

Orthopedist urges higher FP pay

As a board-certified orthopedic surgeon who enjoyed a fulfilling and lucrative career, I have great admiration for my colleagues in family medicine. I particularly admire their intense dedication to their patients, for whom they work very hard without ever complaining about their lower reimbursements.

Several years ago, I began a new chapter in my career teaching orthopedics to family medicine residents. I now lecture and precept residents at 6 different programs in Spokane, Washington, and New York City, all on a volunteer basis.

This experience has given me a greater understanding of the difficulties family medicine faces. Just last week, Jessica, a talented resident, told me that she'd been encouraged by friends and faculty advisors to pursue a surgical specialty. The reason? Her grades and evaluations were so high that she could easily qualify for this far more lucrative area of practice. At a time when FPs have such a valuable contribution to make—arguably the most valuable in all of medicine—I can't help but feel that this reflects poorly on the US health care system, and on the academic system that prepares our nation's physicians.

As a member of the Society for Patient-Centered Orthopedic Surgery, I am convinced that substantial improvement in our health care system is possible only if it is primary care-driven. Members of this society believe not only that primary care physicians are underpaid, but that specialists are overpaid. According to a national survey by the Medical Group Management Association, FPs averaged \$189,000 per year in 2010; orthopedists, \$515,000.¹ This inequality is irrational and needs to be corrected.

While many factors influence students' choice of specialty, data show that financial reimbursement plays a key role in this choice. There is a near-perfect correlation between the number of American applicants to various residency programs and the anticipated income earned in those specialties.²

A disproportionate number of specialists compared with primary care providers is the result. Countries that have more balanced

distributions of physicians have medical outcomes that are better than ours, and health care costs that are lower.³

Improving FP reimbursement will not cause students to choose primary care for the wrong reasons. In light of huge educational debt, however, it will allow many more talented students to pursue their dreams in primary care.

I hope that the inequitable reimbursement (and skewed numbers of specialists vs primary care physicians that result) will be addressed by our politicians as we strive to improve our dysfunctional medical system. If our leaders cannot do it, then it falls to those of us within the medical profession to work together to address unequal compensation for the same lifesaving work.

A question I regularly ask my family medicine colleagues is whether it is best for them to remain members of the Relative Value Scale Update Committee (RUC). It is important to realize that the future of the RUC rests with family physicians. If the American Academy of Family Physicians (AAFP) dropped out of the RUC while noting that it was fundamentally unfair to primary care doctors, it is quite likely that the Centers for Medicare and Medicaid Services would find a more equitable solution. Alternatively, family doctors could demand greater representation on the committee and attempt to change it from within.

Either way, I believe it is paramount for the AAFP to assert itself in this debate. Reducing the gross inequity between medical specialties would result in better care for all of our patients.

Robert E. Rutherford, MD
Coeur d'Alene, Idaho

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In praise of high-dose oral B12

"Is high-dose oral B12 a safe and effective alternative to B12 injection?" (Clinical In-



A talented resident was advised to become a surgeon rather than an FP. The reason? She could easily qualify for this more lucrative specialty.

quiries, *J Fam Pract.* 2012;61:162-163) is a well-documented and practical review. I would like to present additional data that may be of interest to family physicians.

Cobalamin (vitamin B12) is absorbed by intrinsic factor-independent passive diffusion. High-dose oral B12 (≥ 1000 mcg/d) can cure cobalamin deficiency, and may also induce and maintain remission in patients with megaloblastic anemia.¹

Two prospective, randomized controlled studies comparing oral and intramuscular (IM) vitamin B12 documented the efficacy of oral B12 as a curative treatment.^{2,3} One study involved 38 patients, several of whom had pernicious anemia (PA), who showed improvement in hematological parameters and vitamin B12 levels after 4 months of oral cyanocobalamin therapy using a higher dose (2000 mcg/d) of cobalamin.² Another involved 60 patients, and reported significant improvement of hematological parameters and vitamin B12 levels after 3 months of oral cyanocobalamin therapy (1000 mcg/d).³

A Cochrane review also supports the efficacy of oral B12 as a curative treatment, with a dose between 1000 and 2000 mcg, initially taken daily and then weekly.⁴ In this analysis, serum vitamin B12 levels increased significantly in patients receiving oral B12, and those taking oral B12 and the IM group showed an improvement in neurological symptoms.⁴

Our working group (CARE B12, Hôpitaux Universitaires de Strasbourg) has developed an effective oral curative treatment for patients presenting with food-cobalamin malabsorption (FCM) and PA, using crystalline cyanocobalamin.¹ In a first study, we prospectively followed 10 patients with cobalamin deficiency and well-established FCM who received 3000 or 5000 mcg oral crystalline cyanocobalamin once a week for at least 3 months. After



3 months, all had increased hemoglobin levels and decreased erythrocyte cell volume. However, 2 patients had only minor, if any, response. Serum cobalamin levels were increased in all 8 patients in whom it was measured.

We also conducted an open study of 10 patients with well-documented cobalamin deficiency related to PA who received 1000 mcg/d oral crystalline cyanocobalamin for at

least 3 months. After 3 months, serum cobalamin levels were increased in all 9 patients in whom it was measured; 8 patients also had increased hemoglobin levels, and all 10 had decreased mean erythrocyte cell volume. Three patients experienced clinical improvements.

Analysis of several other studies has shown that all patients treated with oral B12 corrected their levels of the vitamin and at least two-thirds corrected hematologic abnormalities,¹ and one-third experienced clinical improvement.

We currently recommend that patients with PA take 1000 mcg/d oral cyanocobalamin for life. Oral B12 allows patients to avoid the inconvenience and discomfort of injections. It is less expensive than IM B12 and can be particularly useful for the elderly, and for patients on anticoagulants or antiplatelet agents, for whom IM injections are prohibited.

Emmanuel Andrès, MD
Strasbourg, France

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➤ **Oral B12 allows patients to avoid the inconvenience and discomfort of injections; it is less expensive than intramuscular B12, as well.**