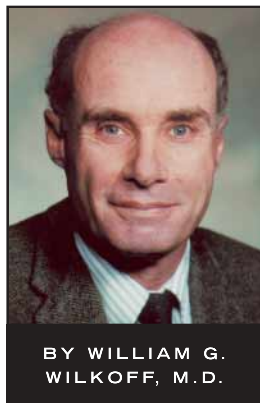
LETTERS FROM MAINE

Keeping Up in a Grand Manner

While in the past I have criticized the American Board of Pediatrics for adopting a proctored, closed-book exam format, I remain deeply appreciative of the board's decision to "grandfather" me and excuse me from the burden of recertification.


BY WILLIAM G. WILKOFF, M.D.

Although I suspect that the decision is based primarily on the old-dog-new-tricks myth, I hope the board also is giving me some partial credit for maturity. Maturity that might allow me to be trusted to keep my clinical skills current without the threat of recertification. Likewise, I hope that my choice of continuing education activities supports the wisdom of the board's decision.

Although the Bureau of Licensure here in Maine requires me to participate in 50 hours of category I educational experiences each year, it doesn't seem to care whether I am learning anything relevant to my practice. In fact, I am sure the bureau would be ecstatic if I went to Fiji and took a 2-week course in the Cosmetic Botoxification of Septuagenarians.

But, as a conscientious grandfather, I have tried to choose activities that are relevant to my daily clinical challenges. However, I am also a bit of a tightwad and hence don't want to invest much money or time in my continuing education activities. Expensive junkets to beautiful vacation spots to sit inside taking classes that may or may not be well taught have lost their appeal.

Being a rather distractible sort as well, I have learned that I can't tolerate the pain and frustration of being cooped up in a classroom (with or without windows) when I know there are recreational activities waiting outside just a few steps away. The odds that I won't stick around after the first coffee break are too high to make traveling for CME courses worth the time and expense.

The three CME activities I have chosen for myself are cheap, handy, and focused. The backbone of my curriculum is Pediatric Notes, the bimonthly letter founded by the late Dr. Sydney Gellis. In its well-chosen and smoothly written abstracts and commentary, I usually find one or two articles that are very relevant to my clinical situation. The open-book tests at the end of the year aren't painless, but at least I can work at my own pace in the comfort of my favorite rocker.

More painful and less relevant are my monthly copies of the American Academy of Pediatrics' Pediatrics in Review. I know that it is important to refresh the withering roots of my basic science education, but it hurts.

As soon as they arrive, I toss them in an old wooden bucket next to my rocker until it's time to subject myself to the torture of modern air travel. The accumulated Reviews give me something to read during those long airport layovers.

On one hand, I view reading them as a masochistic combination of more pain on top of pain. On the other, I see it as paying my dues for the privilege of bicycling on the quiet country roads of southern France.

The newest addition to my CME curriculum doesn't earn me any reportable credits. But, it is probably the most relevant and the most fun. The class meets once a week on Tuesday, when I have a standing invitation to visit my granddaughter, Hannah, who lives a short 10-minute walk away.

There also are numerous unscheduled seminar and lab sessions that meet throughout the week.

Although I see scores of little children each week in the office, it's been 30 years since I have had the chance to observe an infant in the relaxed atmosphere of a home environment.

Last month I relearned how infants learn to solve the problem of getting small bits of food into their mouths. This week's class is dealing with the advanced infantry crawl.

Because I am still struggling not to impose my parenting philosophy on my son and his wife, class participation is limited to tickling, knee-bouncing, and a wide variety of animal sound imitations. Each session is a wonderful opportunity to see if my timeworn advice to other parents still makes sense. And I've discovered some of it doesn't.

I don't know whether the American Board of Pediatrics would consider the changes I have made in my practice style as the result of my CME sessions with little Hannah to be "evidence based." But then, I don't really care because I've truly been grandfathered. ■

DR. WILKOFF *practices general pediatrics in a multispecialty group practice in Brunswick, Maine. To respond to this column, write to Dr. Wilkoff at our editorial offices.*

LETTERS

Make Reflective Practice a Habit

We agree with Dr. William G. Wilkoff that reflection is a "cornerstone … of medical education" ("Reflecting on Education," Letters from Maine, February 2006, p. 25).

