Letters to the Editor

The Journal welcomes letters to the editor. If found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with Journal style. All letters that reference a recently published Journal article are sent to the original authors for their reply. If no reply is published, the authors have not responded by date of publication. Send letters to Paul M. Fischer, Editor, The Journal of Family Practice, 519 Pleasant Home Rd, Suite A-3, Augusta, GA 30907-3500, or Fax (706) 855-1107.

DRUG SAMPLES

To the Editor:

Obtaining drug samples used to be so simple: the pharmaceutical representative would stop by the office and leave samples with the receptionist. Now, to get samples, the receptionist is bypassed, and the physician has to stop seeing patients to sign a form and risk getting snagged into hearing a sales pitch, which begins, "Just a few seconds of your time, doctor—I know you're busy."

Before the implementation of the Prescription Drug Marketing Act of 1987 *(21 USC § 353)* no record-keeping of sample distribution was required. The Act was a result of congressional findings that the "existing system of providing drug samples to physicians through manufacturer's representatives has been abused for decades and has resulted in the sale to consumers of misbranded, expired, and adulterated pharmaceuticals."

In solving one problem, the Act has created another. Manufacturers apparently are using the law as a way of increasing promotional efforts by requiring physicians to personally sign for receipt of samples. Each company has its own forms that, according to the representatives, must be signed by a physician. Some companies even require their representatives to witness the signature.

The requirements set forth in section 353(d) of the Act, however, are much different from the representation made by the pharmaceutical industry. The form that is presented for signature is not a receipt, but a request form. The Act states, "Drug samples may only be distributed . . . to practitioners . . . if they make a written *request* for the drug samples . . ." (emphasis added). Except for mailed samples, the Act has no requirement that physicians actually have to sign for *receipt* of prescription samples (telephone conversation with Margaret O'Rourke, Food and Drug Administration, May 26, 1993).

In our office, we have instituted a drug sample formulary, and we use this list to request by letter specific samples from manufacturers. Although the letter meets every requirement of the Act, all manufacturers still require a physician to sign a specific form at the time of delivery, stating that a signature is "required by law."

We believe there are several reasons for this practice. Standard forms make record-keeping easier. It also may be a lack of understanding of the actual Act. However, the primary aim may be to increase contact, or "face-time," between physicians and pharmaceutical representatives to help develop a relationship between them. Thirty seconds of conversation while signing the form may not include any mention of a drug but may help "open the door" the next time the representative has a presentation.

The good intent of Congress to prevent drug diversion has been twisted to serve the promotional goals of the pharmaceutical industry. Clinicians should be aware that they can obtain appropriate drug samples beneficial to their patients (as well as to the drug industry) without being subjected to additional promotional efforts.

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PHYSICIAN SATISFACTION

To the Editor:

I am one of the family physicians who participated in the 1990 survey reported by Skolnik et al *(Skolnik NS, Smith DR, Diamond J. Professional satisfaction and dissatisfaction of family physicians. J Fam Pract 1993; 37:257–63)*. The survey raises several important issues among family physicians regarding the growing need for primary care.

It is truly unfortunate that President Clinton's health care reform plan fails to address many issues that are vital to fostering and promoting primary care. From the questionnaire results, it is obvious that the two biggest negative influences on family physicians are third-party payers and paperwork hassles. President Clinton's plan will still have someone else running the show and paying the tab—call it whatever you like: HMO, PPO, HIPC, or whoever else becomes a major payer in managed care.

According to my former colleagues who participated in managed care contracts, the paperwork hassle is still there—it is just a different kind of paper chase with referral forms, audits, etc. Almost half the physicians surveyed listed malpractice liability as a practice problem as well as a cost issue. There is little meaningful tort reform in the Clinton package because of the strong legal representation among our lawmakers.

More than half of the family physicians feel that they are significantly undercompensated for their time and work. We are asked to perform an integral part in health care provision, management, and cost containment, yet we are "smacked in the face" by a ridiculously disproportionate resource-based relative value scale, which continues to penalize primary care.

So it appears that our politicians will again adopt a Band-Aid approach to health care reform. The problems in our health care delivery system are multifactorial, and the shortage of primary care physicians is just one of them. Nonetheless, it appears that needed ammunition from the "docs in the trenches" is sorely lacking in this "war" waged on our health care delivery system.

