform should cover the uninsured, preexisting conditions, and preventive services, and prohibit denials for the seriously ill. We all agree. He says "ObamaCare" does that, although not perfectly, and labels criticism of the health care package as politics, fiction, and "downright disgusting."

But why does government need to be the instrument by which we achieve these goals? Market forces can do the same thing by making government a partner—not a prosecutor—by legislating interstate competition by insurers; free access to medical savings accounts; and meaningful tort reform. ObamaCare does little of this, especially tort reform.

Dr. Susman implores us to ignore politics and become patient advocates. (Just get the job done any way possible.) But this is irresponsible and impractical.

Forty years ago when I practiced in Canada, I ignored politics and solely advocated for patients. The vast majority of doctors simply accepted the concept of giant government intrusion—and we got it. We got a plan that covered all of Dr. Susman's concerns. But we also got hospital closures, severe rationing, long waiting lists, outdated equipment, confiscatory taxes, and looming bankruptcy. We were zealous, but extremely naïve.

Today, Canada is desperately trying to privatize, while the United States is desperately doing the opposite. Why is it that the same doctors who implore us to practice medicine based on evidence refuse to prac-



tice evidence-based social engineering? How many failed social experiments must these academics witness before they realize that big government can't run health care well?

Calvin Ennis, MD, FAAFP
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Drug testing is inexpensive? Not always, says this doc

As a recently retired physician who worked in family practice, palliative care, and occupational medicine for more than 30 years, I read "Is it time to drug test your chronic pain patient?" (*J Fam Pract.* 2010;59:628-633) with interest. I myself suffer from arthritis in the neck and low back, for which a medical school colleague prescribed a very low dose of hydrocodone prn several years ago. I believe my resident physician may have read your article right before my last office visit; he suggested a drug screen was appropriate for me because hydrocodone is a "high-risk" medication.

I understood, of course, and readily agreed. After all, I did thousands of these screens during my years of practice—at a cost of about \$5 per test. The authors of your article apparently did not research the average retail cost of the test, stating only that it is "inexpensive." Imagine my surprise when I saw the bill—\$676 for the drug screen alone. My insurer readily paid its portion of the "allowable" charge (\$434).

The medication itself is wonderful; it helps keep me functioning and costs me about 8 cents per pill, so I won't complain too much. But I suspect that most of your readers would be surprised by the true cost of this "inexpensive" test at a major medical school.

Mack Tyner, MD
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NPs + FPs: Finding ways to work together

On behalf of the Coalition for Patients' Rights, a national coalition of more than 35 health care organizations, I applaud Dr. Susman's editorial on NP-family physician collaboration ("It's time to collaborate—not compete—with NPs," *J Fam Pract.* 2010;59:672). As our nation searches for ways to ensure quality and access to care for all, we believe that an interdisciplinary approach across professions is in the best interest of Americans.

Positive voices like Dr. Susman's are an important part of advancing the dialogue.

Maureen E. Shekleton, PhD, RN, FAAN
Coalition for Patients' Rights

I started my career with the Indian Health Service, where NPs have worked for many years with MDs. Currently I am with a community health center with too few physicians to see all the patients; we have 4 MDs and



3 NPs. Successful collaboration requires that clinics make decisions about the following:

- Will the NP see urgent care patients primarily—or treat chronic care patients who need lots of education to get their glucose under control, say, or stop smoking?
- Will the NP do routine physicals and leave complex issues for the doctor, or will the MD do all the physicals so that nothing is missed?
- Will the NP practice like an independent provider (within state laws), or team up with an MD and share the caseload?

It's time to move past "should we work with NPs?" and into "how can we best work with NPs?"

Lindley Gifford, MD
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