LETTERS

ACGME Wasn't Thinking Ahead

There is no questioning the accuracy of Dr. Sidney Goldstein's comments about the shortage of health professionals, but unfortunately, describing a problem that already is occurring does not suggest a significant insight ("A Dwindling Medical Workforce," January 2006, p. 2).

Having practiced in rural North Carolina, I have observed for years the increasing problem with recruiting physicians and the decrease in their availability to serve an aging population. Ten years ago, there was a move to reduce the number of available medical subspecialists because of the perceived excess of cardiologists and gastroenterologists. These specialists are now in short supply and will become increasingly in demand as our population ages.

The real issue: Why did the Accreditation Council for Graduate Medical Education permit, and actually promote, the reduction in training of physicians in the medical subspecialties? And why did the council permit the rate of physician training to plateau in an era when it was clear that the baby boom generation was rapidly approaching the age of increasing medical need?

It is discouraging for a physician in practice to recognize that individuals in a position of authority failed to anticipate what is clearly now a disaster in the making.

Gary R. Schafer, M.D.
Forest City, N.C.

Gray Zones in Treating the Elderly

Dr. Sidney Goldstein's very important column on treating heart failure in the elderly points out the gray zones in managing the condition in this group of patients ("Heart Failure Guidelines and the Elderly," October 2005, p. 2).

I have been practicing cardiology for more than 30 years and can see the pitfalls in taking a guidelines-based cookbook approach without considering quality of life.

Should we consider placement of automatic implantable cardioverter defibrillators and biventricular pacemakers in nursing-home patients with multiple medical problems and, in some instances, cognitive deficiencies, who have heart failure with ejection fractions less than 30 or 35%?

It imposes a significant moral, ethical, and legal dilemma for us, especially physicians who like to treat the patient rather than an abnormal test. As pointed out in the column, there is concern that "any deviation from the published guidelines will make them vulnerable to litigation." Isn't quality of life much more important than all the increments in quantity of life which the newer technologies bring?

Fareed Khaja, M.D.
Ann Arbor, Mich.

Recovery Audits Invite Fraud

In November 2005 we received a notice from Medicare demanding two "overpayments" of $98.70 and $99.65 for a February 2001 service ("Medicare Audit Is Questioned," February 2006, p. 37).

We paid the amount but have been unable to obtain either a copy of the charges in question or an explanation of benefits. We are stonewalled, even though Medicare claims the record is available, and they will send it. In my experience, when such collections are against accounts that are 4 years old, the charges are often inaccurate. If the contractor collects $60 to $200 from each provider at such a late date, chances are the provider is not going to challenge the payment. Many payments can be fraudulently collected and can provide a substantial profit to these contractors.

Divis K. Khaira, M.D.
Sun City, Ariz.

Registry Is Invasive and Unnecessary

The goals of the New York City health department in developing a diabetes registry are noble, but it will obtain protected health information without patient consent ("NY Diabetes Monitoring Program Raises Privacy Concerns," February 2006, p. 6).

I meet with my diabetics every 3 months to review labs and adjust therapy. What more is the health department going to add? Sure, there are patients who don't keep follow-up appointments or are not compliant with treatment. But if they will not respond to their own physicians, will they respond to a form letter, or to an unknown voice calling on the phone?

A diabetic registry violates patients' privacy, disrupts the doctor-patient relationship, and will prove to be another ineffective, unnecessary government intervention.

Toby Taylor, M.D.
Utica, N.Y.

LETTERS

Letters in response to articles in CARDIOLOGY NEWS and its supplements should include your name and address, affiliation, and conflicts of interest in regard to the topic discussed. Letters may be edited for space and clarity.

Mail: Letters, CARDIOLOGY NEWS, 12230 Wilkins Ave., Rockville, MD 20852

Fax: 301-816-8738

E-mail: cardnews@elsevier.com