As you can see from my address, I am no longer in rural practice in Pennsylvania. I am among 109+ physicians who have left that state in search of relief from the above medical quagmire. I am now employed by a hospital-physician medical group, have minimal third-party and paperwork hassles, am financially just as well off without having to run a medical practice, and have more leisure time to spend with my family. I just hope that one day the politicians will open their eyes and wake up to what is really going on in health care. A copy of these important research studies should be sent to every one of them!

Pasquale D. Baratta, MD
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ASSISTED SUICIDE

To the Editor:

I would like to state my strong ob-

jections to Dr Brody's editorial promoting physician-assisted killing.[1]

"Assisted suicide" and euthanasia of the sick and dying is an ideological idea that is being promoted by a small group who, unfortunately, have many sympathizers in academia. However, like other 20th-century ideologies, it doesn't quite work when used in the real world of imperfect people, as Koenig's article so bluntly points out.[2]

When Brody cites a case of "rational suicide" performed so as not to burden a family, not only is he ignoring the possibility of social pressure, familial coercion, or depression, but also he seems oblivious to the possible impact such ideas would have on society.

Just as environmental-impact investigations precede ecosystem changes, we must discuss what impact euthanasia would have on the social ecology before we permit such a radical social change.

Do we really wish to live in a society where we encourage the elderly, sick, and handicapped to kill themselves—or encourage their families to do so by proxy—so they will not be a burden to their families or to society?[3,4] If we are asked to kill, are we obliged to do so? Do we decide what is right and wrong by behavior polls? If the majority of people approve of a form of killing, does this mean we should ignore our inner instincts and obey society?

Finally, when Brody insists that giving pain medicine to a dying person is the same as killing, your readers should be aware that this argument is used frequently by Dutch physicians to justify direct killing[5]: by minimizing what they are doing to "routine medical practice," they can psychologically "double," seeing their deed not as killing, but as a "healing matter."[6]

The difference, of course, is twofold: the decision by the physician that there is life unworthy of life, and the decision that killing is a therapeutic act in the hands of a physician.

Instead of following the example of the Dutch physicians of 1993, as Dr Brody naively suggests, might I suggest that physicians follow the example of the Dutch physicians of 1940, who were the only group of physicians in Nazi-occupied Europe who completely resisted joining in any of the Nazi euthanasia programs.

> It is to the everlasting honor of the medical profession in Holland that they recognized the earliest and most subtle phases of this attempt and rejected it. . . . They had the foresight to resist before the first step was taken and they acted unanimously and won out in the end. It is obvious that . . . the German medical profession could likewise have resisted had they not taken the fatal first step. It is the first seemingly innocent step away from principle that frequently decides. . . ."[7]

N.K. O'Connor, MD
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2. Koenig HG. Legalizing physician-assisted suicide: some thoughts and concerns. J Fam Pract 1993; 37:171–9.
3. Aldrich NW Jr. Doing the right thing: toward a socially responsible death: Lear's 1991; Oct:74.
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5. Capron AM. Euthanasia in the Netherlands: American observations. Hastings Cent Rep 1992; Mar–Apr:30–3.
6. Lifton RJ. Doubling: the Faustian bargain. In: The Nazi doctors: medical killing and the psychology of genocide. New York: Basic Books, 1986.
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The preceding letter was referred to Dr Brody, who responds as follows:

While all of Dr O'Connor's concerns are highly pertinent to a full exploration of assisted suicide and euthanasia, space permits me to comment on only one issue, which I consider the most urgent. I did not argue, as she claims, that "giving pain medicine to a dying person is the same as killing." In general, when a physician administers analgesia in terminal illness, it is quite clear that the intention is pain relief and not the hastening of death; and the causal role of the medication in hastening the patient's death is purely speculative. Indeed many terminal patients in severe pain surprise everyone by living longer once the pain is relieved. To claim that analgesia equals euthanasia is a very dangerous and counterproductive position if it causes any family physician to hesitate to use narcotics in the high doses that are often required. My questioning of whether administration of "symptom relief" was morally equivalent to euthanasia was confined to one very unusual sort of case—the induction of barbiturate coma under circumstances that strongly suggested that the patient's death was both intended and directly caused by the physician.

