

LETTERS

Limit Recertification to Subspecialty

Subspecialists should be required to recertify only in their own subspecialty ("Subspecialists Recertifying Only in Own Field," June 2005, p. 21). Further, I think this should be done through take-home modules that we can complete at our pace.

The idea behind recert is for us to keep our knowledge and practice current. General medicine MDs who do core internal medicine every day say that they feel the test questions are often esoteric and do not have much to do with the actual practice of medicine. And the answers can be different based on who wrote the question, whether they were looking for last year's information (when the test was made) or last month's information (when a new article stated something different), etc.

Most subspecialists practice with some internal medicine that is related. But to ask every subspecialist to keep up with every advancement in every field including their own becomes impossible. Physicians send their patients to us because they think we know more about a certain aspect of medicine than they do. To be a good doctor—general or specialist—one has to have gained a good fundamental knowledge of medicine during medical school and residency. Hence, I feel that the time com-

mitment, stress, and cost of certifying in both internal medicine and a subspecialty do not achieve the goal of making better, more updated physicians.

Also, the physicians who certified *many* years ago and are still practicing are not asked to recertify in medicine!

Recertification in one's own subspecialty should be done through required CME from subspecialty meetings and realistic test questions that can be completed in an open book/literature search fashion. A sit-down exam in a hall is not what I look forward to when I am 50, 60, or 70!

Lily Agrawal, M.D.
Downers Grove, Ill.

Fear of Lawsuits Can Cloud Objectivity

I read with great interest Dr. Sidney Goldstein's editorial on implantable cardioverter defibrillators ("Who Should Receive an ICD?" March 2005, p. 2).

Recently I had a patient who qualified for one. I try to go over the pros, cons, and the indications for the procedure itself. I would have liked to have been fully objective as to my recommendations with respect to this therapeutic intervention. But I could not help but think that I should discuss with the patient the possibility that this might not be a good idea for him; that,

God forbid, should the patient die of sudden cardiac death, some distant relative would appear with a malpractice lawyer.

As much as I do not like to admit this to myself, this fear and concern is playing more and more of a part in the medical decision-making process.

Henry Storch, M.D.
Olean, N.Y.

Logic vs. 'Knee-Jerk' Guidelines

I enjoy Dr. Sidney Goldstein's columns, and I especially appreciated his comments about guidelines ("Practice Does Make Perfect," Heart of the Matter, April 2005, p. 2).

He remains upbeat when certain aspects of the medical profession can look so dismal. In spite of all the hype, so often monitoring the patient is superior to the knee-jerk guidelines that we are compelled to follow. I thank Dr. Goldstein for his unusually logical perspectives on the profession, and even on life.

Nick Augenstein, M.D.
Grants, N.M.

Data Collection Takes Time

Your article on the development and impending use of clinical performance measures in the ambulatory care setting sent chills down my spine ("Coalition Defines

Set of 26 Clinical Care Measures," June 2005, p. 20).

I don't want to suggest that development of the performance measures is an unworthy goal or that we aren't all interested in improving quality of care—of course, we are. The chilling part is the sad truth about who is going to pay for and expend valuable time on the collection of these data—it's you and I! We can just add this to the rest of the busywork we already spend 50% of our days on (Medicare equipment forms, [Family and Medical Leave Act] papers, disability paperwork, patient drug assistance forms, etc.).

Stewart Eads, M.D.
North Charleston, S.C.

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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

GUEST EDITORIAL

Allow Hospitals to Pay for Physicians' IT Systems

Physician adoption of electronic health records is woefully inadequate, and current Stark and antikickback laws are part of the problem. Congress should pass reforms that create new exceptions to these statutes so that hospital systems and other entities can choose to provide physicians with health information technology, particularly electronic health records. Such reforms will speed the adoption of health IT, quickly close the "adoption gap" between large and small physician practices, and improve the lives and health care of millions of Americans.

Health IT, especially electronic health records, undoubtedly saves countless lives and vastly improves patient safety and increases access to care—from preventing dangerous drug interactions and other medical errors to identifying best practices and having real-time patient data at the point of care. Study after study demonstrates the stunning power of health IT to improve patient health.

In addition to improving quality, health IT saves the health care system substantial sums of money. A recent study in Health Affairs stated that an interconnected health IT network could save upward of \$80 billion a year. Those are savings that could be used for other priorities, like insuring every American and reducing health care costs for all.

Unfortunately, health IT has not been embraced and championed on a grand scale, despite its impressive outcomes. Ac-

ording to the Centers for Disease Control and Prevention, only 17% of all physicians currently use electronic health records.

The main reason for the lack of widespread adoption is uncertainty about who will pay for the necessary infrastructure. One potential private-sector solution is for large hospital systems and other entities, such as drug manufacturers, to play a major role. They have the resources and prestige to provide community physicians and clinics with the hardware, software, and expertise necessary to move physicians into the information age.

However, as the Government Accountability Office recently reported, "physicians may be reluctant to accept IT resources from a hospital or other provider, knowing that the resources may be viewed as [a financial incentive] and that any referrals the physician subsequently makes to the provider may be viewed as having been made in return for such resources in violation of [Stark and antikickback laws]."

These laws certainly go a long way toward protecting the system—and patients—from fraud and abuse by criminal providers and suppliers. However, by preventing hospitals that are willing to assist community physicians with purchasing health IT, the laws pose a significant barrier to widespread adoption—and to subsequent improvements in health.

To break down this barrier, legislative reforms must be enacted to the Stark and

antikickback statutes to create exceptions that protect hospitals and physicians from prosecution for collaborating on health IT.

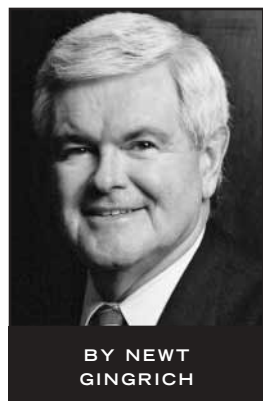
Several bipartisan bills pending in the Senate are promising: Majority Leader Bill Frist (R-Tenn.) and Sen. Hillary Rodham Clinton (D-N.Y.) teamed up on a broad health IT bill with Stark and antikickback reforms. Sen. Chuck Grassley (R-Iowa), Sen. Max Baucus (D-Mont.), Sen. Mike Enzi (R-Wyo.), and Sen. Ted Kennedy (D-Mass.) have also introduced a bill.

To expedite health IT adoption, Congress must make these exceptions available immediately. However, the exceptions should also include a requirement that once data interoperability standards are announced, only technologies that comply with those standards will qualify for an ex-

ception. This will allow doctors to use the technologies to refer their patients to any hospital they choose.

We support Stark and antikickback laws when they seek to protect patients and lower health care costs by eliminating fraud and abuse in the system, but by standing in the way of widespread health IT adoption, these laws are costing countless lives and billions of dollars. It's time to enact health IT exceptions to both of these statutes before even more American lives are lost. ■

MR. GINGRICH was speaker of the U.S. House of Representatives, 1995-1999. He is founder of the Center for Health Transformation, which promotes increased use of health information technology.



BY NEWT GINGRICH

PAIN RELIEVERS



"I already diagnosed myself on the Internet. I'm just here for a second opinion."