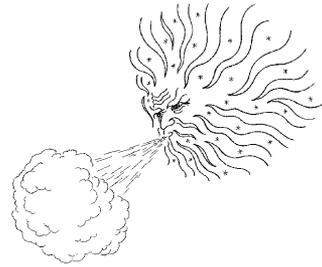




Commentaries

Reimbursement for Experience-Based Medicine



The editor of *Annals of Neurology*, the publication of the American Neurological Association, recently wrote an editorial trying to come to grips with insurance reimbursements being unrelated to experience. As we all know, insurers pay flat rates depending on diagnoses, whether the patient gets good care or not, so long as it is documented care. What I hadn't realized until I read the article was that there is a body of published data that actually tracks "quality" of care in relation to physician's age and duration of practice.

What surprised me was that these data, perhaps not the best epidemiology work extant, indicate that "experience" is *not* associated with improved care, and is often associated with worse outcome.

It's not simply that I'm now an older physician that makes me respond to this like I've heard nails on a chalkboard (a metaphor appropriate for an older person) but rather that I wouldn't have believed that when I was younger, and don't now. When I first started out I used to call my old mentors frequently about troubling cases, refer to the big academic centers for second opinions, and send my EEGs for review. After I got my sea-legs, I reduced my second guessing to a low level, as I learned that when I didn't know something and had an opportunity to research the area, chances were the other guy didn't either.

The literature indicates that younger cardiologists produce better results than older ones, that younger PCPs follow guidelines better than older ones, and that by any criterion of quality or outcome, younger physicians do as well or better than the older ones. On the one hand I can believe this, yet on the other I'm not so sure. Do the older doctors get the more difficult cases? For some of the studies this is clearly not true. Patients were tracked by diagnostic codes in very large numbers using insurance company data.

Obviously I wonder if the older doctors are out of date. We all have to work

harder, see more patients for less money than we used to. This means less time for journal review, attending conferences and "keeping up" in general. This time-crunch means that those more recently trained have less keeping up to do. Perhaps their skills in technical areas are better. Or they perform better on the measuring scales because they were trained with the measuring scales in mind. One of the major philosophical debates regarding "No child left behind" is whether teaching to score better on a standardized exam is of any value other than improving test performance. Some, but clearly not all, of these outcome studies may reflect that. But, on the other hand, how can one measure the physician-patient relationship? How can one compare the reassurance a patient feels from a doctor who has helped hundreds of patients cope with the same problem to one whose experience is limited? Is there any way to compare the experience of returning to a doctor who has had a twenty-year experience with the patient and his family to that of a younger doctor? The doctor-patient relationship is sometimes more important than choosing the first line treatment instead of the second. These are intangible; and we are limited, of course, to measuring what we can measure.

The various medical disciplines have tackled the problem of keeping up to date by re-credentialing exams every 10 years. While I am an ardent supporter of this I have not renounced my "grandfather" clause protection that lets me avoid the process. Am I keeping up? How can I tell? In my own narrow subspecialty I'm pretty confident that I do and I have a number of objective measures to support that. In the wider spectrum of neurology am I up to date? Hard to say. In the academic sphere where one interacts with neurology residents it's much easier. They correct you. They quote the expert with whom they rotated the month before, to tell you what is now timely, perhaps work not yet published. Out in the "real world" it is impossible to be sure.

Should doctors be paid differently based on experience or expertise? Do they do a better job? Evidently not by established measures. Are they less expensive, able to rely more on experience than expensive testing? We don't know. In the academic workplace, pay is based on seniority, and collections. In private practice it is not. The Mayo Clinic, an academic-private practice, has a flat payscale that ignores seniority. I don't think a flat reimbursement is right, again perhaps because of my age. Yet that's what insurers pay. One pays more to an experienced famous lawyer than to a newcomer. Yet if I go to a famous doctor or an unknown one, the fee is the same, unless the doctor refuses insurance. Yet psychiatric fees vary enormously in the big cities, with some doctors charging \$600/hr, and some \$150. They can do this because they refuse insurance. The patient pays out of pocket and the insurance company pays whatever percentage they deem "reasonable." Even when the economy was humming along, this would be impossible in most parts of the country. And if we decide that quality is important, how is that to be determined?

I have thought of abandoning acceptance of insurance, thus reducing overhead enormously and increasing my charges, but then my patients, largely Medicare, almost all insured, would have to pay a lot more; and many of them cannot. Which is why, of course, medicine is so different than law, accounting or other businesses.

If and when our disaster of a healthcare system gets straightened out, this will be another issue that we should confront.

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