

Resignation to Cuts Is Pervasive

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tire as early as I had hoped to. That's a major thing. I think most physicians want to retire around the age of 60 or 62.

"I'm 55 and I just don't see that happening for me."

Dr. Flood said that he worries he won't be able to compensate his small office staff at the level they have come to expect and that he has been proud to offer them.

If the 10% cut to fees under Medicare goes through, "I would probably have to lay some people off in a hurry."

For Dr. Sandeep Gupta, a private practice rheumatologist in Long Beach, N.Y., the most distressing element of the continuing cuts in reimbursement is that "we get paid here to do, not to think." Rheumatology is a cognitive specialty, he said.

Proceduralists will find a way to deal with looming cuts or with reimbursement that doesn't match inflation, Dr. Gupta commented—they'll simply do more procedures. But rheumatologists are in a different situation.

"I actually get paid for my thinking and that seems to be the most endangered portion of medicine. That's the real problem with these cuts. They will teach us to think even less."

Despite his frustration over cuts to Medicare fees, Dr. Gupta, who has been the only rheumatologist in his city of 35,000 people for more than 3 years, said he has become resigned to reimbursement cuts, both those that have already taken place and those slated to take effect this July.

He said he has not felt the need to run a thriftier practice. There is not much fat to cut, anyway. "It just isn't possible. What would you do, you'd start attending all the calls by yourself? That wouldn't happen." He agrees that health care spending is out of control. "A lot of money has to be saved and I'm not against that. But there are lots of other places.

"There are lots of other ways [than cutting reimbursement]."

Nevertheless, despite reports of their colleagues refusing to take on new Medicare patients or even severing ties with their current Medicare patients, none of the three physicians interviewed for this article has opted to go that route—yet.

Dr. Gupta said, "There's no such thing as, 'I'm not going to accept new Medicare patients.' ... If one is closer to retirement one [could do that]."

"But for people who have a prolonged life in medicine ahead of them, it's very hard to plan to not take patients, unless your practice is absolutely full," he added.

Dr. Goldman agreed. "I have not restricted my access to Medicare patients. They can get appointments any time of day. ... I could limit the number of Medicare patients I see, [but] I don't think that's right. There are doctors out here who are not taking Medicare and I say to them, 'What are you going to do when you're 65?'"

Especially frustrating to Dr. Goldman is the seemingly widespread perception among the public and lawmakers that physicians afford a lavish living and are merely whining about a cut in already

large salaries. "We have a very conservative lifestyle," he said, referring to himself and his wife.

Dr. Flood echoed Dr. Goldman's sentiment. "I come from a really poor family," he said. "When I was an intern I was earning more than anyone in my family had ever earned." But times have changed. "[Now,] I make enough to support myself and my wife. We're fairly frugal," he said. "That allows me to pursue my hobby of rheumatology." ■

DATA WATCH

Top 10 Therapeutic Classes by U.S. Sales in 2007, in Billions

Lipid regulators	\$18.4
Proton pump inhibitors	\$14.1
Antipsychotics	\$13.1
Antidepressants	\$11.9
Anticonvulsants	\$10.2
Erythropoietins	\$8.6
Antineoplastic monoclonal antibodies	\$6.8
Angiotensin II antagonists	\$6.6
Anti-arthritis biologic agents	\$5.3
Bisphosphonates	\$4.6

Source: IMS Health

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Are certain patients at greater risk for rapidly progressing RA?