While the concept of reflective practice has been a central tenet of adult education since the early 1980s, it has only recently found its way into medical education.

Perhaps the principle of reflection has always been there, but it has not been made explicit. But unless this concept is made explicit, it can't truly be taught or assessed.

Dr. Wilkoff is also right on the money when he states that those of us who teach and see patients need to be consciously thinking about what we are doing (reflection-in-action), what we have done (reflection-on-action), and what we intend to do next time in similar circumstances (reflection-for-action) to improve our performance.

It is this continuous, conscious thought process that will keep the physician on the cutting edge of the "war against disease" and "out of the lawyers' crosshairs."

Dr. Wilkoff seemed to imply, "Here we go again. Those ivory tower academics are giving us yet another issue to think about within the context of our already hectic professional lives!"

Our response is that reflection is a skill and an art, like much in medical practice, and it needs to be learned and mastered. Once mastered, it becomes a habit, a habit that is no more time consuming than medical documentation. Yes, we believe that it is one of those skills essential to quality medical practice. And yes, we believe that we must teach reflection skills to all trainees and physicians. In fact, the focus of reflection is mindful practice, which is how we can better ourselves without feedback from outside observers. It is definitely linked to critical thinking, and like humanism, needs to be a habit and a conscious awareness.

Dr. Wilkoff seems to have bought into the art of reflection by using our article as a way to reflect on his vision of the ideal model in the training of students. While we did not begin to claim that reflective practice might be an impetus to reinvent medical education, we would agree that the concept we introduced, along with Dr.Wilkoff's reflections on medical education, should leave your readers with much food for thought.

And we will be sure to revisit our 74-word sentence!

Margaret Plack, Ed.D.
Larrie Greenberg, M.D.
Washington

Dr. Wilkoff replies:
And here I thought kicking back and having a beer before dinner was a bad habit. Maybe I have been reflecting all these years.

I didn't realize that riding on the cutting edge could be so much fun.

'Pay as You Go' for Vaccines

Dr. Ann Francis hit the nail on the head ("Immunization Access," Guest Editorial, February 2006, p. 30).

As pediatricians, we should not be in the position to ensure the survival of drug companies, nor to underwrite the availability of vaccines to the populace. We are asked to pay cash for vaccines prior to using them and much in advance of receiving payment for them.

Even if a drug company allows me 60-90 days to pay, it may be several months before the vaccine is used, and many months before reimbursement by the insurer.

Our relatively small pediatric practice with five full-time equivalent providers spent almost $500,000 on vaccine purchases in 2005 to get back a "cost plus" return on our investment, plus an administration fee.

God forbid the drug companies have a price increase, and the contracted reimbursement is 6 months in the update.

Each manufacturer has a representative who visits our office twice a month to promote old and new vaccines. I propose that they provide us with vaccines and maintain an inventory of utilization, and that they ask for payment only after the vaccine is used.

As more and more vaccines are added to our armamentarium, our financial outlay may force us to send patients to public health facilities. Then the manufacturers will get the government-contracted rate.

I am curious how other practices see this "pay as you go" method as a solution to the ever-expanding vaccine marketplace, with diminishing returns to pediatricians overall.

Richard A. Levitt, M.D.
Roswell, Ga.

Using Credit Cards for Medical Care

Dr. Joseph S. Eastern's account of using credit cards in medical practices is most intriguing ("How to Slash Accounts Receivable," Guest Editorial, March 2006, p. 23).

We have flirted with the idea and found resistance, but I suspect it is because of duplication and fears of identity theft.

The problem with medical care is always when to pay for it. Balancing preventive medicine costs with catastrophic costs is the dilemma. Preventive medicine is discretionary, and the consumer has no control over the catastrophe. The credit card allows one to choose the time of payment, and generates interest to the credit card company rather than fees to the insurance company. It would be much more efficient if we put all medical care on a credit card. If the interest rates were more reasonable, that could include most catastrophic care. Now all that has to happen is for that to be tax deductible like the premiums businesses pay for employer-paid health insurance. Deal with the politics of that!

John R. Dykers Jr., M.D.
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