LETTERS FROM MAINE

Cost-Conscious Care

BY WILLIAM G. WILKOFF, M.D.

My lifestyle and preferences don't include much television viewing anymore. Certainly for the last 8 years I have completely avoided watching any presidential addresses because I found them very uncomfortable and embarrassing. But this week I found myself watching a rebroadcast of President Obama's address to the American Medical Association.

I like him, and like most Americans, I want him to do well. His speech touched all the bases in the health care ball game, and he was refreshingly frank in sharing his opinions. I wasn't embarrassed that I had voted for him, but some of the things he said made me a little uncomfortable.

I have already shared with you my concerns that electronification of health records is going to be a costly nightmare whose payback won't come until long after President Obama has left office—I'm counting on two terms. The basic premise is worthy, but the systems just aren't out there to do the job. When 40% of physicians are functioning as beta testers, it's going to get ugly.

A second, more subtle discomfort crept out of one of the president's statements that at first blush seems to be unarguable. He promises a system that allows you to be physicians "instead of administrators and accountants." He adds: "You didn't enter this profession to be bean counters and paper pushers. You entered this profession to be healers."

First, any physician who views himself primarily as a healer is suffering from severe ego inflation. But I'll forgive that as a slip of the tongue. However, some—including many physicians—could interpret Mr. Obama's first statement to mean that physicians will no longer need to concern themselves with the cost of the care we provide.

If you haven't read Atul Gawande's most recent article in the New Yorker ("The Cost Conundrum," June 1, 2009), after you finish this column set down PEDIATRIC NEWS and immediately access the article on the Internet. Dr. Gawande explores why the cost of medical care in McAllen, Tex., is twice the national average and twice that in El Paso County, a similar geodemographic area. The quality of care in each area is similar.

What he discovers is that in McAllen, the culture of the medical community has shifted toward the entrepreneurial, health-care-for-profit end of the spectrum. Dr. Gawande observes correctly that physicians learn next to nothing about finance in medical school and that many physicians remain "oblivious to the financial implications of their decisions." But in McAllen, a high percentage of physicians seems to have learned so much about making money in medicine that they have lost the focus on quality.

Good-quality health care doesn't necessarily cost more. In fact, the more I read and observe, the more I find that many expensive tests and interventions are proving to be worthless, and could and should be eliminated.

As appealing as President Obama's promise of financial obliviousness may sound, we don't want to lose sight of the costly ripples and tsunamis of our decisions and interventions. Those of us in solo practice and small groups must understand the concept of overhead to survive. But, even if you are buffered by layers of administration in a large corporation, you have an obligation to know what your patients are paying and why.

As Dr. Gawande observes, "The lesson of high-quality, low-cost care is that someone [I would add all physicians] has to be accountable for the totality of care."

And that includes its cost. ■

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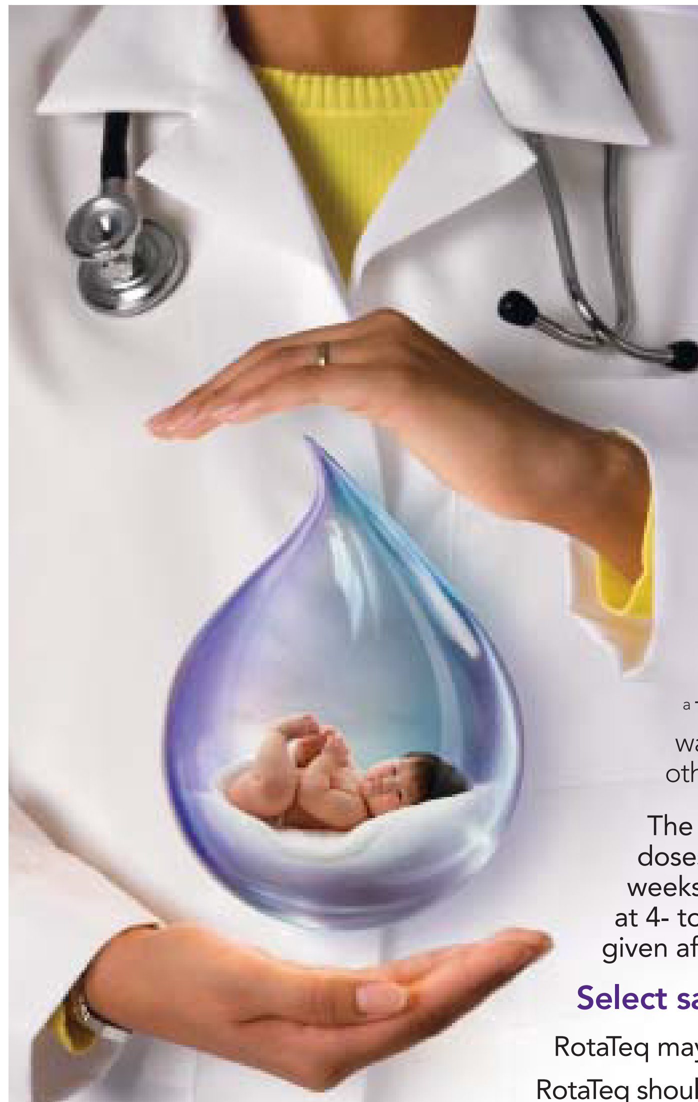

Preventing rotavirus:
An answer may already be in your hands

FACT: RotaTeq is the only rotavirus vaccine with an indication that includes the G2 serotype.

Historically, G2 has been the second most common cause of rotavirus gastroenteritis (RGE) in the United States, after G1.[a]

FACT: RotaTeq is a pentavalent rotavirus vaccine indicated for the prevention of RGE in infants and children caused by the G1, G2, G3, and G4 serotypes.

[a] The distribution of serotypes identified in 1996–1999 was G1, 76.1%; G2, 11%; G3, 2.6%; G4, 1.1%; G9, 4.3%; other, 5%.[1]

The vaccination series consists of 3 ready-to-use liquid doses of RotaTeq administered orally starting at 6 to 12 weeks of age, with the subsequent doses administered at 4- to 10-week intervals. The third dose should not be given after 32 weeks of age.

Select safety information

RotaTeq may not protect all vaccine recipients against rotavirus.

RotaTeq should not be administered to infants with a demonstrated history of hypersensitivity to the vaccine or any component of the vaccine.

No safety or efficacy data are available for the administration of RotaTeq to infants who are potentially immunocompromised, or to infants with a history of gastrointestinal disorders.

Caution is advised when considering whether to administer RotaTeq to individuals with immunodeficient contacts.

No data are available for RotaTeq when administered after exposure to rotavirus.

In clinical trials, the most common adverse events included diarrhea, vomiting, irritability, otitis media, nasopharyngitis, and bronchospasm.

In post-marketing experience, intussusception (including death) and Kawasaki disease have been reported in infants who have received RotaTeq.

Before administering RotaTeq, please read the adjacent Brief Summary of the Prescribing Information.

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Reference: 1. Griffin DD, Kirkwood CD, Parashar UD, et al. Surveillance of rotavirus strains in the United States: identification of unusual strains. *J Clin Microbiol.* 2000;38(7):2784–2787.

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