Joint damage is responsible for much of the disability associated with rheumatoid arthritis (RA).¹ Early diagnosis and effective treatment may play a critical role in preventing functional decline and loss of quality of life—especially in patients with poor prognosis.²

The course of radiologic damage in RA is not completely understood. The amount of damage seen on radiographs of RA patients can vary widely. It remains unclear whether erosions and joint space narrowing are equally important in determining degree of radiologic damage. In addition, there is little detailed information on the rate of progression of radiologic abnormalities from disease onset. Some studies suggest a nonlinear, first-order kinetics model with most of the damage progression occurring in the initial years; other studies suggest a linear, stable rate of progression throughout the course of the disease.³

Despite these questions, there is little doubt about the correlation between radiologic damage and disability in RA.¹ Data from 10 prospective, longitudinal studies indicate significant correlations that become more obvious as disease duration increases.¹ It has been suggested that physical disability in early RA is largely determined by disease activity, while in late RA, joint damage plays a more important role.⁴ In addition, patients at risk for long-term disability are those with seropositive erosive disease and high initial average Health Assessment Questionnaire scores.¹

There is a clear case for identifying and treating RA patients early. Finckh, et al, conducted a meta-analysis of 12 studies to examine the correlation between late therapeutic initiation and joint damage. An average delay in treatment start of 9 months altered disease progression over the long term. However, early initiation of therapy reduced radiologic damage, resulting in a dramatically altered disease progression curve. (See Figure 1.)⁵

Despite the evidence that rapidly progressing RA benefits from early and aggressive treatment, early diagnosis has proven difficult in many patients. In many cases, American College of Rheumatology criteria may not be met in patients who nevertheless will deteriorate rapidly.⁶

There are measurable variables at initial visit that can identify patients at high risk for rapid radiologic progression. (See Table 1.) Of particular interest is arthritis of the large joints, especially the knee.⁷ In a Linn-Rasker, et al, regression analysis of 1009 patients, arthritis of the knee at initial presentation was revealed to be a strong predictor of a more destructive course of disease.⁷ Also compelling is a study by Taylor, et al, that demonstrated a clear relationship between sonographic measurements of synovial thickening and vascularity at baseline to magnitude of radiologic joint damage at Week 54.⁸

These markers may present a means to identify rapidly progressing RA patients early in the course of the disease, rather than risking unsuccessful treatment with less aggressive therapies. Early and more aggressive treatment for appropriately identified patients has the potential to reduce further radiologic joint damage and functional decline.²

Figure 1. Early therapeutic initiation alters RA progression over time⁵

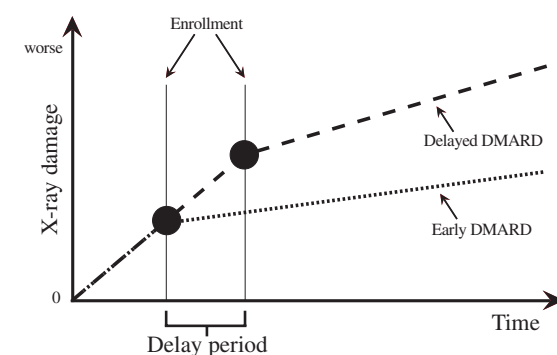


Table 1. Measurable variables at initial visit to identify high-risk patients^{4,6,9}

- Swollen joint count
- Erythrocyte sedimentation rate
- Serum IgM rheumatoid factor
- Arthritis of the large joints, particularly the knee
- Anti-cyclic citrullinated peptide antibodies
- Synovial thickening and vascularity at baseline

References: 1. Scott DL, et al. *Clin Exp Rheumatol*. 2003;21(suppl 31):S20-S27. 2. Quinn MA, et al. *Arthritis Rheum*. 2005;52:27-35. 3. Hulsmans HJM, et al. *Arthritis Rheum*. 2000;43:1927-1940. 4. Jansen LMA, et al. *Ann Rheum Dis*. 2001;60:924-927. 5. Finckh A, et al. *Arthritis Rheum (Arthritis Care Res)*. 2006;55:864-872. 6. Riedemann JP, et al. *Clin Exp Rheumatol*. 2005;23(suppl 39):S69-S76. 7. Linn-Rasker SP, et al. *Ann Rheum Dis*. 2007;66:646-650. 8. Taylor PC, et al. *Arthritis Rheum*. 2004;50:1107-1116. 9. Nishimura K, et al. *Ann Intern Med*. 2007;146:797-808.



800 Ridgeview Drive
Horsham, PA 19044
USA

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