Howard Brody, MD, PhD
East Lansing, Michigan

RBRVS

To the Editor:

It was almost comforting to read Dr Proudfoot's analysis of the pitfalls of the Medicare RBRVS payment system *(Proudfoot ML. A critique of the practice-expense values of the resource-based relative value scale. J Fam Pract 1993; 37:57–67).* I knew intuitively that the "gains" primary care doctors were supposed to receive were not showing up at my office, and that after 8 years in practice, office expenses had grown at an incredible rate compared with the pittances of allowable fees. Medicare and Medicaid have gone up maybe 5% to 10% while the costs of electronic billing, insurance clerks, and paperwork have tripled at least. I am seriously considering closing my practice to new Medicare and Medicaid patients to ensure my ability to continue caring for my other patients.

It is ironic that a reform designed to encourage primary care will have the direct opposite effect. I suspect that Medicare patients will soon find themselves in the predicament of most Medicaid patients, unable to find either a primary care doctor who can afford to see them or a specialist willing to provide services at a reduced fee.

I propose a new adage, to be christened "Dr Murphy's Law:" "There is no problem with health care that a little government intervention will not make much worse." RBRVS was supposed to make payment equitable. Instead, as Dr Proudfoot ably demonstrates, the system is severely biased against primary care and office-based physicians. I hope we do not find ourselves in a situation where Dr Murphy's second law will take effect: "Once government intervention has caused a problem to become much worse, the only cure in Washington's eyes is more of the same."

We should never have agreed to the RBRVS or lobbied for it. Who cares if specialists were ridiculously overpaid? Now they're moderately overpaid and we are going bankrupt.

Susan Reynolds, MD
Affton Family Practice
St Louis, Missouri

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Table 1. Percentages Paid by Michigan Reimbursement Systems of National 50th Percentile Physician Fees for Selected Services (All Specialties)*

CPT Code	Service	Michigan Medicare, %	Michigan Medicaid, %	Michigan BC/BS, %
57454	Colposcopy with biopsy	35	30	46
57511	Cryosurgery of cervix	43	36	55
46600	Anoscopy	53	37	17
11100	Skin biopsy	48	30	66
11041	Debride full thickness skin	32	22	43
11622	Skin cancer removal, neck 1.3 cm	41	31	63

**National 50th Percentile Physician Fees from Wasserman Y.[3]*
CPT denotes Current Procedural Terminology; BC/BS, Blue Cross/Blue Shield.
Adapted from Zuber TJ, Pfenninger JL. The reimbursement manual for office procedures: Michigan. Midland, Mich: The National Procedures Institute, 1993.

To the Editor:

I cannot provide enough accolades for the recently published work by Martin L. Proudfoot, MD.[1] This critique reveals some of the flaws in the methodology of the resource-based relative value scales (RBRVS). Future payments derived from historical data that discriminated against primary care services will never create parity in the medical reimbursement system.[1,2]

Informal surveys that I have conducted at national Medicare coding seminars reveal that two thirds of family physicians now feel their Medicare reimbursements are the same or less under the RBRVS system. Family physicians feel betrayed by the system that originally held so much promise. With the rapid acceptance of RBRVS by private insurers, the financial strain may become severe for family physicians.

I believe that primary care physicians must provide competent and cost-effective diagnostic and therapeutic services in any future health care system. The preferred environment for provision of these services is the physician's office. Although the fees for services in the office are frequently reduced, reimbursements do not appear to be keeping pace with escalating practice and regulatory costs. Proudfoot's critique reveals that prejudicial payments under the RBRVS system to hospitals may push procedural services into more costly settings.

Many Michigan insurance carriers pay physicians only a fraction of the national 50th percentile physician fees (Table 1). Despite the estimated cost benefit to providing in-office services (Table 2), insurers have been reluctant to reimburse surgical trays (99070) or other charges that compensate physicians for office costs. Insurers must be encouraged to support the cost-effective delivery of office services.

I encourage family physicians to notify members of Congress about the escalating reimbursement crisis. I have sent a copy of Proudfoot's article to the Michigan congressional delegation. With the current high-level support in Washington for primary care practice, family physicians must seize the opportunity to be heard and to promote change.

Thomas J. Zuber, MD
The National Procedures Institute
Midland, Michigan

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1. Proudfoot ML. A critique of the practice-expense values of the resource-based relative value scale. J Fam Pract 1993; 37:57–67.
2. Zuber TJ, Jones JA. Physician payment reforms and family physicians [letter]. JAMA 1992; 267:2034–5.
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Table 2. Estimated Costs for Services in Offices vs Surgicenters

CPT Code	Service	Office Charges from Estimated National 50th Percentile Physician Fees (All Specialties),* $	Estimated Surgicenter Charges (Total Physician and Surgicenter Facility), $
57520	Conization of cervix	768	2400
55250	Vasectomy	405	1400
43239	Esophagogastroduodenoscopy with biopsy	548	1100
11642	Skin cancer removal, face 1.5 cm.	433	2000

**National 50th Percentile Physician Fees from Wasserman Y.[3]*
CPT denotes Current Procedural Terminology.

The preceding letters were referred to Dr Proudfoot, who responds as follows:

The frustration and pessimism expressed by Dr Reynolds is warranted. As she notes, there is a huge gap between what William Hsiao, PhD, said RBRVS would be and what HCFA made of it.

The government put in motion the process of bankrupting primary care practices with the freezing of the Medicare fee scale in 1984. HCFA said RBRVS would fix the inequities of the old fee scale, but HCFA moved the same underpayment of practice expenses of the 1984 fee scale into RBRVS. As Dr Reynolds notes, physicians with high percentages of Medicare and Medicaid patients in rural and inner-city areas are most affected, and these practices are currently being forced out of business. By 1994, the trend of underpayment of practice expenses for primary care services will have been in place for 10 years. Nothing has occurred since RBRVS was implemented in 1992 to change this trend. Rhetoric touting health care reform as favorable to primary care physicians is not worthy of our trust after HCFA continued the underpayment of practice expenses in its implementation of RBRVS.

Dr Zuber provides data that confirm that HCFA's policy excludes cost-efficient minor surgical practice in the primary care office. HCFA's payment policy forces physicians to do procedures in more expensive hospitals and surgical centers. The flawed national fee scale implemented by HCFA is not a correction for escalating health care costs but one of its causes. Under the government policy that has now been in place for almost 10 years, HCFA policy precludes cost-efficient minor surgical care in the primary care office.

Martin L. Proudfoot, MD
Edmonds, Washington

CONCURRENT CARE

To the Editor:

The editorial on concurrent care *(Bruening WH, Andrew JL, Smith DM. Concurrent care: an ethical issue for family physicians. J Fam Pract 1993; 36:606–8)* was timely and challenging. The premise that the physician-patient relationship is a covenant more than a contract is noteworthy.

To push the point a bit further, imagine that the 70-year-old diabetic in renal failure, or his family, was the direct guarantor of payment. This may be hard to imagine for anyone whose experience is restricted to the kind of tertiary-care–dominated institution described in the editorial, but it is realistic in the county where I practice. When the patient or his family is paying the bills, forces come into play that frequently push the physician into the position of team leader.

Would it be too much to suppose that there may have been an ethical error on the part of the patient or his family in taking for granted remuneration of the physicians by third-party payers? Granted, the diabetic and his family may have lacked the wherewithal, but imagine what the impact on the physician would have been had the patient frankly advised, "Doc, I don't know how I can pay for all this, but I sure appreciate everything you are doing." Maybe then the family doctor would have been at the care conference, even if he knew he wouldn't be paid for it.

Isn't it mutual respect between patient and physician—not ability to pay—that keeps us going?

Peter S. Franklin, MD
Parkman, Ohio

The preceding letter was referred to Dr Bruening, who responds as follows:

We appreciate the letter by Dr Peter S. Franklin on our editorial on concurrent care. We have no basic disagreement with his comments, which prompt further observations.

First, patients do have an obligation to pay for services rendered. Second, practicing medicine in a small town or rural setting may be very different from practicing medicine in a tertiary care setting. Third, the inability of a patient to pay in the setting Franklin describes is most likely not a new scenario to the family practice physician. The doctor and the patient or patient's family have known each other for some time. Fourth, physicians have a professional obligation to do some pro bono work, but there is a practical limit to how much pro bono work a physician can do. Finally, the lack of a third-party payer is not restricted to small-town and rural settings.

We do not believe that a physician should make bedside decisions about a patient's ability to pay. Dr Franklin is absolutely correct when he says that mutual respect is what keeps us going. Of course, that respect is compatible with a covenant notion of patient-physician relationships, but we do not think it is compatible with a contractual notion of that relationship.

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